EXAMINING THE MEANING-MAKING OF HIV/AIDS MEDIA CAMPAIGN MESSAGES:
A FEMINIST ETHNOGRAPHY IN GHANA

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ABSTRACT

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This dissertation is an ethnographic study that theorizes the processes and mechanisms through which HIV/AIDS meanings originate in the Ghanaian setting. Whereas AIDS media discourses exemplify dominant representations, I argue that there are other meanings co-constructed by various members of a society. To support this assertion, I provide a fresh focus for mapping how particular individuals in the society symbolically structure their own HIV/AIDS meanings.

I do this by applying postcolonial theories and feminist methodologies. I examine how dominant HIV/AIDS communication messages are received within everyday contexts. I used HIV/AIDS communication materials developed and circulated in Ghana for the past nine years. I used 26 communication materials including posters, television, and radio commercials. These communication materials are a part of two-phase HIV/AIDS National Strategic Framework implemented in Ghana. I engaged different qualitative inquiry approaches such as interviewing, participant observation, direct observation, as well as document review. A total of 39 participants living in the city of Accra were involved in this study.

I used this study to demonstrate that, in the Ghanaian postcolonial context, HIV/AIDS campaign messages interact with particular beliefs and past experiences to become ideas in everyday practices. I also conclude that disciplinary measures such as abstinence, faithfulness, and condom use, that individuals subject themselves to, are
enabled by a web of discourses contained in HIV/AIDS media campaign messages. Also, considering unique colonial experiences and development practices that inform participants understanding of AIDS, I conclude that meaning-making is context specific. Therefore, it is important for HIV/AIDS communication practitioners to acknowledge specific struggles, experiences, and stories that alternative disease interpretations in a particular context suggest.
This work is dedicated to God – for upholding me with the right arm of His righteousness.

To my family – Collins, my loving husband; Ayeyi, my sweet daughter; Nkunim, my newborn son, who symbolizes the victory the Lord has given us.
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Examining the Meaning-Making of HIV/AIDS Media Campaign Messages: A Feminist Ethnography in Ghana

Introduction

I begin this dissertation with some highlights from my fieldwork encounters. A week after arriving in Accra, Ghana, my mum needed to have her medication refilled. I volunteered to get her refill from a nearby pharmacy. This particular pharmacy is one of the popular places I grew up knowing about in the Bubiashie area. Making my way toward the pharmacy I became excited, enjoying every moment of returning “home.” I walked down Mankobia Street, made a sharp turn on to the major road. Here I could hear familiar honking sounds from taxis and trotros (system of mass transit), each trying to gain the attention of potential passengers.

A block away stood a chain of stores at the corner of which is the pharmacy. I walked leisurely towards this retail store still rehearsing the name of the medication. I entered the shop feeling a strong sense of familiarity. The image of shelves carefully stocked with different kinds of medication looked like a picture frozen in time. Not much has changed, I thought. I then tried to recall if the salesperson behind the counter was the same woman I used to buy from years ago. However, the strongest familiarity in this shop was with the old 21 x 30 cm HIV/AIDS sticker posted in front of the register. Standing a foot away from it, I could easily note a resemblance between this sticker and the HIV/AIDS communication materials I was using for this research project.

The walls in this pharmacy were literally clogged with several fairly new stickers, yet the message on the worn AIDS poster drew attention to itself. One could hardly ignore the image of a bold yellow-hand sticking out in between the statement “Stop AIDS, Love Life.” Whereas
other inscriptions on this poster were no longer legible, this statement boldly stood out on the faded gold and black background. The message on this old and beaten poster undoubtedly exerted a strong force echoed in the voices of my research participants. It reminded me of participants who kept repeating the statement, “Stop AIDS, Love Life” during our conversations.

Like many circulating HIV/AIDS messages in the city of Accra, this poster has come to represent the society’s past and present experiences. My numerous conversations with research participants indicate that AIDS is only a recent societal experience among a series of historical encounters with the outside world. Therefore, the epidemiology presents an opportunity for the community to reenact cultural struggles that accompany individual attempts at deciphering obscure global phenomena such as colonialism and the concept of “development.” In distinct ways, the disease symbolizes everyday anxieties, fears, hopes, uncertainties, expectations, beliefs, realities, justifications, and desires that individuals hold in this society.

For about three decades now, ever since the first cases of AIDS were diagnosed, individuals, like my research participants, continue to struggle with the diverse and contradictory meanings the disease generates. The mysterious and life-threatening nature of HIV/AIDS compels us to try to make sense of these meanings. Attempts to map out what this cultural event means have been consequential for many, especially postcolonial subjects who often draw on ambiguous interpretations enabled by both colonial and traditional knowledge systems. In this milieu, researchers must be attentive to the distinct histories and experiences of postcolonial societies when they make inquiries about how exactly HIV/AIDS has become known to these communities.

Obviously, this research project is not the only one that has been conducted about the disease. Research indicates that, unlike other diseases, AIDS attracts enormous scholarly and
popular press investigations (Fee & Fox, 1992). The global outbreak of AIDS created a high
interest level in the medical sciences. Consequently, the discipline produces enormous literature
for purposes of surveillance, diagnosis, and treatment (Triechler, 1999). Although this area of
research is useful for examining the biological nature of the disease, the medical field’s inability
to provide a cure for AIDS has led to a collapse of the prerogative it enjoys over AIDS research.

Accordingly, over the years different disciplines, including scholars in critical
communication (Hart, 2000; Lupton, 1994), have responded to the AIDS phenomenon. Since
the 1980s critical and cultural studies scholars have noted struggles between official and
unofficial representations and meanings of AIDS (Austin, 1990; Crimp, 1998; Hart, 2000;
Lupton, 1994; Triechler, 1988; Watney, 1987). Whereas their works raise pertinent questions
about hegemonic discourses about AIDS, they disregard the active role various constituents play
in a society to co-create meanings for the disease. Hence, they overlook the fact that everyday
AIDS discourses embody struggles that accompany individual meaning-making attempts of any
cultural phenomenon.

As a critical researcher I need to clarify why everyday meaning making of HIV/AIDS has
been the focus of my research for the past four years. I hope this will help explain my investment
in this subject and my research that uses popular HIV/AIDS communication messages to explore
the place everyday AIDS discourses hold in Ghanaian society. In 2002 I began a long journey to
the United States as an international student. In most of my development oriented classes, one
issue kept coming up, HIV/AIDS in Africa. I am not oblivious to the current 3.1% HIV
prevalence rate (Ghana AIDS Commission, 2007) in my country Ghana, nor am I unaware of the
UNAIDS (2007) report that labels Africa as one of the worst hit regions. However, the persistent
association of HIV/AIDS with Africa creates discomfort for me. How and why a global disease
is commonly linked with a specific geographic region, Africa in this case, is an arguable parallel that fascinates me.

Whereas the equating of AIDS with Africa has become common, for me it presents a great opportunity for integrating my academic interests in health communication and postcolonial feminist theory with my personal African experiences. At this intersection, the familiar phrase, “AIDS in Africa,” has not only become outlandish but has also grown to be an entry point where I began to envision broad epistemological questions about everyday experiences. Like Parameswaran (2001), little questions led me to rethink and reconnect the personal with the political.

In this dissertation, the actual question I am motivated to ask is: How do we know what HIV/AIDS is? In other words, how is AIDS constructed as a disease? I am also concerned with how we know it specifically within the Ghanaian context. Although I agree with Treichler (1999) that “AIDS” is not merely an invented label, my postcolonial feminist perspectives push me to explore how the discourse of AIDS has material implications in the everyday lives of people with a colonial past. I am also committed to these broad questions because, like Press (1996), I perceive it as an avenue for understanding the impact a particular culture can have upon me as I observe others of relatively similar backgrounds.

My specific purpose is to theorize the processes and mechanisms that enable and shape particular HIV/AIDS meanings in the Ghanaian setting. Whereas AIDS media discourses exemplify dominant representations, I argue that there are other paradoxical meanings constructed by various groups in the society. To support this assertion, I hope to provide a fresh focus for mapping how particular individuals in the society symbolically structure their own HIV/AIDS meanings. I do this by examining how dominant AIDS communication messages are
received within everyday contexts. I demonstrate that in the Ghanaian postcolonial context HIV/AIDS campaign messages interact with particular beliefs and past experiences to become ideas in the practice of everyday life. Through these arguments, I carve out a unique intersection between health communication, international development communication, and cultural studies.

In order to achieve this aim I am guided by four pertinent questions. First, I looked out for what meaning-making mechanisms are adopted by research participants as they try to understand HIV/AIDS campaign messages. Second, how are HIV/AIDS campaign messages coded in everyday HIV/AIDS discourses? Third, what cultural, social, and historical norms accompany individual HIV/AIDS meanings? Four, why do individuals associate particular representations with HIV/AIDS campaign messages? To help address these questions, the dissertation is divided into five chapters.

Chapter 1 provides the trajectory that made disease outbreak a matter of concern in colonial Africa. It also highlights how both the colonized and the colonizer reacted to epidemics. The chapter reviews literature to demonstrate how epidemics were controlled through the implementation of specific regulations. This chapter uses Foucault’s observation about discipline as an angle for understanding how the colonized African body was controlled during epidemics. This chapter also demonstrates African resistance to these regulations by highlighting Africans’ reactions to Western-imposed medical practices. In addition, chapter 1 conceptualizes sexuality in Africa. This literature is important because sexuality has become one of the many activities used not only to define disease on the African continent but determine the kinds of responses proposed. Furthermore, drawing on Foucault’s (1995) notion of discourse and Said’s (1976) concept of Orientalism, chapter 1 provides a theoretical discussion of disease discourse. The final part of this chapter describes the methodologies adopted in this project.
Chapter 2 provides a history of HIV/AIDS as a disease. It explores the history of AIDS globally and its specific occurrence in Ghana. This chapter also discusses the current status of AIDS in Ghana. In addition, it elaborates on how the government of Ghana has responded to the disease so far. It provides an explanation of the two-phase National Strategic Framework on HIV/AIDS, which has become the national agenda adopted by the government since 2001. This chapter explains the details of the framework, parts of which are currently being implemented. This chapter also uses some of my interviews with senior-level officials to illustrate government’s response to the disease. To offer a background to AIDS responses in Ghana, this chapter discusses the broad “development” framework used to explain the spread of the disease in many developing countries. It also defines how this trajectory impacts health communication research and practice applied to AIDS in these contexts. Drawing on postcolonial perspectives, this chapter also provides an additional critique of dominant “development” frameworks.

Chapter 3 focuses on the narratives of my research participants. This chapter highlights how notions of fear of AIDS lead to specific individual “in/actions.” It tries to understand how/why research participants code, define, and react to HIV/AIDS in particular ways. In doing so, the chapter first explains Gilman’s (1988) thoughts on disease representation. It expands this framework by returning to Foucault’s (1995) conceptualization of bodies under regimes of discipline since this study suggests the adoption of new measures used to discipline bodies to conform into health. Therefore, this chapter returns to Foucault’s notions to demonstrate how the same/similar concepts adopted during the colonial era are re-enacted in contemporary times of disease outbreak.

Chapter 4 presents a cultural reading of three specific HIV/AIDS television advertisements in Ghana that perform sexuality. These scripts are the “Boys’ Night Out,” “Sorry,
No Sex,” and “In the Dark.” This chapter begins with a theoretical discussion on sexuality. It then moves to narrate the three HIV/AIDS television scripts discussed here. This discussion is followed by a comprehensive analysis of sexuality that uses participants’ interpretation of these three scripts. It explores how these scripts conform to or deviate from participants’ sexual experiences and ideologies. In so doing chapter 4 plumbs the cultural relevance AIDS discourses hold by suggesting the contexts within which sexuality takes on meaning. In addition, this chapter uses participants’ sexual experiences to understand gendered power relations that accompany heteronormative sexuality. It also applies a postcolonial feminist theoretical lens to understand ambivalences in certain heterosexual power relations that challenge established notions of inter-gender sexual relations.

The final chapter includes my reflections on the entire research process. It focuses not only on the findings of this research but also on the entire dissertation as a journey. It interweaves the summaries and findings of this project with my personal epistemological, methodological, and political considerations of feminist ethnography. It also highlights isolated fieldwork experiences that led to a rigorous post-fieldwork self-questioning. Most importantly it describes specific fieldwork interactions that define my subject position as a researcher. It also highlights ethnographic situations that reinforce the constant negotiation of class, cultural, and educational differences (i.e., material, social, and political power differences) between me, the researcher, and participants. This chapter considers various affinities my cultural and social capital allowed me to have with participants. Chapter 5 also uses my research experiences in a postcolonial context to echo the need for attentiveness to histories of colonialism and development. It also discusses the limitations of feminist ethnography while envisioning new direction for this project’s future, an approach that critically engages both theory and practice.
Chapter One: Disease in the Colony

Explaining and Reacting to Disease Outbreak in Colonial Africa

This chapter focuses on the path that made disease outbreak a matter of concern in colonial Africa. It uses Foucault’s observation about discipline and punishment as an angle for understanding how the colonized African body was controlled during epidemics. This chapter also demonstrates the African resistance to these regulations by highlighting Africans’ reactions to Western-imposed medical practices. In addition, this chapter conceptualizes sexuality in Africa. Drawing on Michel Foucault’s (1978) notion of discourse and Edward Said’s concept of Orientalism (1976), it further provides a theoretical discussion of disease discourse. The final part of this chapter presents the methodologies adopted in this project.

Headrick (1994) argues that the impact of colonialism on health conditions in Africa is complex. Thus, it will not be enough for me to simply compare colonial pandemic contexts with postcolonial pandemic situations, neither will it be appropriate to simply discuss literature on the imposition of Western concepts of disease on traditional African perspectives. However, all these are necessary within an encompassing framework for understanding how contemporary pandemic situations are conceptualized in any African community (Headrick, 1994). To illustrate this complex theorization, I draw on medical discourse, historical works, and colonial and cultural studies.

Africa and Europe had centuries of trade relations characterized by the exchange of goods and services that preceded colonization. However, relations between these two global regions became different during the colonial period. Hall (1997) describes colonization as the advancement of European powers for the control of territories, markets, and raw materials during the period of high imperialism. During this period, Europe became the colonizer and took control
of resources (labor, raw materials and so forth) in Africa needed for European economic development (Headrick, 1994). Therefore, during the colonial era, economic transactions and social relations were no longer “mutual.” Also, African ways of living were coercively changed in the name of education and civilization that intentionally served the colonizer’s economic and political goals (Hall, 1997; Headrick, 1994). Even though Africans resisted to the best of their abilities, the struggle was hardly considered to be on an equal footing given that, both metaphorically and literally, Africans were fighting with spears while Europeans used guns.

Furthermore, disruptions that accompanied the colonial takeover are usually described as drastic considering the speed and thoroughness with which the penetration was executed (Headrick, 1994). Although most regions of the African continent were colonized, tropical Africa is said to have been one of the last regions to experience formal European colonialism, which occurred between the 1870s and 1920. On the West African coast, however, the Gold Coast, now Ghana, was the first British colony to be established in 1874 (Pellow, 1999). Ghana is also among the first countries to gain independence from British colonial rule during the mid 1950s.

In highlighting the significance of colonial penetration of Africa, Headrick (1994) identifies material and cultural changes in African health conditions during the colonial era. She discusses changes in health status from four different angles. First, she comments on the most basic, which is biological. The second is political and economic, and she looks at health changes that occurred as by-products of administrative decisions. The third is the effects of medicine and health services. Finally, she discusses health conditions during the colonial period from a cultural perspective, addressing how people, raised in a particular traditional milieu, viewed what was happening (Headrick, 1994).
Drawing on these perspectives, scholars discuss one of two things about health conditions within African colonies. Some researchers emphasize how increased intercommunication during the colonial period induced a complex interchange of diseases within colonial states (Curtin, 1968; Headrick, 1994; Pellow, 1999; Tilley, 2004). Other scholars, however, highlight responses and reactions of both colonial subjects and colonial masters to disease outbreak (Burnet, 1962; Farley, 1991; Field, 1937; Headrick, 1994; Heaton & Falola, 2006; Patterson, 1981; Quinn, 1979; Summers, 1991; Vaughan, 1991; Worboys, 2001).

Discussions on possible interchange of diseases are premised on the unprecedented numbers of Europeans who either passed through or were stationed in the African region during the colonial era. During the colonial days, people frequently moved from place to place since the new colonial administration required constant movement of administrative staff from one African region to another (Headrick, 1994; Vaughan, 1991). In addition, Pellow (1999) argues that by the eighteenth century, mixed unions in European coastal settlements had become a common phenomenon. Scholars avow high mobility of populations and potential interactions facilitated the introduction and exchange of diseases (Headrick, 1994; Pellow, 1999; Vaughan, 1991). Historical examples include the outbreak of sleeping sickness across the African continent, which occurred immediately after the colonial intrusion (Headrick, 1994; Pellow, 1999; Tilley, 2004). In addition, diseases like small pox and syphilis are said to have occurred after the onset of colonialism (Headrick, 1994; Pellow, 1999; Tilley, 2004). The following section of this chapter draws on various theoretical observations to examine how the colonized African body was controlled during epidemics.
Disciplining the Colonized Body

Sociocultural representations of disease are understood since their symbolic meanings are socially created and shared. In practice, such symbolic representations are fully realized through images of the sick body. This is because the body serves as a visual medium for meanings assigned to a particular disease. Consequently, Gilman (1988) argues that throughout history, diseases ranging from madness to sexually transmitted infections, such as AIDS, have all been depicted through the use of the sick human body.

By functioning as a repository of meanings for disease, the body, during epidemics, is easily interpreted as a threat to social order, particularly public health. Therefore, to help maintain stability during epidemic situations, the body, whether sick or not, is freely occupied, scrutinized, analyzed, and disciplined through the implementation of particular structures. In this complex web of disease interpretation and societal response, it is important for this project to explore the role bodies play in both the construction and the maintenance of power relations. This inquiry is even more plausible within the colonial context.

To help explain the key position the body can assume in contexts where power is at play, I draw on Grosz’s (1994) conceptualization of what the body as an entity is. In her book, *Volatile Bodies: Toward a Corporeal Feminism*, Grosz emphasizes the peculiarity of the body, describing it as an object that is able to take itself, as well as others, as subjects. This process of bodily subjectification enables bodies to become centers of perspective, insight, reflection, desire, and agency (Grosz, 1994). Grosz’s observation opens up an angle for understanding attitudes directed toward particular bodies as actions that hold deeper meanings beyond themselves. Her conceptualization also confirms the need for exploring disease responses that target particular
bodies, especially responses that created the pervasive image of a silenced and wounded African body during the colonial era (Boehmer, 1993).

To help provide an understanding of the deeper meanings colonized bodies held during the colonial period, I turn to studies that examine several colonizers’ responses to disease outbreak in African colonies (Farley, 1991; Worboys, 2001). Farley (1991) describes the colonizers’ response to disease in the colony as an “imperial triad” of “definition, imposition, and non-involvement” (p. 293). Here, health problems and solutions were a preserve of Western-style medical practitioners (Farley, 1991). Expanding on this notion, scholars such as Worboys (2001) perceive colonial medical responses as an enterprise much broader than merely an imperial triad. First, colonial medical responses are also considered as a vehicle that enabled the spread of Western Christianity through the efforts of medical missionaries (Worboys, 2001). Second, they can be described as a means through which medical ideas, practices, and institutions of modernization were imposed on colonial societies and indigenous cultures (Worboys, 2001). The third and final perspective recognizes colonial medical responses as the work that state and voluntary institutions undertook, albeit unevenly, to protect the health and welfare of African peoples (Worboys, 2001). These other perspectives, Worboys believes, project Western-style medical practices in the colony as both mission and mandate.

Although these arguments lay a good groundwork for understanding colonial responses to disease, they also call attention to specific medical structures which demonstrate how power hierarchies play out in these missions and mandates. Using distinct situations in the history of colonial Africa, I argue that Western-style response to disease in Africa was a cultural force that exercised its Eurocentric missions and mandates by targeting the African body. To demonstrate this argument, I move to discuss specific and historical disease response structures implemented
in various colonial African contexts. These are instances that highlight how sick African bodies and entire movement of colonized populations were regulated. These examples not only speak to how the colonizers disciplined colonized bodies but also how they maintained power hierarchies within the colonial environment.

In studying the history of epidemics in Ghana, Scott (1965) identifies two plagues that occurred in 1908 and 1924. Colonial reaction to these plagues indicates the imposition of a Western-style response and how it impacted on the everyday lives and movement of the colonized. According to Scott (1965), one of the first actions taken by the colonial government was to seek expert assistance. Sir W. J. Simpson was, therefore, sent from London in 1924. Upon arrival, Simpson tried to contain the epidemic within the vicinity of Accra, to prevent dissemination either by sea or by land. To this end, he established a “sanitary cordon” through which no one could pass without a valid certificate of vaccination against plague (Scott, 1965, p. 7).

This exercise in Ghana is similar to the Belgian Congo case where the movement of sick people, especially to uninfected regions, required the use of health passports (Headrick, 1994). To require a certificate of vaccination or health passport before movement to specific places is allowed suggests an element of force. In other words, movement from one place to another required the use of an official document only acquired through an imposed structure of certification or vaccination. This means the process did not allow people to choose willingly to be vaccinated. On the contrary, they were obliged to get vaccinated if they wanted to move from place to place.

Furthermore, to ensure that such forced restrictions were sufficiently adhered to, other colonial administrations legalized their health requirements. This was a process that provided
legal support for the colonizer to be actively involved in the private matters of the colonized. For instance, in Uganda when syphilis was declared a “Dangerous Disease” in 1909, the colonial administration instituted ordinances that legally forced people to undergo examinations (Summers, 1991, p. 793). During medical inspection, when evidence of a sexually transmitted disease was found on an individual, he/she was required to undergo treatments (Summers, 1991). In cases where people refused to go for weekly syphilis shots or daily gonorrhea treatments, the local chief was authorized to have them hauled in for treatment (Summers, 1991). These examples display a rather complex structure that purports to address disease but also enforces hierarchical structures of power through impositions and restrictions.

I theorize this intricate pattern of disease control drawing on Foucault’s notion of discipline, surveillance, and panopticism. Applying Foucault’s (1995) framework of “discipline,” these colonial methods of segregation, isolation, scrutiny, and forced treatments can be appropriately described as general formulas of power mechanisms. Foucault defines power mechanisms as a means through which one may exercise a hold over others’ bodies so that they may operate as one wishes, with the “techniques, the speed and the efficiency that one determines” (Foucault, 1995, p. 138). Evidently, colonial masters used these techniques to protect their boundaries from disease infiltration. However, at this point, I would like to explore the political utility such power mechanisms can hold in a colonial context.

In *Discipline and Punish: The Birth of the Prison*, Foucault (1995) captures details of epidemic situations in Western societies where similar techniques were used to curtail diseases. He observes that disciplinary measures meticulously control the operations of the body and also assure “the constant subjection of its forces,” by imposing upon them a relation of “docility-utility” (p. 137). Akin to African colonial instances, disease outbreak in the Western
communities called for strict partial partitioning, ceaseless inspection, alerted gaze everywhere, and the erection of observation posts (Foucault, 1995). Besides the fact that such techniques were operating in both Western and non-Western societies, Foucault draws attention to the immediacy of power in such instances. He describes the power in operation as exceptional; it is not only mobilized against “evil” (disease), but it also makes itself present and visible everywhere with the body as its target (Foucault, 1995, p. 205).

Foucault (1995) theorizes the presence of power by presenting vivid descriptions of what happens when plague hits. He states:

Power is exercised without division, according to a continuous hierarchical figure, in which each individual is constantly located, examined and distributed among the living beings, the sick and the dead – all this constitutes a compact model of the disciplinary mechanism. The plague is met by order; that of the disease, which is to sort out every possible confusion. (p. 197)

Within the colonial context, sanitary cordons, vaccination passports, and legal structures became established disciplinary mechanisms that dealt with plagues. In practice, these techniques granted mobility only to the “healthy” bodies. To a large extent, restrictions, requisitions, and consequences that accompany these techniques demonstrate the urgency with which disease responses were implemented. To “be allowed” or “not to be allowed” to move from one place to another required the colonizer’s endorsement, an approval process that examines the body to determine its position – either as “healthy” or “sick.” Essentially, prognosis and treatments were not willful ventures but forced undertakings.
In addition to overt disease prevention mechanisms, historical accounts suggest colonial power was enacted through health campaigns in different ways. Thus, for instance, scholars such as Vaughan (1991) would argue health campaigns are no different from other blatant disciplinary regimes. Subtly operating from a distance, campaigns were used to bring healthcare directly to the people instead of waiting for them to report to fixed centers (Vaughan, 1991). Through campaigns, the colonizer was able to contain and prevent disease (Patterson, 1981; Vaughan, 1991); this meant a regulation of the behavior of the colonized.

To highlight simultaneously the effectiveness of campaigns as a power technique and a surveillance apparatus, I draw on Foucault’s (1995) theorizing of the “panoptic schema” (p. 205). Whereas the element of power in campaign strategies may not be visible, it can be nicely described as a “panoptic schema” operating more or less as a “generalizable model of functioning” (Foucault, 1995, p. 205). Foucault defines panopticon as a mechanism of power reduced to its ideal form: “its functioning, abstracted from any obstacle, resistance or friction” (p. 205). Through mass mechanisms, the panopticon enforces local control and mastery of the body based on the notion of perfect visibility and internalized discipline. The usefulness of this schema lies in its ability to reduce the number of people who exercise it, while increasing the number of those on whom it is exercised (Foucault, 1995).

Equally, public health campaigns intending to make behavioral change were used to reach large numbers of Africans during the colonial era. In her text, *Curing Their Ills; Colonial Power and African Illness*, Vaughan (1991) observes that colonial campaigns conceived of Africans as an undifferentiated mass, a part of a dangerous environment that needed to be controlled and contained. Evidently, colonizers used campaigns to deal with the large multiplicity of Africans on whose bodies particular forms of “behavior” were to “be imposed”
Considering its intended purposes, Vaughan (1991) claims that health campaigns became an integral part of the “aggressive expressions of colonial power” (p. 43). Therefore, public health measures were, by definition, administrative as much as medical. In other words, the medical officer in colonial Africa was “indistinguishable from the administrator in the eyes of the African community” (Vaughan, 1991, p. 43).

In African disease contexts, the overwhelming presence of colonial power, constantly positioning, scrutinizing, and distributing colonized bodies – both sick and healthy – is important in specific ways. In a way, it demonstrates the contradictions of colonial relations and processes: power and vulnerability, visions and realities. Although the colonizers hold power, their panicky reactions indicate their vulnerability, as well. The colonizers’ frustrations, fears, and anxieties that emerge from the ambiguous colonial process were vented on the colonized body. Clearly, the colonizers were protecting both the “self-boundaries” and the geographic boundaries from disease infiltration. Disease was a threat not only to the colonized but to the colonizer as well. Therefore, in some cases, priority was given to protecting the health of European functionaries, soldiers, traders, and managers to support the political and economic health of each colony (Worboys, 2001).

A colonizers’ ability to protect colonial boundaries also meant defending their interests and empire. Colonial “powers believed that until epidemics could be stopped, tropical Africa’s economic future hung in the balance” (Tilley, 2004, p. 23). In this regard, Tilley (2004) observes that disease outbreak was one of the most unsettling experiences the French, British, German, Belgian, and the Portuguese powers faced in the first decade of the twentieth century. For instance, Grischow (2006) argues that in the Gold Coast (now Ghana), the British colonizer’s
reactions were driven by the fear that sicknesses would threaten labor supply and the agricultural potential of its Northern Territories (Grischow, 2006).

In addition, the control of bodily movements suggests the continuous and constant operation of colonial power in everyday experiences. Instances where a basic human act – mobility – requires the colonizer’s endorsement depicts the extent to which the lives of the colonized people were suppressed. They are also important because they have become historical miniatures through which we capture the ambiguities and contradictions of colonial life experiences. In distinct ways, these historical constructions demonstrate how the colonial process blurred the public/private and the personal/political lives of the colonized. Health conditions of the colonized that needed to remain confidential were rendered public/political through forced examinations and treatments.

_African Resistance or Compliance?_

Describing the colonizer’s powerful command over epidemic situations should by no means negate agency and resistance demonstrated by the colonized. In many cases, scholars examine and use colonial authority to theorize agency and resistance by signaling out gaps and anxieties in its operations (Biccum, 2002; Cooper, 1994). In order to pry apart ways in which colonial power was contested, scholars have documented the cultural and political significance of African reactions to imposed Western-style medicine during disease outbreaks (Headrick, 1994; Quinn, 1979; Summers, 1991; Vaughan, 1991; Worboys, 2001).

According to Patterson (1981), African reactions to disease were generally informed by prevailing societal perspectives on illness which differed from Western ones. This observation is very much in keeping with details Quinn (1979) provides about how the “Dahomian” people, a West African community, reacted to the appearance of smallpox in their society. For citizens of
Dahomey, smallpox was a problem much more than a bodily illness. According to Quinn (1979), African commentaries suggest the Dahomian people applied a metaphysical reasoning toward their explanation of disease outbreak. Therefore, the spread of smallpox was attributed to one of two reasons. First, the presence of smallpox meant a woman/man or a community had violated either religious norms concerning the community or the ancestors. Second, the community could attribute it to the work of a sorcerer. Such prognosis, in turn, determined which gods or ancestors, local cults, or witchcraft were affected. In compliance with this definition, treatment is generally a prescribed sacrifice for resolving or re-establishing order (Heaton & Falola, 2006; Quinn, 1979).

Within this framework, metaphysical interpretations and judgments are used as a means by which “individuals and the society achieve equilibrium” (Quinn, 1979, p. 34). Patterson (1981) also argues that whereas this African notion accords disease a pivotal place in the network of beliefs, the European thought views the sick person as one whose health interferes with the ability to work or to fulfill social roles. Unlike the latter, the former also allows for the demonstration of communal solidarity, personal integration, and spiritual balance (Patterson, 1981; Quinn, 1979). Evidently, each ideology functions within different epistemologies of knowledge formation within the respective communities.

Distinctions between traditional African disease concepts, on one hand, and Western notions, on the other, carry crucial ramifications for choices Africans made and the paradoxes they entailed. When options were available, Africans had to decide between a variety of practices, which included both traditional African healing systems and Western medicine (Headrick, 1994; Patterson, 1981; Vaughan, 1991). In selecting, Patterson (1981) believes Africans demonstrated varying levels of receptivity toward the Western healthcare system. Some
Africans preferred their own familiar medicines to the alien customs of the Europeans and by resisting imposed Western treatments, they remained relatively unaffected by modern medicine (Patterson, 1981; Worboys, 2001).

In addition, Summers (1991) argues that modern medical interventions which met strong African resistance were treatments that undermine core African morals. By portraying modern forms of medicine as “objective,” Western treatments became inconsistent with specific contextual belief systems the African populations were accustomed to. Therefore, the imposition of Western medical treatments did not only destabilize African disease interpretations and treatment options but also intervened and violated traditional customs of African lives (Summers, 1991). In Uganda, for instance, the official medical service had little success in reaching women as a category of patients because their relatives shielded them from the compulsory examination, notification, and treatment programs (Summers, 1991). These strategies were believed to be problematic because they bypassed African families to aim treatment and propaganda at individuals (Summers, 1991).

In painting a broad picture, Worboys (2001) asserts that Africans were not only reactive and defensive to Western medicine. According to him those who adopted modern medicine did so cautiously and in a pragmatic manner. To reinforce this sentiment, Patterson (1981) asserts that many Africans took an eclectic approach, seeking the best elements of various medical systems. Thus, African healers and patients were found to have proactively selected and synthesized options available to them (Worboys, 2001). In this regard, scholars argue that even though African healing systems were flexible and adaptive, they were also resilient (Patterson, 1981; Vaughan, 1991; Worboys, 2001).
While addressing the subject of African reactions to Western medicine, Vaughan (1991) argues for a wider awareness that Africa was not a blank slate on which biomedicine drew its designs. She writes:

African people were engaged with the practices of biomedicine, and at times engaged in the elaboration of the biomedical discourse on Africa. Biomedicine, we must remember, was practiced not only on Africans but by Africans, and is therefore, in some senses, as African as other healing systems practiced on the continent. (p. 203)

She further debates, Africans’ participation in the colonial biomedical discourse does not necessarily indicate compliance. Instead, their involvement was often a necessary step toward resistance and the forging of new identities through resistance (Vaughan, 1991).

Vaughan’s (1991) account of such African contestations nicely fits Homi Bhabha’s (1994) treatment of “mimicry” (p. 85). According to Bhabha (1994), mimicry “emerges as one of the most elusive and effective strategies of colonial power and knowledge” (p. 85). It is conceptualized as the colonial desire for a reformed and recognizable Other; the Other, who is the subject of difference, is almost the same but not quite. Here the colonized, who is reformed, to an extent, is seen to be acting as if White, but not quite; because he still needs to be recognized as the Other (Bhabha, 1994; Cooper, 1991).

Among other things, this concept helps us theorize how Africans absorbed those elements of biomedical practice which seemed effective and impressive (Vaughan, 1991) while maintaining specific traditional African practices. The notion of mimicry draws attention toward inexplicable aspects of colonization that seek to reform and regulate the African, and yet keep him/her recognizable and different from the colonizer (Cooper, 1994). The point where the
African conforms to Western ways, but is still recognized as the Other, can be described as the new identity. A person’s ability to synthesize both Western and African healing systems leads toward the forging of a new form of African identity, an identity totally different from the colonizer.

During the colonial era, these inexplicable points of double articulation, ambivalence, and disavowal are known to have destabilized the colonizer’s view of boundaries and control (Bhabha, 1994; Cooper, 1994) and possibly led to resistance. This is a resistance that constitutes a powerful force that identifies mobile and transitory points of struggle, producing cleavages in a society that shifts about, fracturing unities and effecting regroupings (Cooper, 1994). In the current atmosphere of postcolonial pessimism, I argue that such transitory points of struggle linger in African communities, albeit differently.

In other words, power and identity struggles that accompany experiences and encounters with disease outbreak is not a thing of the past. But, ideologies and norms that accompanied the processes through which Africans made meaning of and reacted to epidemics during the colonial era are very much a part of contemporary African lives. I argue that, just as colonial reactions to disease serve as a “referendum on attitudes toward the colonial enterprise” (Headrick, 1994, p. 35) so does contemporary reaction to the AIDS pandemic indicate individual responses to modern structures of control – political, economic and social – evident through the discourses the disease generates in societies.
Using Sexuality to Define Disease in Africa

The advent of AIDS in Africa, with its highly sexualized dimensions, has made it more possible today, than before, to examine how sexuality is used to conceptualize disease on the continent. Historically, discussions on African sexuality have been framed in two ways. On the one hand, African sexuality is defined as a primitive, uncontrolled, and excessive practice that carries a deadly disease (Vaughan, 1991). On the other hand, the supposed primitiveness of African sexuality is perceived to be reassuringly innocent (Vaughan, 1991). The danger, according to this viewpoint, resides rather in the degeneration of this innocent sexuality which is seen to have come about through social and economic changes of colonialism (Vaughan, 1991). Accordingly, sexuality in Africa is perceived either as noble or ignoble (Becker, 2005).

Despite differences in perspectives, both frames mirror more general representations of the African society, Vaughan (1991) argues. They essentially “other” African sexuality as something that belongs to the realm of nature (Becker, 2005). Within this general construction, the Black man, like the Black woman, is defined as quintessentially sexual, albeit in different ways (Arnfred, 2005). The Black man’s sexuality is not only perceived as perverse, but he is also represented as virile and promiscuous (Reid & Walker, 2005). The primary object of his desires, unfortunately, is the “subordinate, child bearing African woman” (Reid & Walker, 2005, p. 186).

From such theses as this emerged a false dichotomy that contrasts African sexuality with Western sexuality. Work done by Caldwell and his research associates emphasize this distinction (Caldwell, Caldwell, & Orubuloye, 1992; Caldwell, Caldwell, & Quiggin, 1989). To demonstrate that sexuality in Africa is different from Eurasian sexuality, Caldwell et al. (1989) argue Africa is a coherent society, “indeed, an alternative civilization – very different in its workings, including its patterns of sexual behavior” (p. 185). These authors contrast African sexuality and
Eurasian sexuality, arguing that the latter attaches moral and religious value to sexual activity. However, sexual activity in Africa is free with no moral attachments. They also believe fairly permissive sexual attitudes are found generally across sub-Saharan Africa (Caldwell, Caldwell, & Quiggin, 1989).

These assertions continue to provoke scholarly debates (Ahlberg, 1994; Heald, 1995; Reid & Walker, 2005). Responding to Caldwell, Arnfred (2005) argues that Caldwell’s definitions function to co-construct that which is European/Western as modern, rational, and civilized. Scholars also caution that these categorizations, which are typical of colonial discourses, are fed by sexual anxieties, fears, desires, and fantasies usually projected on to men and women on the African continent (Arnfred, 2005; Reid & Walker, 2005). The connectivity between sexual anxieties and the colonial encounter leads to the belief that colonial disgust always bears the imprint of sexual desire (Young, 1995).

In critiquing the colonial encounter in Black Skin, White Masks, Frantz Fanon (1967) describes colonial objectification of the Black man as basically sexualized. He believes it is crucial to give considerable importance to the sexual phenomena if one needs to understand the racial situation from the perspective of individual consciousness. His study makes us recognize how the same object can be a repository of both disgust and desire. Fanon claims desire and repugnance occur simultaneously because both are evoked by contact; and contact alone is enough to evoke anxiety, which leads to a conflict between desire and aversion. Therefore, the colonial encounter presents a push pull situation. Whereas the fundamentals of the colonial process suggests a push away from the colonized subject, the element of contact inherent in the same colonial process also initiates sexual attraction – touching, caresses, and sexuality (Fanon, 1967).
Fanon continues to clarify the paradox inherent in the colonial process using his observations of how White women behaved when they were among Black men at dances. According to him, most women made involuntary gestures of flight with their faces filled with fear. However, the Black man who asked them to dance would have been unable to commit any act at all against them at that point. Nonetheless, the White woman’s anxieties would make them react in this manner because in relation to the Negro, everything takes place on the “genital level,” meaning she (the White girl) is nothing but a putative sexual partner as far as the Black man is concerned (p. 157).

According to Fanon (1967), such anxieties emerge from the White man’s understanding that:

For the Negros, they have tremendous sexual powers. What do you expect with all the freedom they have in their jungles! They copulate at all times and in all places. They are really genital. They have so many children that they cannot even count them …. For the sexual potency of the Negro is hallucinating. (p. 157)

The constant rehearsal of such myths makes sexuality an integral part not only of the colonial encounter but also of other contemporary interracial, gendered, sexual, and class relations and discourses. It is important to note that the practice of these myths has expanded over the years. They are not only attributed to the Black man/woman, they are also projected on to commercial sex workers and gay/lesbians, categories of people whose sexuality we know less about. Therefore, anxieties about the Other’s unknown sexual practices are used as a framework for interpreting sexualized diseases.

For the colonial state, concerns about the Other’s sexuality led to the establishment of constitutive relationships between sexualities in political and economic contexts which contained
and controlled sexuality (Phillips, 2005). Therefore, colonial domination also came to involve scrutiny of intimate relations (Shoepf, 1995). To ensure its effectiveness, Phillips (2005) asserts, “colonial companies and governments carefully formulated and enforced rules about who should, could, or could not marry, and about who could or could not have sex with whom, where, and when” (p. 293). Regulations that occurred in Britain during the Victorian period, for instance, illustrate how this played out. Laws enacted during this era addressed different areas including contagious diseases (CD) (Phillips, 2005). The CD acts and ordinances regulated prostitution in designated areas and required female prostitutes to submit to medical inspections and confined those diagnosed with syphilis or gonorrhea to detention wards.

While the legacy of colonial sexual anxieties exists, the appearance of HIV/AIDS, a highly sexualized disease, in Africa has not only redefined understandings of sexuality in Africa, but has also given renewed impetus to its complexity (Reid & Walker, 2005). I therefore use my conversations with research participants as an opportunity to seek out some of these complex notions of sexuality. Also, because my reading of the literature suggests sexuality as one contested area in colonial and postcolonial discourses, it would be inappropriate to simply emphasize the identification of colonial sexual images as negative or positive. Instead, I try to understand the processes of subjectification that these stereotypical discourses have made plausible in contemporary times. I also examine how these notions are contested. In the next section I theorize how disease discourse emerges in a society.

*Theoretical Thoughts on Disease Discourse*

AIDS has generated multiple discourses, meanings, and stories that overlap, intersect, and contradict (Treichler, 1988). Unpacking these does not only demonstrate the complex ways through which everyday meanings and representations emerge, but also indicates how a
discourse can be “prescribed, precluded, shut down or opened up” (Clark, 2006, p. 462) in a society. The fundamentals of these mechanisms and processes are adequately explained by Foucault’s (1978) conception of discourse and Said’s (1976) concept of Orientalism.

In the Foucauldian (1978) sense, discourse is conceptualized as a cultural construct produced and symbolically structured by all members of a society. It is a complex network of relationships between individuals, texts, ideas, and institutions, with each node having an impact, to varying degrees, on other nodes, and on the dynamics of the discourse as a whole (Clark, 2006; Olsson, 2007; Rabinow, 1984). Although this is not a deterministic statement of a causal relationship between various facets of society (Clark, 2006; Olsson, 2007; Rabinow, 1984), it still suggests prevailing power struggles.

When the issue of power is connected with discourses, it is easy to assume specific institutions (media and scientific) determine societal discourses when it comes to a disease such as HIV/AIDS. What this presumption disregards is the active role played by individual members within the societal structure. To reinforce the involvement of individuals in this meaning-creation process, Gilman (1988) argues individuals make sense of deadly diseases by personally constructing boundaries between themselves and those categories of individuals whom they believe (or hope) to be more at risk than they are (Gilman, 1988). Obviously, the endeavor to distance oneself from disease well informs the individual discourses, meanings, and representations created for the phenomenon.

Even though discourse can easily be conceptualized as an abstract theoretical construction, Foucault (1978) emphasizes that any discourse is inextricably tied to its particular sociohistorical context and cannot be studied or understood if divorced from this context. This conception draws from the fundamental belief that no universal understanding exists beyond any
historical and societal contexts. Evidently, discursive frames suggest established relations between any cultural and historical context and particular material subjects or realities (Mohanty, 1988; Olsson, 2007). This notion of discourse does not only perceive discursive frameworks as a social practice but also sees them as being “simultaneously reflective and constitutive of frameworks of meaning. As such social conditions are viewed as giving rise to the forms of talk available” (Clark, 2006, p. 463).

This argument holds a lot of relevance for discussions on HIV/AIDS discourses. Although AIDS is a global disease, it has become obvious that the very act of “seeing disease” is socially coded in many complicated ways (Gilman, 1988, p. 3). This means the kinds “of talk” available for explaining a disease entity will be based on the specific societal contexts. Thus, postcolonial citizens draw from their colonial past and geographical contexts for particular discursive resources that best explain the disease for them. Furthermore, in contemporary times, we need to realize that social crises (like “diseases” such as HIV/AIDS) are not just historically situated. However, Clark (2006) argues they are “structured by political economies and institutions (global, national, familial – gendered and racialized) and inextricably meshed with the social ideologies and cultural codes within particular contextual parameters” (p. 464). The fact that this global crisis is interconnected with social and political ideologies calls into question epistemological, methodological, and political implications of knowledge production about the “Other.”

Said’s (1976) conception of Orientalism is instrumental for unpacking how the “Cultural Other” – that is, people suffering from AIDS and the disease itself – is discursively represented. According to Said (1976), the idea of the Orient is not only a “tradition of thought” but also a created “body of theory and practice” functioning as an accepted system of knowledge about the
Orient (p. 132). Here, a society becomes conscious of the Orient only through this knowledge system. Similarly, our understandings of AIDS cannot “exist apart from the practices that conceptualize it, represent it, and respond to it” (Crimp, 1988, p. 3). In prying apart this mechanism of knowing, the question of why we know the patient suffering from HIV/AIDS only in and through particular practices becomes crucial (Crimp, 1988). In other words, through what “exclusionary process” is the reality about HIV/AIDS mediated to us (Clark, 2006, p. 463)?

The concept of representation is often used to respond to these questions. Even though several scholars have been actively involved in the representation crises movement, I particularly draw from postcolonial scholars (Mohanty, 1988; Said, 1976, 1994, 2005). Taken as a philosophical subject, the idea of representation implies prior assumption of difference between reality and its doubles. This conception presents two issues. First, the idea of difference raises concerns about a degree of fit between reality and its reproduction in the mind. Second, it validates an extant distance between the knower and the known (Fabian, 1990; Hall, 1997). This later theorization of difference is analogous to Said’s (2005) premise of “exteriority” (p. 87). He argues that if knowledge about the Orient is said or written and if the Orientalist describes the Orient and renders its mysteries plain, then the “Orientalist is outside the Orient, both as an existential and as a moral fact” (p. 87).

This theory makes “representation” the principal product of “exteriority,” between the Orientalist and the Orient (Said, 2005, p. 87). In this case, we can choose to either focus on the level of accuracy between a reality and its depiction by the Orientalist or spotlight discursive regularities we identify within various Orientalist depictions of a particular reality. Even though I understand each of these perspectives, I am convinced by Said’s (2005) argument for an emphasis on internal consistency of Orientalism and its ideas about the Orient despite or beyond
any correspondence, or the lack thereof, with a “real” Orient. He suggests that emphasis should not be placed on evidence of representations as “natural” depictions of the Orient, or correctness of the representation to some great original, but on “styles, figures of speech, setting, narrative devices, historical and social circumstances” (p. 87).

Said’s (2005) argument parallels a suggestion made by Treichler (1992) concerning AIDS representations. She suggests that “if we relinquish the compulsion to separate true representations of AIDS from false ones and concentrate instead on representations and discursive production, we begin to sort out how particular versions of truth are produced and sustained, and what cultural work they do in given contexts” (Treichler, 1992, p. 385). I also believe that emphasis on discursive regularities can present a higher level of abstraction for understanding HIV/AIDS meanings.

The concept of power has also been crucial for understanding Orientalism. Said (1994) argues that ideas, cultures, and histories cannot be understood or studied without their force, or more precisely their configurations of power, also being studied. This is because Orientalism depends for its strategy on a flexible positional superiority. He believes the relationship between the Occident and the Orient is a relationship of power, of domination, of varying degrees of complex relations. He states that the Occident is studied in the academy “for display in the museum, for reconstruction in the colonial office, for theoretical illustration in anthropological, biological, linguistic, racial and historical theses about mankind and the universe, for instances of economic and sociological theories of development” (p. 132). Although this is indicative more of the North-South power dynamics, it is similar to how the bodies of those suffering from HIV/AIDS are locally examined and scrutinized by others. Also, it presents a crucial nexus for
drawing attention to the larger terrain of interconnected forces within global and local spaces (Shome & Hegde, 2002).

Said’s (1994) argument for power is by no means in direct, corresponding relationship with political power in the raw. Rather, he believes discourses are produced and exist in an uneven exchange with various kinds of power – “power cultural,” “power moral,” and “power intellectual” (p. 132). Like Foucault, he shifts the ordinary consideration of power to include ways of saying and knowing. In this milieu, power must be understood as a multiplicity of force relations that can be found everywhere and embraces everything (Foucault, 1978).

I hope to use this study to demonstrate how specific contexts do inform the diverse meanings ascribed to HIV/AIDS. Before I do this, I detail out the methodology applied in this study in the next section.

Methodology

Expanding the Scope of Ethnography

Ethnography, as a method, follows traditions in anthropology. However, two scholars are acknowledged as establishing modern ethnographic standards (Boas, 1928; Malinowski, 1945). Building upon their works, later scholars, including several communication studies scholars, have produced a methodologically sophisticated form of interpretive ethnography that opens the way for contemporary ethnographic theories (Conquergood, 1991; Denzin, 1997; Madison, 2005; Thomas, 1993).

Current theories of ethnography emphasize subjective human experience, contingencies of truth claims, value-laden inquiry, and local knowledge (Conquergood, 1991; Geertz, 2003; Madison, 2005; Press, 1996). In compliance with these elements, Conquergood (1991) describes ethnography as an “embodied practice” wherein the “embodied researcher” becomes the instrument (p. 180). This form of ethnography emphasizes specific dimensions in research. It
foregrounds the experiencing body situated in time, place, and history (Conquergood, 1991; Lengel, 1999; Madison, 2005). The “situatedness” of ethnography, among other things, takes the researcher close to important issues and attitudes expressed and contested in gesture, ritual, artifact, symbolic action, and words during the research process.

The bodily nature of ethnographic research has been embraced by various feminist scholars (Abu-Lughod, 1990; Lengel, 1999; Parameswaran, 2001; Radway, 2000). In a historical review, Visweswaran (1997) defines feminist ethnography as a process that “foregrounds the question of social inequality vis-à-vis the lives of men, women, and children” (p. 593). According to Visweswaran (1997), the affinity between feminist theory and social movements hints that “women should not be seen as sole subjects, authors, or audiences of feminist ethnography” (p. 593). To reflect the expansive nature of feminist ethnography, some advocate that various writing forms can be used to script women’s ethnography (Abu-Lughod, 1990; Behar & Gordon, 1995; Finn, 1995; Hernandez, 1995). Others also elaborate upon the question of culture by addressing how women as historical subjects actively engage with a particular culture (Behar & Gordon, 1995; Narayan, 1997; Parameswaran, 2001; Radway, 2000).

Even though a historical perspective on feminist ethnography is crucial, Lengel (1999) acknowledges the need to also look at “contemporary moves toward criticism and self-reflexivity” (p. 229). This is a critical turn in the study of feminist ethnographies that builds upon the overall problematics generated by feminist research; it highlights issues through feminist perspectives and also examines sources of social power (Harding, 1997). This process requires the inquirer’s class, race, culture, gender, assumptions, and beliefs to be placed in the same critical plane as the overt subject matter (Harding, 1997). Therefore, through this rigorous self-
reflexivity, feminists are able to question their positions in the field and also interrogate notions of “Self” and “Other” (Lengel, 1999, p. 230).

**Toward a Postcolonial Feminist Ethnography**

Among feminist ethnographies that interrogate “Self/Other” is a growing body of works by Third World women who (situated in Western Academy) return home to study their own cultures (Gajjala, 2004; Khan, 2001; Minh-ha, 1989; Narayan, 1997; Ong, 1995; Parameswaran, 2001; Spivak, 1994). Given the relationship between anthropology and imperialism (Kanneh, 1998), and the linked Orientalist representations, these postcolonial feminists wrestle with the implications that a native/outsider ethnographic research can hold. They highlight the politics of location and representation associated with such attempts (Khan, 2001; Lal, 1999; Minh-ha, 1989; Narayan, 1997; Ong, 1995; Parameswaran, 2001).

Regarding location, postcolonial feminist researchers grapple with their bifurcated and hyphenated selves (Harding, 1997; Malik, 2003; Nfah-Abbenyi, 1999). Usually, Western education, on the surface, places such scholars in advantageous social and class positions. They are also required to assume epistemic privilege and give authentic native accounts which sometimes indulge the problematics of the twin senses of “speaking for” and “making present” (Natrajan & Parameswaran, 1997). Furthermore, this dilemma is deepened by the postcolonial feminists’ gender(ed) and postcolonial identities (Nfah-Abbenyi, 1999). Having the “crises of representation” at the back of their minds, postcolonial feminists emphasize the need to situate research responses within larger historical and social contexts that can frame meaning and also avoid the risk of perpetuating stereotypes (Malik, 2003). Given the overwhelming depiction of Third World people as passive, Natrajan and Parameswaran (1997) suggest ethnographies should acknowledge that “people have always been actively participating and making choices in their lives, prior to, and outside of the scholarly work of representation” (p. 43).
Drawing from this line of research, I am particularly conscious that this study on HIV/AIDS in Ghana can easily reinforce free-floating perceptions that construct Africa as disease fraught (Heaton & Falola, 2006; Jarosz, 1992; Khan, 2001). However, to seek out and also analyze such grand narratives, I apply theoretical foundations rooted in African feminism, a methodological framework that allows me to paint the contemporary picture of AIDS in Ghana alongside a specific African historical context. In so doing, I specifically draw from Ama Ata Aidoo’s critical and creative works (Aidoo, 1999; Dzokoto & Adams, 2007; Ivory, 2003; McWilliams, 1999; Nfah-Abbenyi, 1999; Uwakweh, 1999).

Ama Ata Aidoo is a well-known Ghanaian novelist, playwright, and poet. Her critical and creative writings led to the development of an African feminism which is not only based on the cultural traditions of the community and the region but also relates the political to the personal (Azodo & Wilentz, 1999). Aidoo is identified as one of the African women pioneers addressing the fact that a Western feminism may not be appropriate for all peoples at all times (Azodo & Wilentz, 1999). Rather, she turns to her own Akan cultural milieu to examine what in that culture could direct an indigenous women’s movement that would make sense to the people (Azodo & Wilentz, 1999). Consequently, she has become a strong voice in African and international politics (Azodo & Wilentz, 1999). Furthermore, Aidoo attempts in her fictional works to (re)cover and (re)member Africa’s history in relation to colonial experiences. She uses this perspective as a vantage point for reviewing and evaluating the consequences of colonialism and its impact on the postindependence phase of African history (Odamtten, 1994).

Aidoo’s postcolonial, gendered, and indigenous theorizing (Aidoo, 1999; Dzokoto & Adams, 2007; Ivory, 2003; McWilliams, 1999; Nfah-Abbenyi, 1999; Uwakweh, 1999) allows for broadly conceptualizing disease and representation within the Ghanaian postcolonial context.
Also Aidoo’s works (1965, 1970, 1999), some of which I studied in high school, can be placed among “ethnographies of women,” a body of work that deliberately uses narrative devices to relay a “woman’s point of view” (Viswesaran, 1999, p. 603).

In different essays, Finn (1995) and Hernandez (1995) emphasize how the multiple and nuanced voices of women as ethnographers and writers blurs distinctions between the two forms of genre – critical fiction and ethnography. The gray area between ethnography and critical African writing has been previously established by Kanneh’s (1998) work, *African Identities: Race, Nation and Culture in Ethnography, Pan-Africanism and Black Literature*. In this text, Kanneh pays attention to connections between fictional African novels and ethnography. She argues both forms of genre should be seen as a nexus for re-articulating culturally and socially mediated ideological material.

From this perspective, Aidoo’s works can be described as an “insider’s anthropology” which does not only articulate colonial structures of knowledge but also opens itself up for alternative realities of postcolonial cultures (Kanneh, 1998, p. 23). Through narrative devices, Aidoo creates a dynamic way through which others can “read women within culture” (Wilentz, 1999, p. 6) and also know her views about her society and her life (Abu-Lughod, 1990). In a similar vein, ethnography is defined as a form of inquiry and writing that produces descriptions and accounts about ways of life of the writer and those written about (Denzin, 1997). For instance, in the critical essay, “Unwelcome pals and decorative slaves or glimpses of women as writers and characters in contemporary African Literature” Aidoo turns the personal hurt she feels from the silence of the African community on her critical works into a forceful critique. In this piece, she problematizes her experiences as a woman writer in postcolonial Africa during the 1970s and 1980s (Aidoo, 1999; Wilentz 1999). Aidoo believes that such critical attempts can

Like Aidoo, my methodological approach partly draws upon my personal experiences growing up, my schooling, and working within the Ghanaian postcolonial context. I insert myself in this methodology and explore what disease means to individuals in Ghana. This methodological grounding provides a distinctive reading of HIV/AIDS within the Ghanaian culture as a complex reality. It highlights how HIV/AIDS representation in Ghana is informed by the multifarious nature of this particular non-Western cultural context. In addition, this approach creates an alternative space for retelling the story of HIV/AIDS in Africa, which is different from the totalizing discourses we encounter in the West. It does this by critically engaging the everyday lives of participants in a different way – a political way through which the struggles of Third World people are acknowledged (Balmurli & Parameswaran, 1997).

In addition, alternative knowledge is produced through this ethnographic process which views research participants as cultural producers capable of self-knowledge, people whose voices, views, and dilemmas insist on being heard (Balmurli & Parameswaran, 1997; Benson & Nagar, 2006; Narayan, 1997; Spivak, 1994). Furthermore, through the self-reflexivity feminist ethnography offers, I have the opportunity to articulate my views on HIV/AIDS representations in Ghana using my personal experiences from living and also “returning” to this society.

The Research Approach

In an effort to develop the potential depth that ethnography offers, this study engages different qualitative inquiry approaches. It employs the interviewing method, participant observation, direct observation, as well as document review. In the following paragraphs I describe the research site, the specific approaches employed, and the HIV/AIDS communication materials used in this study.
Research Site

The study was conducted in the city of Accra, located in the Greater Accra region of Ghana. The Greater Accra region is the prime administrative, educational, industrial, and commercial center in Ghana (Ministry of Local Government, 2006). The population of Accra (1.7 million) is more than one-half (57.1%) of the total population in the Greater Accra region (Ministry of Local Government, 2006). This population is almost evenly distributed among men (50.2%) and women (49.8%) (Ministry of Local Government, 2006). Greater Accra also has the highest (63%) literacy rate in the country. Seventy-one percent of men in this region are literate compared with 54% of women (Ministry of Local Government, 2006). This region is the most diverse province in Ghana. Major ethnic groups represented in this province are the Ga-Adangbe group (48%), Akan (15%), and Ewe (12%). Two major religions represented in this region are Christianity (83%) and Islam (10.2%) (Ministry of Local Government, 2006). In addition, Greater Accra is the most urbanized (83%) and developed province with ready access to medical facilities. Like all other regions in Ghana, Greater Accra continues to record HIV/AIDS prevalence. In 2001, the region recorded 16% cumulative HIV cases (Agyei - Mensah, 2001; Ghana Health Service, 2006; Ministry of Local Government, 2006). According to the 2007 Ghana HIV Sentinel Survey Report, the Greater Accra region recorded a 3.4 % HIV prevalence rate in 2007.

Accra is heavily impacted by HIV/AIDS communication messages as indicated by the circulation of HIV/AIDS communication materials. It demonstrates that Accra has not been left out of the two-phase HIV/AIDS National Strategic Framework implemented in the country. The first phase of the National Strategic Framework was executed between 2001 and 2005, and the second framework began in 2006 and is expected to end in 2010 (Ghana AIDS Commission, 2005). In addition, Accra is known to not only embody the nation’s economic trends but also to
epitomize social and cultural transformations in the nation. The contemporary nature of the city is very relevant to this study on HIV/AIDS, a disease described as a modern-day pandemic. Some of the other reasons why Accra was chosen are less academic in nature but are nevertheless suggestive of a much deeper personal investment in the study. I once lived and worked in this city, where I had the opportunity to conduct different research projects.

Fieldwork

Fieldwork was conducted during the months of December 2007 and January 2008. I began the research process by first contacting and recruiting research participants. Research participants were recruited in different ways. In November 2007 I e-mailed copies of recruitment slips to two former research colleagues in Ghana who had agreed to begin the process of recruitment before my arrival. Through word-of-mouth these colleagues were able to recruit some participants before my arrival in Accra. They used the recruitment slip to inform participants about the study and to obtain basic demographic and contact details from potential participants. Upon my arrival, I again contacted these participants through phone calls to confirm interview date, time, and venue.

I also contacted additional participants at their homes, offices, shops, and salons to recruit for and request participation. During recruitment interviews, I obtained basic demographic and contact information. I explained that the purpose of the study was to gather individual interpretations of HIV/AIDS as a disease. I also gave copies of the consent form to those who were willing to participate. I read them the contents, explaining that participation was completely voluntary, and their answers would remain confidential. The document also explained that risks associated with this study are no greater than those encountered in daily life. I then scheduled a specific date, time, and venue where I would meet participants for the interviews.
To ensure that this research process was to be conducted in an ethical manner, I had to seek approval from the Human Subject Review Board at Bowling Green State University. I obtained an approval of the letter of consent (included in the Appendix A) made available to participants. Also, necessary precautions were taken to protect research participants’ anonymity and safety by using pseudonyms.

Selection/Description of Research Participants

A total of 39 participants living in the city of Accra were involved in this study. I randomly selected 19 females and 20 males to reflect the almost evenly distributed gender breakdown of the Accra population. Also, to be able to acquire a broad spectrum of ideas from different age groups, I randomly selected 20 young adults between 18 and 25 years of age. The other half (19 participants) were also age 26 years and older. Since the study was conducted in English language, I intentionally selected participants who had obtained at least senior secondary education. Nine of them were still students at various levels – college, polytechnic, and vocational.

Participants in the workforce were also involved in different occupations such as teaching, sales, secretarial, and industrial services. Participants’ ability to express themselves in the English language was important because all the communication materials were in English. The participants come from different ethnic backgrounds – Akan, Ewe, Dagomba, and Ga. Research participants were from both Muslim and Christian faiths. Despite their level of literacy most of these participants could be described as average Ghanaians who belong to the low income class. Talking to average Ghanaians was important because they brought everyday perspectives to the subject of HIV/AIDS in Ghana.

It is important to note that four participants involved in the study were senior-level officers from four organizations – Ghana AIDS Commission, CARE International, Ghana Social
Marketing Foundation, and West Africa AIDS Foundation. These are organizations that focus on addressing the problem of HIV/AIDS in Ghana. All four participants have attained higher education degrees. Two of them are medical doctors involved with treatment, care, and support for People Living with AIDS (PLWA). The other two also work in the area of policymaking, research, and implementation of HIV/AIDS related strategies. These senior-level officers were involved because their perspectives on HIV/AIDS in Ghana helped me better understand AIDS programs being implemented in Ghana.

*The Researcher*

At this point it is important for me to locate myself as a researcher interacting with these participants. I am a Ghanaian woman born in Ghana. I had my basic, secondary, as well as university education in Ghana. I am of *Akan* descent. I am also a Christian. I worked as a researcher in Accra, Ghana until 2002 when I moved to the United States to pursue further studies. I am currently a Ph.D candidate at Bowling Green State University. I returned home in 2007 purposely to conduct this HIV/AIDS study.

Positioning myself in this manner is important because I believe my class, race, culture, gender, assumptions, and values impact the lens through which I investigate the matter of AIDS in Ghana. This is worth mentioning because Conquergood (1991) believes ethnography is an embodied practice wherein the researcher becomes the main instrument of the study. Therefore, my perspectives as a Ghanaian woman, student in the United States, and a Postcolonial feminist greatly influences my interpretation of the information I gathered from the field.

In addition, I want this project to be seen both as an “insider’s” and an “outsider’s” inquiry that produces descriptions and accounts about ways of life of me (the researcher) and the participants. I want to use this project as a venue for understanding the impact that the Ghanaian
culture had upon me as I observe people with relatively similar backgrounds (Press, 1996). Whereas my class and educational levels were similar to that of the four senior-level members I interviewed, I would describe myself as different from the other participants. For instance, only a few of the participants were in the process of acquiring a degree from a University. The highest level of education that most of them had acquired was at the senior secondary level. Hence, my status as a PhD candidate was above ordinary for most of my participants.

Despite the distinct class and educational differences, I found other affinities I share with participants. My literacy in specific social relations and local languages in the Ghanaian setting offered me a subject position that partially connected me with participants at various levels of the ethnographic interaction. Apart from the English language I could interact with participants on a very casual note using local languages. I could also understand some of the “aside” conversations participants engaged in. I believe such affinities simultaneously enabled me to recognize that which strongly binds me with participants and that which disconnects us (Enslin, 1994). In this case I became both an “insider” and an “outsider”. Moreover, I could understand several gestures that participants performed during my interactions with them.

*Structured Interviews*

I conducted structured interviews with the four senior-level officers who participated. Three of these interviews were conducted through face-to-face encounters. Two of the interviews were conducted in participants’ offices. The third was held over lunch at a hotel. Due to a busy schedule, the fourth individual had to respond to my structured questions through e-mails. The structured interviews include my conversations with the Director General of Ghana AIDS Commission and the Research and Monitoring Officer of Ghana Social Marketing Foundation. I
also interviewed the HIV/AIDS and Health Advisor for CARE International, Ghana/Togo/Benin. In addition, I interviewed the medical doctor of West Africa AIDS Foundation (WAAF).

These interviews followed pre-established questions I had developed for each of the individuals. The structured interviews centered on their organizations’ role in educating the public about HIV/AIDS, as well as providing care, support, and treatment for people living with AIDS. Interviews with these individuals provided a broader framework for situating responses from the general public.

*Unstructured Interviews/Participant Observation/Direct Participation*

The unstructured interviews were conducted in two formats; group interviews and one-on-one interviews. Group interviews were mostly conducted among research participants who already had social ties with each other. Most participants were either friends or family members, who knew each other before the interviews. This means that participants within such group interview sessions were already familiar with other participants. In all, I conducted 6 group interviews which involved 33 participants. Each group interview session had between 3 and 6 participants. Two of the groups consisted of female participants, 2 were made up of males, and the other 2 groups had both female and male participants. The group interviews took place either at participants’ homes, local bars, or church premises. Sometime we also sat right by the roadside. The group interview sessions lasted between 30 and 120 minutes.

Group interviews were useful because they did not only allow a meeting between multiple ideas but also demonstrated particular dialogue processes viable for illuminating issues of difference in the participants’ world (Morley, 2000). Through group interviews, the study was able to create a space for participants to interact and share their opinions about the disease. In addition, group interviews in which women and men spoke about a highly sexualized disease
provided opportunities for them to debate, contradict, and affirm their views about a range of
gendered social issues in Ghana.

In addition to group interviews, I conducted 12 one-on-one unstructured interviews. During group interviews, I asked participants’ permission to follow up with one-on-one conversations with them. I scheduled appointments with those willing to participate, meeting them individually at their homes and at local restaurants. I also held individual interviews with others who had not been a part of previous group interviews. The one-on-one interview sessions lasted between 30 and 75 minutes. Through individual interviews, I was able to supplement collective views from group sessions with subjective and diverse accounts. Also, the more private nature of individual interviews created a space for participants to open up and share more about their lives than they did in the group sessions. Also, the follow-up one-on-one interviews allowed me to be actively involved in participants’ lives outside of the group setting.

In some instances, participants had to meet me at a distance and walk me to their homes. These experiences presented the opportunity for me to participate in their daily activity of walking neighborhood streets. I also had the opportunity to be involved in traditional Ghanaian welcoming rituals such as being offered photo albums by the host. Such participant-observation and direct participation made it possible for me to connect participants’ responses with their lived experiences.

The unstructured interviews (group and individual) opened with general discussions on HIV/AIDS. This led to participants sharing their views and experiences with the disease. During discussions, participants were also shown posters, and radio and TV commercials on HIV/AIDS. At this stage I had the opportunity to observe how participants reacted to HIV/AIDS communication messages. Radio commercials were played on a CD player; video materials were
played on a DVD player. The posters, which were printed on 10 x 12 inch paper and laminated, were displayed either on tables or walls. The flow of each interview was largely determined by specific interactions enacted on the ground.

*Description of HIV/AIDS Communication Artifacts*

I began collecting HIV/AIDS communication materials circulated in Ghana during the month of November 2007. At the preliminary stage of the study, I contacted five organizations in Ghana that focus on addressing the problem of HIV/AIDS. These organizations were Ghana AIDS Commission (GAC), Ghana Social Marketing Foundation International (GSMF), Ghana Sustainable Change Project (GSCP), Ghana Education Service, and Lintax, Ghana. Through e-mails, phone calls, and personal contacts, I requested HIV/AIDS communication materials developed and circulated in Ghana by these organizations. All the above-mentioned organizations, except for Ghana Education Service, provided a total of 26 HIV/AIDS communication materials used for this study. Fifteen of the materials were posters; eight were TV commercials; and three were radio commercials.

These communication materials are a part of two-phase HIV/AIDS National Strategic Framework implemented in Ghana. The first phase is a major nationwide campaign launched in 2001 to promote abstinence, faithfulness, and condom use. Because condom use was relatively low at that time, there was more emphasis on condoms as a preventative means (Ghana AIDS Commission, 2005). The second phase of the National Strategic Framework is currently being implemented in Ghana.

*Interpreting Fieldwork Information*

As already noted this study engaged the interviewing method, participant observation, direct observation, as well as document review. Therefore, I included information from both the structured and unstructured interviews. All interviews were audio taped. Considering that tape
recording alone could not capture important information, I also kept journals that detailed personal reflections and my own descriptions and accounts of particular experiences. It also documented my understanding of various observations I made on the field. The data also included my review of the HIV/AIDS communication materials I used, as well as Ghana AIDS Commission reports.

I interpreted the information by first transcribing the numerous interviews. After transcribing I listened to the interviews over and over again. During this process I was able to immerse myself into the stories that participants shared. I tried to place myself within participants’ experiences. When particular stories fascinated me I tried to listen and read concurrently. By doing this I was able to gain a deeper understanding of the responses. After this, I finally employed a system that allowed me to identify topics, themes, comparable episodes and patterns in participants’ stories and experiences. I reviewed these over and over again until I was able to sort the topics and themes in larger subdivisions.

Since participants’ shared experiences cannot be separated from the broad picture of AIDS in Ghana, I use the next chapter to describe the history of HIV/AIDS globally and its specific occurrence in Ghana. I also narrate how HIV/AIDS emerged as an issue of concern for the government of Ghana focusing on the two-phase HIV/AIDS National Strategic Framework (NSF). In addition, I explain and critique the mainstream development framework. I define how this “development” interpretation impacts health communication approaches applied to the AIDS problem in Ghana.
Chapter Two: The History of AIDS in Ghana

*Examining a Nation’s Response to the Disease*

This chapter describes the history of HIV/AIDS globally and its specific occurrence in Ghana. It focuses on how HIV/AIDS emerged as an issue of concern for the government of Ghana. It also discusses the two-phase HIV/AIDS National Strategic Framework (NSF) adopted as a means for curtailing the incidence of HIV/AIDS in the country. Furthermore, it examines the contribution that the NSF campaigns have made in defining historical moments of the epidemic in Ghana. It uses conversations I had with senior-level officers in organizations that focus on HIV/AIDS in Ghana to explain some of the defining stages in government response to AIDS in Ghana. I believe an examination of the history and current status of the disease in the Ghanaian will provide a helpful context for understanding how contemporary individual views about the disease emerge.

AIDS began as a sudden, unexpected disease outbreak around the world between the late 1970s and early 1980s (Gilman, 1987; Rushing, 1995). This was at a time when most people believed that pandemics were a thing of the past. Scientists believe AIDS is caused by the human immuno-deficiency virus (HIV), which compromises the body’s immune system. HIV destroys the body’s ability to fight infections. The disease is said to be transmitted primarily through intimate sexual activity, exposure to contaminated blood, and prenatally from mother to child. In all instances of HIV infection, the most likely consequence is death from the disease (Fee & Fox, 1992; Gilman, 1987; Hart, 2000; Nelkin, Willis, & Parris, 1991; Rushing, 1995).

For almost three decades now, the world has helplessly witnessed the rapid spread of the disease. In 2008, UNAIDS reported that an estimated 33 million people worldwide are living with HIV. As the global community tries to comprehend and acknowledge the immense impact
of HIV/AIDS, there is an increasing urgency to respond in a way that will reverse the devastation and destructiveness caused by the disease. Although every region in the world has been affected by the disease, it is most pronounced in Africa (UNAIDS, 2007). The region records two-thirds (63%) of all persons infected with HIV (UNAIDS, 2007). Although Ghana is not one of the most severely hit among African countries, the prevalence figures in the country have been equally disturbing.

In Ghana, ever since the first case of AIDS was diagnosed, the disease has slowly become a public concern for two reasons: its spread and its patterns. According to Amoa (2005), the first cases of HIV/AIDS were reported in the country’s health facilities in 1986. By July 1991, 4,824 HIV positive-patients were diagnosed in the country. This number increased to 10,285 cases by December 1992 (Agyei-Mensah, 2001; Anarfi, 1995; Yankah, 2004). By July 1993, the number had risen to over 12,000. Currently, although the HIV prevalence is low, HIV is firmly established within the whole of Ghanaian society. Considerable variations are found by geographic region, gender, age, occupation and, to a lesser degree, urban-rural residence (Agyei-Mensah, 2001; Anarfi, 1995; Yankah, 2004). The HIV and AIDS population in 2007 was estimated at 320,000 (UNAIDS, 2008).

These statistics suggest that over the years the disease has affected all kinds of Ghanaians - males, females, and different age groups. Most of the initial cases (98%) of HIV in Ghana were identified among people with a history of extended visits outside the country, particularly former residents of Ivory Coast, a neighboring country (Agyei-Mensah, 2001). Consequently, HIV was initially thought to be a disease of prostitutes and people with a history of travel. This notion was strengthened because, in Ghana, sexual intercourse is the predominant mode of transmission. Studies indicate that 85% of all infections in Ghana occur through heterosexual relationships
Research also indicates that more females are infected than males. In addition, there is high HIV incidence among the 15 to 49 age group in Ghana (Agyei-Menah, 2001; Oppong, 1998).

Ghana was among the first countries in the West African subregion to have taken decisive steps to control the spread of the disease early on (Benefo, 2004). The government of Ghana took initiatives when it recognized the potential spread within the Ghanaian community. The country is said to have responded to the challenges of the epidemic even before the first case was reported in 1986 (Ghana AIDS Commission, 2005). The earliest national response was the establishment of the Technical Committee on AIDS formed in 1985. It created as an advisory institution to the government on HIV/AIDS issues, this committee, working in conjunction with the Ministry of Health and the World Health Organization (WHO), was charged with developing a short-term plan for AIDS prevention and control. The committee’s advice led to the introduction of blood screening in 1987 and the approval of a medium-term plan developed with WHO’s Global Program on AIDS by 1988 (Ghana AIDS Commission, 2005).

From 1989 onwards, the work of the Technical Committee was continued by a new organization, the National AIDS/STD Control Program. This new organization was created in the Ministry of Health, with responsibilities for prevention, management, and control. It organized activities such as mass-media campaigns and workshops to inform the public on ways to reduce high-risk behavior, especially by promoting condom use (Ghana AIDS Commission, 2005). Some of these activities were supported by other non-governmental organizations such as the Planned Parenthood Association of Ghana, the Ghana Social Marketing Foundation, Family Health International and other international entities like Johns Hopkins University (Ghana AIDS Commission, 2005).
However, at the beginning of the twenty-first century, the need for effective management and a unified response to the HIV/AIDS epidemic prompted the government to adopt a multisectoral approach to address the developmental challenges the epidemic presented (Ghana AIDS Commission, 2005). This new comprehensive response structure marked a departure from the earlier health-oriented approach. The initiative also led to the founding of the Ghana AIDS Commission (GAC) in 2001. According to Amoa (2005), GAC is the premier organization charged with the responsibility of leading others in the fight against the disease and its associated ramifications.

The GAC was established by Act 613 of parliament to provide leadership in the management and coordination of national response to the HIV/AIDS problem. It also collaborates and works closely with a range of organizations including ministries, departments, and agencies (MDA), NGOs, community-based organizations (CBOs), private sector enterprises, faith-based organization (FBOs), and development partners in the implementation of HIV/AIDS programs in the country. In the past the commission has been defined and guided by a National HIV/AIDS Strategic Framework (Ghana AIDS Commission, 2005).

The National HIV/AIDS Strategic Framework

With national and international support on the HIV/AIDS issue, the government of Ghana has adopted a two-phase HIV/AIDS National Strategic Framework. The first phase was implemented during a five-year period (2001 to 2005). Followed by a second phase which began in the year 2006 and is expected to end in 2010 (Ghana AIDS Commission, 2005). To address the HIV/AIDS epidemic in Ghana, key intervention areas have been proposed as NSF strategies. Each area is supported by a set of broad strategies, which will serve as the basis for guiding the development of action plans by all MDAs, NGOs and other private-sector institutions.
Significantly, Ghana’s development partners have been quick to support the multisectoral approach. For instance, in June 2002, the World Bank took the lead in establishing the Ghana AIDS Response Fund (GARFUND), offering a total of $25 million credit, to support the NSF 2001-2005 (Ghana AIDS Commission, 2005).

According to a 2005 GAC report, the first phase of the NSF (2001-2005) successfully guided the implementation of the national response, leading to some major achievements. The implementation of NSF I triggered the enactment of several policies and guidelines to create an environment conducive to the delivery of HIV/AIDS services. It also stimulated the preparation of policy documents, such as the 2004 National HIV/AIDS and sexually transmitted infection policy, the National HIV/AIDS Workplace Policy, the 2002 Guidelines for Anti-Retroviral Therapy, the Policy on HIV/AIDS for Faith Based Organizations, the National Guidelines for the Development and Implementation of HIV Voluntary Counseling and Testing, National Policy Guidelines on Orphans and Vulnerable Children, Draft National Guidelines for Blood Safety, and the National Monitoring and Evaluation Plan of 2001-2005 (Ghana AIDS Commission, 2005).

NSF I provided broad guidelines for sector MDAS district assemblies, NGOs, and civil society to develop specific HIV/AIDS plans and activities appropriate to their circumstances. The high level of consultation during the preparation and the implementation of activities promoted in NSF I encouraged the development of a national consensus on combating the epidemic. This consultation process also generated social and political support from national, traditional, and religious leaders (Ghana AIDS Commission, 2005).

Through these policies and structures, the Ghana AIDS Commission (2005) has seen an increase in awareness, community participation, and support over the first five-year period.
Consequently, it developed a second phase (NSF II, 2006-2010). The second NSF is supposed to guide the vastly expanding effort to deal with the epidemic. It also provides the framework for implementing HIV related activities through seven key intervention areas. These are; policy, advocacy and enabling environment; coordination and management of the decentralised response; mitigating the social, cultural, legal and economic impacts; prevention and behavioral change communication; treatment, care, and support; research, surveillance, monitoring, and evaluation and mobilization of resources and funding arrangement.

In addition to implementing these NSF projects, the government has also signed and subscribed to various international treaties, conventions, and declarations on HIV/AIDS (Ghana AIDS Commission, 2005). For instance, in June 2001 the government of Ghana endorsed the Abuja Declaration of 1998 and the Declaration of Commitment on HIV/AIDS adopted by the United Nations General Assembly Special Session on HIV/AIDS (UNGASS). As a signatory to the two declarations, Ghana re-affirmed its commitment to HIV/AIDS. In fulfillment of its commitment to UNGASS, indicators on HIV/AIDS activities have been submitted to UNAIDS. At the 2003 African Union Meeting in Maputo, all heads of state, including Ghana, renewed their commitment to reduce the impact of the epidemic. Commitments to these obligations have informed some of the strategies that have been adopted in Ghana so far (Ghana AIDS Commission, 2005).

Among the international conventions which have impacted the management of HIV/AIDS are the Universal Declaration of Human Rights, the International Convention on Economic, Social, and Cultural Rights, the African Charter on Human and People’s Rights, Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), and
the Convention on the Rights of the Child (CRC). Ghana was the first country to sign the latter, indicating strong commitment to the rights of children.

In a personal interview with me, Professor Sakyi Awuku Amoa, the Director General of the Ghana AIDS Commission, discussed the specific areas of HIV that the Ghana government, through the GAC, is focusing on currently. He said the government intends to reduce the current prevalence rate of HIV in Ghana to the barest acceptable minimum. This involves putting in place strategic directions to address the pandemic from two angles. The first is advocacy and awareness creation. Amoa believes this strategy ensures that “the population understands the nature of the pandemic, the characteristics, the key features and how to avoid getting the infection …. general education on …. how the disease spreads, the mode of transmission and the mode of prevention and control” (S. A. Amoa, personal communication, December 20, 2008).

Second, the GAC is focusing on people living with HIV and AIDS in Ghana. To help create an enabling environment for these individuals, the commission is addressing the issue of stigma and discrimination which, according to Professor Amoa, is still a major problem in Ghana. The third area of concern has to do with treatment and care services. As far as the Director General is concerned, this means “making sure that the health delivery system provides treatment for the opportunistic infections, as well as treating those who need the anti-retroviral treatment” (S. A. Amoa, personal communication, December 20, 2008).

Ability to effectively balance prevention, treatment and care for those living with HIV/AIDS has been a major challenge in Ghana. This challenge is evident in sentiments that senior-level officers shared with me. Currently, more focus has been shifted toward treatment and care of people living with AIDS, which has unfortunately led to the neglect of prevention. Dr. Duh Mbroh, Health Advisor for CARE International, Ghana/Benin/Togo, echoes this view.
He remarks that in “the past couple of years the funds are going into treatment” (D. Mbroh, personal communication, December 21, 2008). A researcher from Ghana Social Marketing Foundation, International also opines that at the time when Ghana was seeking funds through the Global Fund (GF) there was much emphasis on receiving anti-retroviral drugs for those infected. The funds needed for public education was, however, not enough. Eventually, all funds that Ghana had were used for anti-retroviral, care, and support. Unfortunately, new infections keep occurring, but the government was “not making so much noise” (S. Agyei, personal communication, December 20, 2008).

In all these efforts, communication has been paramount for the GAC, and the government of Ghana, for that matter. The Director of GAC affirms the importance of communication in this process remarking that communication is “number one” for the GAC. Because it is important for the public to understand the pandemic, know the mode of transmission, and to appreciate the prevention mechanisms, the GAC has developed a communication and behavior change strategy document, which guides the dissemination of HIV and AIDS information at all levels in Ghana.

During the interview, Professor Amoa also cautioned that the review of HIV/AIDS communication strategies in Ghana must recognize the different stages that the pandemic has evolved through in the country. Earlier on when the disease was first identified, HIV communication employed fear tactics to get people to appreciate the seriousness of the pandemic. This idea was also emphasized by the GSMF International Researcher, an official who was directly involved in the development of the initial HIV/AIDS campaigns in Ghana. He believes “for every campaign and for a behavior change there is the need for an amount of fear tactics to be used. People should see
themselves to be at risk. There should be fear factor. We created fear and the fear did work” (S. Agyei, personal communication, December 20, 2008).

After this initial stage, Amoa noted a “middle point.” He believes that HIV messages thinned out at this stage. During the second stage we find that fear appeal messages have put the public on their guard, therefore, there was no need to push the fear factor. Rather, “you must move out of the fear appeals for people to see the other side of the coin. Make them feel the other realities in life” (S. Agyei, personal communication, December 20, 2008). This second stage was followed by the current phase which focuses more on reconciliatory messages that ask the public to accept people living with HIV and AIDS. Such messages are necessary because the fear appeal messages, unfortunately, create more stigma. Hence, there is “the strong need to undergo the anti-stigma campaign” (S. Agyei, personal communication, December 20, 2008).

My personal reading of the communication materials in Ghana also reflects these challenges. The bulk of AIDS messages in Ghana capture the historical moments that the disease has evolved through. For instance, a review of the “Stop AIDS, Love Life” messages does not only reveal the use of fear tactics, but also highlights how the government of Ghana reacted to the disease during the early stages. The extreme attention given to campaigns that use fear tactics is evident in how frequently my research participants recounted “Stop AIDS, Love Life” radio and TV commercials. Also, one can easily identify the current stage where attention is focused on the anti-stigma campaigns in Ghana. During my fieldwork in December 2007 and January 2008, messages with the theme, “Who are you to Judge,” were being circulated as a part of the anti-stigma campaign.
Conceptualizing AIDS Communication in a “Development” Context

Although both developing and developed regions are affected, the rapid spread of AIDS in developing countries (UNAIDS, 2007) leads Altman (1999) and Poku (2002) to reasonably see “underdevelopment” as a major determinant of the spread of AIDS. According to Poku (2002), all diseases in Africa, including AIDS, must be placed in the context of the continent’s underdevelopment. Consequently, scholars often explain AIDS within the entire development picture (Altman, 1999; Poku, 2002; Tufte, 2005). Therefore the following section of this chapter explains, and also critiques the mainstream development framework. It defines how this “development” interpretation impacts health communication approaches applied to the AIDS problem in Ghana. In addition, it uses postcolonial perspectives on the “development” project as a point of entry to critique popular AIDS discourses.

At the initial stages, HIV/AIDS was considered health problem where solutions were only limited to biomedical and health related issues. This included areas such as access to health services, voluntary counseling and testing, and treatment, care, and support (Tufte, 2005). However, currently, the AIDS problem is often defined through the “development” lens. Even though the concept of “development” has become a highly contested arena in academic spheres, it is frequently seen as a post world war two Western phenomenon associated with the modernization perspective (Tucker, 1999).

Development is defined as an idea which strives to account for the uneven patterns of development around the world, while recommending measures to overcome “underdevelopment” (Tucker, 1999). In so doing, development discourses do not only propose solutions for the missing link that can lead to development but also position the process as universal, inevitable,
and inherently valuable (Biccum, 2002). According to Tucker (1999) this development thinking, culminating in the UN Development Decades in the 1960s, originated from the United States.

In his text, *Communication and Development: Critical Perspectives*, E. M. Rogers (1976) critiques such mainstream strands of development thinking. His assessment provides a good perspective for understanding how development issues, including HIV/AIDS, are generally problematized. He notes in his analysis that Western models of development assume that the major causes of underdevelopment reside within underdeveloped nations rather than external to it. Therefore, individuals within these systems, as well as the social structure of these communities, are blamed as the cause of underdevelopment (Rogers, 1976). Rogers believes that during the 1950s and 1960s this blame-attribution became widely accepted not only in Euro-America but also by most government leaders and by many social scientists in Latin America, Africa, and Asia (Rogers, 1976).

Historically, the blame-attribution thesis has been used to define different problems such as poverty, wars, famine, and HIV/AIDS. People affected by HIV/AIDS are usually blamed for having a kind of behavior/attitude that facilitates the spread of HIV. At the initial stages of the pandemic, HIV infection began to spread through sexual networks of gay men, commercial sex workers, and/or intravenous drug users (Singhal & Visanthi, 2005). From these demographics, experts came up with a number of perceived attributes of HIV/AIDS patients. Among these attributes, sexual orientation and addiction to drug use gained centrality in the construction of the disease and its victims (Gilman, 1988). The epidemiological conclusion was that HIV virus transmission depends on human behavior related largely to sexuality and drug use (Airhihenbuwa, Mankinwa, & Obregon, 2000; Gilman, 1988; Melkote, Muppidi, & Goswami, 2000; Rogers, 1995).
From such theses as this came the commonly held perception that views AIDS patients as being sexually promiscuous. Hence, individuals affected by AIDS are not only sufferers but have also become the source of their own pollution (Gilman, 1988). Accordingly, experts did not only problematized the sexual behavior of AIDS patients, but also targeted the knowledge, attitudes, and behaviors of potential victims. Yet these perceptions have not changed but have become entrenched over the past three decades. In 2005, for instance, a conclusion from Singhal and Visanti’s (2005) study on the role of popular narratives in stimulating public discourse on HIV and AIDS indicated that AIDS is still located as a disease of ignorance. Not only is the sexual behavior of the victim a problem but his/her knowledge level also leaves much to be desired. And it is their level of ignorance that makes them vulnerable to the disease.

Interrupting Dominant Development Discourse

Although mainstream development thinking has become prominent, alternative perspectives from dependency and liberation theories have also emerged since the 1970s. These alternative theories push, among other things, for the inclusion of other voices and knowledges in development. Over the years, such critiques have been expanded by postcolonial scholars who engage the entire colonial venture (Natrajan & Parameswaran, 1997; Said, 1976). Their works explore modern ventures, like development, through which imperial relations established by formal colonization resurface. An appropriate examination of such new forms of imperial relations is provided through the complex portrait painted by Said (1976). He examines how Western knowledge systems are bound with the construction of both colonial and postcolonial ways of knowing and acting in the West, but more significantly, also around the world (Briggs & Sharp, 2004; Said, 1976).
In 1976 the influential work, *Orientalism*, by Edward Said invigorated critical inquiry into the dominant framework within which the “Orient” is contained and represented by the “Orientalist.” He created awareness about the links between power, knowledge, and representation. Said (1976) defines Orientalism as the “knowledge of the Orient that places things Oriental in class, court, prison, or manual for scrutiny, study, judgment, discipline, or governing” (p. 41). His concern was with the discursive formations that sought to perpetuate the position of strength enjoyed by the “Orientalist” from the West over the “Orient,” the cultural other.

More than anything, knowledge systems established through Orientalism represent the Oriental as “irrational, depraved, (fallen), childlike, ‘different;’” thus the European is rational, virtuous, mature, ‘normal’” (p. 40). Said identifies a semblance between how the Oriental identity is constructed and how other peoples (delinquents, the insane, women, and, the poor) variously designated as backward, degenerate and uncivilized in Western societies, are also framed. Despite the fact that these categories of people are geographically situated differently – Oriental peoples in the Orient, and the uncivilized in the West - they are all perceived as problems to be solved.

Said (1976) believes Oriental knowledge that existed during colonial times is extant in the modern era. According to him, the Orient has become modernized and the modern Orientalist image still bears traces of power that can resurrect the Orient. He asserts this is power that dwells in new scientifically advanced techniques. Having transported the Orient into modernity, the tradition of continuity is based upon a common discourse and praxis typically found in the development project. Invariably, Oriental knowledge that constructs the Orient as a problem is echoed by development discourses. Also, the constant proposal of solutions and
recommendations generated to guide Third World countries along the “development path”
speaks volumes to this understanding.

Sharing similar sentiments, Natrajan and Parameswaran (1997) confidently identify
“development” as a project that perpetuates the Orientalist knowledge. They argue:

Just as Orientalist knowledge played a destructive role in the colonial period, it
continues to do so in the post-colonial period as the “modernization” of the Third
World. If the institutional support for Orientalist knowledge during colonialism
was provided by colonial institutions, the support for Orientalist knowledge
during post-colonial times is provided by development institutions. (p.33)

These scholars also suggest that postcolonial transformation of Orientalist knowledge into
development practice was initiated at a time when colonial regimes were being overthrown and
nation-states were emerging in the so called Third World. They believe the development model
supports and maintains power structures that existed during the colonial era. Therefore, in
contemporary times, the dominant position that was occupied by ex-colonial powers is assumed
by development practitioners who control projects in Third World contexts.

Also associated with this power positionality is the acceptance of the “development”
philosophy by leaders of new nation-states, such as Ghana. Even though “development” theories
manifest in various national and international initiatives in Ghana – Structural Adjustments
Programs, educational reforms – I will specifically focus on their impact on the Ghana
government’s interpretation of and response to the AIDS problem. After reviewing Ghana
government’s documents and HIV/AIDS communication approaches, as well as interviewing the
GAC Director General, it is obvious the HIV/AIDS problem in Ghana is defined as a
development issue. Professor Amoa does not mince words in suggesting that the Ghana
government reads AIDS as a development problem. He asserted that the government initiated a national response which manages HIV/AIDS as a developmental issue (Amoa, 2005). In this regard, the government has contracted various development partners such as (IDA) World Bank Credit and has created the Ghana AIDS Response Fund (GARFUND).

In addition to overtly expressing the “development” ideology, AIDS campaigns in Ghana are fundamentally implemented through the dominant development oriented behavior change approach. According to the 2005 Ghana AIDS Commission Report, the current NSF is employed as a behavior change communication agenda for HIV/AIDS. Health communication scholars describe behavior change as an approach that intends to close up the knowledge, attitudes, and practices (KAP) gap among high-risk groups (Airhihenbuwa et al., 2000; Melkote et. al., 2000; Muturi, 2005; Petty & Priester, 1994). Undoubtedly, in a development context, behavior change communication identifies and promotes risk-reducing behavior in individuals by increasing knowledge as far as AIDS is concerned.

In Ghana, the major focus of HIV/AIDS communication has been on prevention of mother-to-child transmission, the ABCs of HIV prevention (abstinence, be faithful, condom use), care and support, opportunistic infections, and stigma and discrimination (Ghana AIDS Commission, 2005). However, similar to other HIV/AIDS prevention programs in Africa, there has been more emphasis on the ABC prevention strategy in Ghana (Ghana AIDS Commission, 2005; Lau & Muula, 2004; Poku, 2002). The first component – abstinence – promotes delayed onset of sexual activity. This is based on the belief that if a teenager avoids sexual activity, it is unlikely that either pregnancy or HIV infection will result. The abstinence message claims self-restraint from sexual activity is likely to be 100% effective (Ghana AIDS Commission, 2005). The second constituent (Be Faithful) promotes a reduction in the number of partners and mutual
fidelity between non-infected partners. This is believed to be a major means for reducing sexual transmission of the virus (Ghana AIDS Commission, 2005).

However, the campaign proponents admit that this strategy works only if both partners are faithful and uninfected. It also acknowledges the different meanings people give to the notion of fidelity. For example, “serial monogamy,” in which a person is faithful to one person at a time but keeps moving on to new partners, is seen by some as a type of fidelity (Ghana AIDS Commission, 2005). The last component advocates for condom use among people who cannot abstain, but it focuses solely on the use of condoms by males. There is the belief that condoms are the best option for protection if one is sexually active. Interestingly, the campaign specifically promotes latex condoms as being 95% effective when used correctly and consistently (Ghana AIDS Commission, 2005). Nevertheless, unless one partner feels substantial risk, condom promotion generally has limited success in primary partnerships because it is associated with a lack of trust (Ghana AIDS Commission, 2005).

Behavioral change messages are targeted at the general public, women, youth, prisoners, commercial sex workers, PLWHAs, long-distance truck drivers, long-distance traders, and uniformed services personnel (Ghana AIDS Commission, 2005). The aim is to empower them not only with knowledge and life-saving skills/abilities but also with the confidence and ability to initiate and sustain changes in their lives (Ghana AIDS Commission, 2005). Furthermore, the behavioral change programs are based on the belief that mass media has a central role to play in the fight against AIDS in Ghana. Consequently, both the print and electronic media have been strongly engaged in HIV communication in Ghana (Ghana AIDS Commission, 2005).

A closer examination of such solutions to the AIDS problem is important for specific reasons. From a communication studies perspective, it demonstrates most HIV/AIDS
communication is influenced by the notion of development communication. This is evidenced by the large body of scholarly and professional research on HIV/AIDS that draws from behavior change and persuasion models (Melkote et al., 2000; Muturi, 2005; Panos, 2003). Historically, behavioral change and persuasion campaigns have been modeled upon the transmission concept of communication; it views communication more as a science to produce effective messages (Muturi, 2005).

A 2003 Panos report also concludes that such communication intervention models assume a simple linear relationship between individual knowledge and action, disregarding variations among the political, socioeconomic and cultural contexts that prevail in various regions. In this regard, scholars continue to raise questions about the importance placed on individuals to change their behavior without adequate attention to social, cultural, and physical environmental factors that shape individual roles and expectations (Airhihenbuwa et al., 2000; Melkote et al., 2000; Tuft, 2005).

Other scholars echo this critique claiming that such approaches are one-way communication with an audience at the receiving end (Muturi, 2005; Tulloch & Lupton, 1997). They argue that this model is message focused and not audience centered where information is conveyed from all-knowing technical and medical experts (Muturi, 2005). Unfortunately, this results in the development of communication materials that treat people as objects of change rather than as the agents of their own change (Panos, 2003). They focus exclusively on a few individual behaviors rather than addressing social norms, policies, culture, and supportive environments that will offer individuals the needed agency (Panos, 2003).
A Postcolonial Critique of Popular AIDS Knowledge

The common definition of AIDS as a development problem is frequently applied. Its consequence has been the burgeoning of AIDS scholarship that isolates and targets people’s attitudes and behavior. In Ghana, we can identify three types of AIDS research that follow this pattern. First is a group of works that monitor the prevalence and spread of HIV/AIDS in the country (Akwara, Fosu, Govindasamy, Alayon, & Hyslop, 2005; Oppong, 1998). The second type are studies that identify factors that cause the spread of the disease in Ghana by focusing on people’s knowledge, attitudes, and perceptions (Anarfi, 1993; Awusabo-Asare, Abane, Badasu, & Anarfi, 1999; Cote et al., 2004; Hong, Banta, & Kamau, 2006; Takyi, 2000; Takyi, 2003). A final category is a group of works whose primary focus is on preventive strategies (Panford, Nyaney Ofori, Samuel, & Aidoo Garbrah, 2001; Teye, 2005; Wolf & Pulerwitz, 2003).

Over the years these studies have been immensely informative and useful on the subject of AIDS in Ghana. They have not only been used to examine AIDS patterns in the country, but have also become helpful resources for designing and implementing intervention strategies. However, to provide a fresh focus for understanding AIDS in Ghana, I respond to Said’s (1976) call for a new way of conceiving the separations and conflicts that had stimulated generations of control. He suggests that this is a means for re-reading canonical cultural works. This process does not “demote or somehow dish dirt on them, but allows us to reinvestigate some of their assumptions, going beyond the stifling hold on them of some version of the master-slave binary dialectic” (p. 350).

Said’s idea of rethinking cultural works opens up a space for this project to challenge unacknowledged and unexamined assumptions of dominant, development-oriented AIDS discourses and knowledge. I do this alongside a few critical communication and cultural studies
scholars who place the idea of AIDS representation at the heart of their works (Crimp, 1988; Hart, 2000; Treichler, 1988; Tulloch & Lupton, 1997; Watney, 1987) so that alternative meanings of AIDS can be explored. Applying postcolonial theory, I use the next section of this chapter to navigate through dominant Eurocentric and local African AIDS discourses. Through this process I echo the argument that the process by which AIDS is known is far from being value free.

Ever since the initial cases of AIDS were diagnosed, scholars have engaged in ideological battles over the meaning and social significance of the disease (Crimp, 1988; Hart, 2000; Lupton, 1994; Treichler, 1999; Watney, 1987). Although medical rhetoric on AIDS holds claims to scientific truth and universal objectivity, the “chaotic assemblage of understandings of AIDS” demonstrates that what is considered truth about the disease varies in accordance with individuals’ perceived identities, social status, and lived experience (Treichler, 1988, p. 1). A glimpse at the diverse AIDS meanings generated across time and space suggests that knowledge about the disease emerges from subject position, historical placement, and social context. Thus, the kind of knowledge any individual creates about HIV/AIDS does not only depend on the available cultural products they draw from, but also on their subject position within a particular society.

Extended inquiry into how societies configure knowledge about AIDS may help us to further understand and imbue value to the process. On a casual way we may be tempted to simply assume that we construct an understanding of AIDS only from seeing a close-up shot of bodies dying from the disease. However, I argue that the mechanisms are more complex than this. I contend that the images, portraits, and representations conflate with already existing knowledge systems to form a repository from which individuals begin to map out their own meaning for HIV/AIDS.
This argument is highly evident when we look at AIDS discourses generated over time. From both global and local perspectives, it has been demonstrated that marginalized groups in various communities have become associated with the disease in particular ways. Various scholars critique dominant discourses which construct the disease either as a homosexual affliction, an African disease, an affliction of IV drug users, or disease of prostitutes (Austin, 1990; Gilman, 1988; Jarosz, 1992; Kistenberg, 2003; Lupton, 1994; Lupton, 1999; Treichler, 1999; Watney, 1987; Yankah, 2004).

The practice of men, having sex with men, or prostitutes having several sexual partners lies outside a conventional norm as do the little known sexual practices of the African. In each instance, “difference” in sexual practices becomes a framework within which particular meanings of HIV/AIDS emerge. Here, “uncommon profiles or features” associated with the “Other” become the premise for understanding what the disease is (Yankah, 2004, p. 183). Beyond this, we also need our perceptions about the “Other” in order to understand this disease entity.

Clearly, stereotypes about these groups get “re-presented” and “re-produced” in particular ways. However, what is analogous about these parallels is that the explanations for the disease hinges upon perceptions about the sexuality of these groups of people. Observing this earlier on, Watney (1987) argues that “the entire representation of AIDS hangs upon a telescope which concentrates the disease into a narrow alignment with specific sexual acts” (p. 27). He concludes that promiscuity is used medically, just as morality is medicalized. Following such arguments, Watney questions the classification of AIDS as a sexually transmitted disease. For him, although the HIV virus is primarily acquired through sex, it should not be seen just as STD.
In my exploration of the meaning-making of AIDS as a complex process, these scholarly debates are useful in helping me understand the highly politicized dimensions of AIDS interpretations. They also lead me to acknowledge the specific dimensions these interpretations can assume within the African/Ghanaian context. More importantly, these assertions explain how specific elements perceived through the “development” lens impacts the knowledge of AIDS in Ghana. To adequately illustrate such complexities of HIV/AIDS meanings in Ghana, I turn to narratives from my research participants in the next chapter. I use Foucault’s (1995) theory and Gilman’s (1988) theory to theorize the meaning-making process. I look at how participants’ panic stories about AIDS illustrate the meaning-making attempts, as well as some of the struggles that accompany such attempts.
Chapter Three: Interpreting Disease

Making Meaning of a Dreaded Disease

This chapter focuses on how the fear of AIDS leads research participants to adopt specific disciplinary acts. It also seeks to understand how/why participants code, define, and react to HIV/AIDS in particular ways. To do this, it first explains Gilman’s (1998) thoughts on disease representation. It expands this framework by returning to Foucault’s (1995) conceptualization of bodies under regimes of discipline. This is appropriate because this study suggests the use of new measures which force bodies to conform to specific health standards. It also shows how particular forms of discipline get repeated and re-enacted in societies. In doing this, this chapter is divided into three thematic sections. The first section uses Foucault’s observation of disciplines to explain implicit and explicit regulatory mechanisms participants reference in their narratives. It discusses how people perceived to be carriers of the disease are subjected to specific micro-practices of discipline. It also highlights how concerns about the possible decay of the “self” leads participants to subject their own bodies to disciplinary actions as well. The second, theme delves deep into the panic stories participants shared, highlighting the important role the bodies of AIDS patients play in the meaning-making process. The final section, however, closely reads how participants subjectively struggle to bring meaning to a global phenomenon in a postcolonial context.

In theorizing how disease is depicted, Gilman (1988) unravels complexities that associate people’s fear of disease. He sees fear of disease as a display of insecurity and panic about possible collapse and dissolution. Gilman (1988) suggests this stems from the knowledge of one’s own mortality and impending risks. He believes this fear does not remain internalized. Rather, “we project this fear unto the world in order to localize it and, indeed, to domesticate it”
In so doing, individuals actively deny their own stakes in it. Unfortunately, the process of disavowal does not only remove fear but makes us believe that “it is not we who totter on the brink of collapse, but rather the Other. And it is an-Other who has always shown his or her vulnerability by having collapsed” (p. 1). Such personal renunciation largely impacts how disease is depicted at the practical level. On the surface it contaminates the image we create for disease. Also, the notion that disease is projected on to the Other suggests it is the Other’s image that becomes tainted in the meaning making process.

Gilman’s conceptualization is useful for understanding participants’ utterances about HIV/AIDS. First, it provides an explanation for the references and representations participants provide for HIV/AIDS. Second, it sheds light on the specific in/actions of individuals as they navigate the reality AIDS presents into their culture. Finally, Gilman’s theory adequately complements Foucault’s concept of discipline, which is widely applied in this study. To provide a thorough analysis of participants’ narratives, I return to detail Foucault’s notion of disciplines. I provide Foucault’s observation of the complex micro-power practices in societies which disciplines the body by normalizing its features and development.

Foucault (1995) defines disciplines as “methods which make possible the meticulous control of the operations of the body and assures the constant subjection of its forces” (p. 137). According to him, the historical moment of disciplines is identified as an era when an art of the human body was born. This is period where the body was discovered both as an object of power and a target of power. Following this discovery, the human body was made to enter a machinery of power that explores it, breaks it down, and rearranges it. This is a process Foucault describes as “political anatomy,” a method that defines how one may have a hold over others’ bodies, so that they may operate as one wishes with the techniques, the speed, and the efficiency that one
determines (p. 138). He gives a detailed explanation of how techniques of constraints, prohibitions, and obligations work by distinguishing three specific elements – scale, object, and mode of control.

The first element is the scale of control. This is unique because the mechanisms of discipline and punishment hold the body as an integral part of their plan. It does not treat the body as wholesale, as if it were an indissociable unity. But “it exercises upon it a subtle coercion; it obtains holds upon it at the level of the mechanism itself- movements, gestures, attitudes, rapidity: an infinitesimal power over the body” (Foucault, 1995, p. 136). Second, Foucault comments on the exclusivity of the object of control. He believes that mechanisms no longer made signifying elements of behavior or the language of the body essential. Rather, the wealth, the efficiency of movements, and their internal organization became important. As far as this mechanism is concerned, “constraint bears upon the forces rather than upon the signs; the only truly important ceremony is that of exercise” (Foucault, 1995, p. 137).

Lastly, there is the modality. Foucault (1995) argues that the mechanism ensures an uninterrupted constant coercion. It supervises processes of activity rather than its results, and it is exercised according to a codification that partitions as closely as possible time, space, and movement. Haunschild (2001), in applying Foucault’s analyses of disciplines to issues of health, argues that health activities can be interpreted as micro-practices that discipline the human body. He contends that systematic conceptions of health issues are well structured to create knowledge/power complexes. Within this framework, understanding HIV/AIDS discourses merely as neutral messages would not only be naïve, but would neglect the underlying structures of control and power mechanisms that operate in modern society (Haunschild, 2001).
Disciplining the “Other” and the “Self”

Before using participants’ narratives to demonstrate how the “other” and “self” are disciplined, I will first describe the context that led participants to classify various bodies and also determine which bodies must be disciplined. In December 2007, I arrived in Ghana to conduct fieldwork. Upon arrival I could feel the excitement and energy in the country. Conversations about soccer were highly charged. One could hardly go through the day without hearing the patriotic song that cheers the Ghanaian soccer team on -“Go, Black Stars, go.” Souvenirs designed in Ghana’s national colors (red, gold, and green) were on sale at every corner. All these isolated events were drawing attention toward the upcoming 2008 African Cup of Nations (CAN 2008).

The Africa Cup of Nations is the main international association soccer tournament on the African continent. The first CAN competition was held in 1957, the same year that Ghana gained its independence from British colonial rule. However, it was not until 1963 that Ghana made its soccer debut. In 1963, Ghana did not only host the event but also won the title. The country continued as champions for two years. Overall, Ghana has won the title four times. As a four-time champion, hosting the 26th African Cup of Nations was no ordinary occasion. It was December 2007 but Ghanaians were ready for the event scheduled to begin January 20, 2008, and end February 10, 2008. As hosts, the country was hoping to be crowned 2008 champions.

As hosts of the competition, Ghanaians were looking forward to welcoming committee members of the Confederation of African Football, well-renowned African soccer players, and thousands of fans and spectators from around the world. Alongside heated arguments about which country would be crowned champions, were concerns about the possible spread of HIV during this period. For my participants the opportunity to host this historic event raises crucial
questions in an era where HIV is rapidly spreading. The possible entrance of foreigners into Ghana made participants relive fears and anxieties about HIV/AIDS. In this context, they attempted to classify people who would be entering the country. They perceived some as possible carriers of AIDS and therefore called for the execution of a sorting system that can keep such people out of the country. To shed more light on this, I now turn to the narratives of my research participants.

As my conversation with a group of women between the ages of 26 and 35 years progressed, three amongst them engaged in a sort of mini chat captured below:

Grace, who works as a salesperson for her husband began the discussion saying that:

Even on Unique FM at 9 o’clock they play a song on HIV…they know that next year there will be the CAN 2008 so they have started cautioning ladies that they should be very careful because there are a lot of people who will be coming into the country. (Grace)

Her topic fascinated Regina, a hairdresser. She endorsed Grace’s fears with this response:

All these foreigners who will be coming into the country …. don’t you think that they can…” Even though Regina could not clearly articulate her concerns, she seemed to be thinking about the issue raised. (Regina)

Then Betty, a small business owner, jumped in to conclude Regina’s statement saying: “Yes, some will even come with the intention to sleep around.” After these interruptions, Grace, who initiated this small conversation, bounced back to complete her thoughts about the subject. She said:
When we are going outside the country they make sure you undergo medical examination before you can enter that country. The British Embassy does that. They have specific places you just don’t go in. Ghanaians, when we are going outside the country, are asked to do medical checkup but when people are coming here they don’t. (Grace)

Another man shared a similar sentiment. Kwadwo, a student who had just completed his vocational training, said: “They were having a program on Choice FM this morning and it was said that because of CAN 2008 some ladies have decided to be sex workers for this occasion. So they always go in for lessons on how to walk and talk to people in order to attract customers.”

At the time the research participants were making these statements, I had been in Ghana for weeks and was acting in a patriotic manner as well. I could sing the “Go Black Stars Go” song. I also helped my husband pick out a nice red, gold, green (national colors) Black Stars T-shirt from the market. Like other Ghanaians, although we were hoping to see Ghana crowned CAN 2008 champions, we were also gripped with the fear of possibly losing on home grounds. However, through participants’ sentiments I realized this was not the only fear the tournament presents to Ghanaians. Among other things, the CAN 2008 event triggered research participants to demonstrate their suspicions of foreigners. During the process, I was reminded of Yankah’s study, “Narratives in Times of Crises: AIDS Stories in Ghana” (2004). He had previously encountered similar expressions of fear and anxiety displayed by Ghanaians.

In addition to such lucid expressions of fear, the understanding that AIDS can transcend national borders led research participants to express the need for control of state borders. Participants’ anxieties concerning the entry of foreigners into Ghana speak volumes to how modern-day disciplines operate. Research participants suggest the need for immigration laws that
ensure the entry of only healthy bodies into the country. In this regard, participants reference global discourses and structures of border control. In their simple responses, participants engage much broader debates about disease, boundary protection, and discipline.

Participants’ notions invigorate important discussions on how the fear of disease can lead to the erection of borders and ultimately, the disciplining of those who wish to cross those borders. For instance, they mention other forms of health requirements that apply to Ghanaians traveling to Britain. With the British example in mind, participants propose a Ghanaian travel system that would be applied only to specific border crossers. They also suggest that this system should be able to determine and allow only those who are healthy to enter the country. In this case extreme attention must be given to people entering the country from neighboring African countries.

As I read participants responses I realized that they did not only suggest specific international health travel requirements as disciplinary measures but also as, Foucault (1995) would argue, a method that makes the human body a target of power. For Foucault, bodies are disciplined through the organization and control of space. These are usually procedures that attempt to maximize the efficiency and usefulness of bodies (Crossley, 1996; Foucault, 1995). It is important to note that the passport system and the acquisition of visa fundamentally stems from the need for a country to control its physical space, by determining who can and who cannot enter its borders. In Foucault’s schema the body does not position space around itself, but it is positioned in space. This means the body must be subject to a specific form of disciplinary practice in order to be positioned. Within this conceptualization health travel requirements that categorize a body as healthy and allow it to be positioned and function within a specific space
could be described as a discipline. Also, visa acquisition becomes crucial in this process because it is used to determine if the body would be positioned at a specific space or not.

Furthermore, the practices of functional codification and differentiation of international spaces deployed through passport usage and visa acquisition system becomes a means for securing some control over the bodies that populate them. Therefore, prohibitions and constraints exercised through the passport system are also designed to control movement of the human body from one country into another. Since, without them it is impossible for particular bodies to be positioned within particular international spaces. Hence, the sorting scheme that accompanies visa acquisition system becomes, what Foucault (1995) would describe as, a subtle form of coercion that supervises processes of activity by partitioning as closely as possible space and movement. Foucault’s framework, therefore, allows us to better see the acquisition of visa and the use of passports as processes that can work to brand different groups as disease carriers and also determine how bodies are positioned to ensure the protection of borders.

Huber (2006) after analyzing the proceedings of eight International Sanitary Conferences that address the cholera epidemics, argues likewise. He believes that even though different countries met to cooperate on how to deal with the disease, decisions concerning travel controls emphasized differences between nations and cultures, as well as boundary protections. According to Huber (2006), the use traveling disciplinary acts for separation stems from the vulnerable positions that epidemic situations expose people to. To counter their susceptibility, communities structure regulations that partition as closely as possible “space and movement” (Foucault, 1995, p. 137). Also, Huber’s argument is very much in keeping with Gilman’s (1998) observation that disease, with its seeming randomness, is one aspect of the indeterminable universe that we wish to distance ourselves from. To do this we construct boundaries between
ourselves and those categories of individuals whom we believe (or hope) to be more at risk than ourselves.

Using Foucault’s observation of disciplines to analyze participants’ comments I am reminded of the health requirements I personally had to conform to when I first came to the United States as an international student. The TB tests I had to take to assure the health officers at my school I was fit enough to be a student in the United States. The long lines international students had to stand in to get tested for TB. And the medication one had to take if trait of TB was found in you. At this point I have realized that the disciplining does not end at the embassies with the acquisition of the visa, but also follows you to your destination of travel, as well.

Also, hearing such narratives from participants I realized that the classification process wherein participants tried to localize disease in the “Other’s” body reverberates well-known binary tropes that accompany colonial discourses, albeit differently. In participants’ narratives we find the binary of the rational/civilized colonizer and the irrational/primitive colonized (Boehmer, 1993) recast. During imperial days, the colonizer did not only view Africans as primitive and backward but also believed these factors predisposed them to certain diseases (Vaughan, 1991; Worboys, 2001; Yegenoglu, 1998). This called for disease control that uniquely tied knowledge, vision/seeing, and techniques of rational control and productive domination over the colonized (Yegenoglu, 1998). Therefore, Said (1976) argues that the Oriental, African body was placed under judgment, discipline, and constant scrutiny.

This is a history that neatly ties with contemporary narratives constructed to set the postcolonial civilized/tamed body in opposition to the seductive and/or repulsive/ wild/sick body. Rehearsal of these historic binaries also implies the resurrection of accompanying actions that
target the “Other’s” body. Similar to disease-control mechanisms that regulated “primitive” bodies, the postcolonial carnal, untamed, sick body is also disciplined.

Whereas the international travel health regulatory measures operate at the institutional level, participants’ responses suggest other forms of discipline that also target the human body, but operate at the personal level. In this instance, individuals are responsible for enforcing these disciplines by attempting to create boundaries that protect their personal boundaries from infiltration. In such examples, participants demonstrate other visible matters of discipline that subject both the “self” and others into conformity. In such situations we realize that, although participants expect national authorities in Ghana to develop international state protective systems, they also believe to have personal responsibilities for protecting their own boundaries. Concerns about personal boundary protection were consistently expressed through participants’ understanding of the popular HIV/AIDS campaign slogan, stop AIDS, love life. The statement stop AIDS, love life is used in many of the HIV/AIDS campaigns that emphasize abstinence, faithfulness and condom usage.

Research participants have been advised through countless HIV/AIDS campaign messages that emphasize the statement “stop AIDS, love life.” I realized that the exact meaning this statement generates for participants is crucial for explaining how participants subject themselves, as well as others, to specific disciplinary mechanisms. First, participants’ understanding of the slogan emphasizes their awareness of the subject of self boundary and the responsibility they have to ensure its protection. Second, it speaks to the issue of disciplining the “self” and the “other.” On numerous occasions, participants repeated this slogan, which also reminded them of their stake in the protection venture. During a conversation with one man, I recall asking, “So do you think AIDS can be stopped?” Gerald, who is a teacher, said:
AIDS is already there, OK, we can regulate it, but those who already have it there is nothing that can be done about that. But those who do not have it, we can protect them so that they don’t get it. Although AIDS is there you can still continue with your life, but you have to be careful.

Gerald’s references to regulation and protection are important for exploring the subject of self discipline. According to participants, in situations where they can easily identify HIV/AIDS patients, they make conscious efforts to be distanced from them. Participants explain that HIV/AIDS patients they know are either “kept indoors” or “in isolation to keep other people from seeing them.” One participant goes further to explain that:

AIDS creates a distance between you and your relations. As for me, if I know you have the virus I will not come close to you, coming close to you makes it easy for me to have the virus as well. I will advise myself and stay away. I will not even say hi when I see you. (David, student)

Evidently, participants see the patient as “a vessel holding disease and, therefore, an extension of the disease” (Gilman, 1988, p. 4). Thus, in order to stop AIDS, the patient invariably becomes the target of protective mechanisms determined by the norms of the society (Gilman, 1988). One participant opines that, “The adverts tell us to avoid casual sex. So normally that is all we think about.” Akosua, a female participant, believes condoms reduce the risk of infection, but abstinence is the best. Kwaku, another participant, sums it all up in this statement: “Personally, if you don’t want to get infected you take precautions. If you know through sex you can get AIDS and you don’t want to protect yourself just be faithful and stay with one person or abstain.”

These comments from participants remind us of the kinds of material practices that the AIDS media campaign messages can both encourage and enable. They make us rethink the
processes through which certain attitudes regarding AIDS entered public imaginary as a complex mechanism mediated by power. For instance, in these utterances we gain a clear picture of three disciplinary acts – abstinence, faithfulness, and condom usage – that individuals subject their bodies to. It is important to note that these are protective measures that conform to the ABCs strategy promoted in HIV/AIDS communication materials in Ghana. Applying Foucault’s (1995) notion of disciplines, we can describe these protective measures as specific forms of constraints that target the body. In these cases it is important to mention that it is the self that becomes the object of target. It is worth noting that whilst the international travel requirements are institutional and target the others’ body the self disciplinary measures work otherwise. They are implemented by the participants’ themselves and it targets their own bodies.

In deciphering Foucault’s (1995) concept of disciplining the self, Crossley (1996) argues that one’s experience of one’s body is not immediate, but is mediated by power. Power in this sense, Crossley (1996) believes, refers to particular discursive and perceptual schemas, which are linked to given instituted forms of social practice. Thus, one can say that we only have a particular medical awareness of our bodies. And through this, we only experience our various signs of disease by virtue of a historically contingent web of discourses and practices to which we subscribe. These are also discourses which are tied to the “practices of sanitation, surveillance, and control which regulate our everyday being” (p.111). He also believes we subject ourselves to this regulation by virtue of our identification of ourselves or our experiences through a specific medical model we subscribe to (Crossley, 1996).

Reading participants responses it becomes clear that the web of discourses they are subscribing to and also subjecting themselves to are, the various AIDS campaign messages they have become accustomed to. The HIV/AIDS media campaign messages carefully designed by
various organizations can, therefore, be described as instituted forms of social practice. Here we realize that participants discipline themselves by subscribing to these coordinated forms of practice by either abstaining from sex, or remaining faithful to their partners, or using condoms. Therefore, what we see is the execution of power techniques developed at the institutional level and adopted at the individual level.

Also, we realize that these institutional power forces enable both the discipline of individuals and subsequently, the control of entire populations. Hence, they can be described as productive, since they ultimately produce healthy and self-controlled individuals within a society (Foucault, 1995). Obviously, participants who diligently follow through with these measures become a part of a large population that adopt such self-disciplinary acts and become healthy. Within this framework, the management of the possible spread of HIV/AIDS through the dissemination of media campaign messages can be adequately described as a form of disciplinary power that controls the entire population.

Furthermore, this analysis makes true Foucault’s argument that one’s experience of his/her own body is mediated by power. Participants’ responses give insight into how these strategies become modes of discipline and lifestyle for the self and others, as well as the force which enables such codes of discipline. Looking at how participants conscientiously live by the ABC’s strategy (abstinence, being faithful, and condom usage) we can see that the management of the individual body bears on how well the entire social body is also governed. This is because, Haunschild (2001) argues, both elements require discipline, order, and morality.

Haunschild (2001) highlights the link between disciplining the individual body and the social body to argue that health depends upon morality, since improper lifestyles can become the root of personal illness and individual immorality can also become the product of social disorder.
In this regard, sicknesses like HIV/AIDS in the individual can be intimately linked with disorder and mismanagement of the entire social body. What this Foucauldian analysis reveals of research participants interpretation of HIV/AIDS media campaign messages is that health and illness are instituted concepts individuals’ bodies are observed with, either by the individuals themselves or/and by others. This observation is based upon processes of normalization embedded in a power/knowledge nexus which produces the concept of health/illness within societies (Haunschild, 2001).

It also becomes obvious through these responses that, so far as sexual behavior is thought to be a relevant mode of transmission, participants will continue to see sexual act as inextricably linked with personal values, responsibility, and consequence (Lyttleton, 1995). Lyttleton (1995) argues that establishing a link between sex related disciplinary acts on one hand, and personal values and responsibility on the other, often leads participants to express a sense of morality about what is right and wrong (Lyttleton, 1995). By suggesting they have a high moral sense participants also hold others to the same values. In so doing, they assume knowledge of the do’s and don’ts about HIV infections and expect others to live by the same forms of knowledge. Therefore, commercial sex workers and other people who are perceived to indulge in indiscriminate sex become the target of this pattern of thought. Participants believe it is only when sexual morals are upheld that self-boundaries will be protected from outside infiltration. As Lyttleton (1995) has already noted, HIV/AIDS campaigns are invariably invigorating moral codes that are increasingly becoming part of public discourse.

After using Foucault’s theory to understand participants’ references to specific health regulatory measures that disciplines the other as well as the self, I now turn to discuss how the “other’s” body has become useful in the meaning-making process. I do this using the various
panic stories that participants shared about their experiences with people who had acquired the disease. These stories are relevant because they demonstrate that the body of the “other” is not only a target of discipline, but also holds value in participants’ attempt at deciphering what the disease means.

Panic Stories and Meaning-Making

Participants’ fear of HIV/AIDS is not out of the ordinary. They expressed fear of the disease in various ways. In this section I use their panic stories to demonstrate how “the body” of the AIDS patient has become a vehicle through which participants give meaning to HIV/AIDS. I asked participants if they have ever seen someone with the disease. Some of the panic stories participants responded with appear below:

I was hearing it on the media but I did not know anybody who had the disease until a family member who traveled to Abidjan came back and she was very sick; she started growing lean. She started showing some of the symptoms. That is when I was told that she had contracted the virus and that she was HIV positive. I got to know that it is real. She suffered and later died. It was very strange that nobody wanted to go closer to her. She was in her forties. I remember I was very scared. Everybody started looking down on my family. Everybody was like “ahhhh you have a very a disgraceful family.” The family was looked down upon, the kind of dignity we had in the past was all gone. Once it is in the family, the family is doomed forever. (Kwadwo, student)
There was one at Ako Adjei, a female, she traveled outside to Ivory Coast and brought this from Ivory Coast. I knew her before she left. Her appearance had changed completely when she returned. Before she left she was an attractive lady, but after she contracted the disease, you would not be even attracted to her because of the way the sickness affected her whole system …. also you can see her hair was very soft, thin, and light. (Steven, teacher)

I have seen both a male and female before and they were close relations, very close. Before the disease attacked them they had the beauty and everything…. but after contracting the disease I did not even go close to them, because they vomited every second and also visited the restroom. They put on clothes and within a short period of time they had to go and change. It is too bad. They all went abroad and when they had the sickness then they brought it back for their parents to cure them but it was too late. They are both dead. The female, she was not all that fat so when she got the disease it was too bad to set eyes on her; she was like a broomstick. When you place them at one place they will be there forever, they cannot even move on their own. She could not go to the bathroom by herself. When they cough and you are around it is dangerous. (Kofi, student).

There was this next-door neighbor who went to Abidjan for a very long time, so when she came back the news we had was that the husband was
dead but we didn’t know what caused it. And she came down with her children…. a year later she also started falling sick and visited the hospital with headache. But as time went on she became very lean; when you saw her it was very bad now she couldn’t even do anything…. she was kept indoors so that people will not see her. You could even see her bones, no flesh; it looked disgusting and as time went on she passed away. (Mina, salesgirl)

I have also seen an HIV/AIDS patient before. The person looked very pale and lifeless. That person was a friend’s cousin and he traveled outside to Nigeria and when he returned he was looking very sick and the sickness continued till he died. Upon seeing him I recognized the change. (Richard, unemployed)

Tangled in the above panic stories is the complex process of how participants make meaning of HIV as a disease. Evidently, personal experiences are applied as interpretive frameworks for understanding the HIV/AIDS messages they receive. Therefore, the sick body participants are familiar with is crucial in the meaning-creation process. As the stories suggest, the aunt, neighbor, or acquaintance who acquires HIV is not just a “sick lean body” that scares them. On the contrary, their bodies become a vehicle through which participants “make-believe” the conceptual messages they receive about HIV/AIDS. Therefore, their depiction of AIDS is related to how it is visualized through the “Other’s” body.
During interviews, participants displayed a wealth of knowledge about HIV/AIDS. However, their knowledge was in abstract form and only became concretized in the AIDS patient’s body. To demonstrate this pattern, Kwadwo claims in his panic story that he “was hearing it on media” but it was when his Auntie started showing symptoms of the disease that he got to know it was real. This suggests the virus may be abstract, but it is localized and rendered familiar through the body of the patient. NB, a college student, emphasizes this: “Through viewing on the TV we will see, and even if we don’t know anything about HIV and we see these kinds of skinny people we get interested and would like to know what is going on.” Kwame shared a similar observation, saying: “I wanted to see for myself so I visited a friend who was doing her national service at Korle Bu. And when I went there I saw nice looking people who have the disease; you wouldn’t believe it.”

Whilst the victim’s body holds value in the meaning-making process, it will be insightful to also explore the profile assigned to these bodies. AIDS patients in participants’ stories are consistently profiled as people who travel to neighboring African countries - Ivory Coast and Nigeria- and return with the disease. It is important to note that Ivory Coast and Nigeria featured prominently in the 2008 Africa Cup of Nations tournament. Ghana won third place in the CAN 2008 competition by beating Nigeria at the quarterfinals and also defeating Ivory Coast in the finals stage. Geographically, Ivory Coast borders Ghana on the west, and Nigeria is located in West Africa, as well.

Unfortunately, the opportunity that will allow people from other African countries, especially these two, to come to Ghana had become threatening to Ghanaians. Participants believed that during the event foreigners will come from the same countries where the AIDS patients they knew visited in the past. The consistency in participants’ profiles of AIDS patients,
as well as their anxieties about interactions with foreigners reinforces Gilman’s theory. As Gilman (1988) suggests, fear of a disease does not remain internalized but it is projected on to the world. Not only is it domesticated in an “Others” body but it is also lodged in foreign communities and in foreign bodies. Yankah (2004) also echoes this claim saying, people in general distance themselves from deadly diseases, often depicting it as exotic, and so are carriers of such diseases.

By profiling AIDS patients as such, participants also demonstrate elements of avoidance or circumvention (Yankah, 2004). According to Yankah (2004), this act is consistent with initial discourses that emerged in Ghana when the first cases of AIDS were diagnosed in the 1980s. Yankah (2004) argues that the emphasis on difference, or the conscious avoidance of characterizing carriers as sharing distinctive features, is meant to legitimize intra-group behavior and depict the exotic as deviation. Interestingly, after three decades, similar impressions are still held in the Ghanaian community.

Therefore, the task of hosting an international event, such as CAN 2008, becomes an avenue for reinforcing individual thoughts and anxieties about the disease. As Bancroft (2001) argues, the virus has come to represent the fears and insecurities of many different societies. In addition, the same event that makes it possible for people from different countries to come together also provides opportunity for participants to make distinctions between the kinds of “bodies” that would be present in the Ghanaian community. Consequently, it is plausible for them to determine who would be potential carriers of the deadly disease and who will be infected.

Furthermore, participants’ narratives suggest intersections between individual fears and anxieties about AIDS and involvement in an event such as soccer are important in specific ways.
First, it demonstrates existing interactions between diverging forms of anxieties and fears in the everyday experience and common discourse. It suggests that individual concerns, worries, and expectations are all located on a common continuum and can easily be triggered by any other experience. Second, it becomes clear that it is participants’ interpretation of and participation in ordinary daily acts that opens a space for make meaning of a global phenomenon.

Although, the disease may be seen as foreign, it is participants’ involvement in daily tasks that renders the disease familiar. In other words, the familiar act of interacting of seeing the neighbor with HIV/AIDS brings them closer to a dreaded disease. Among other things, these same acts also blur the same distinguishing features they treasure. Participants’ expression of fear of the disease implies that HIV/AIDS has engendered a sense of crisis and rupture which encourages the implementation of individual and social exclusionary techniques. However, Becker and Geissler (2007) make it clear that forms of exclusivity and restrictiveness are not only a response to the HIV/AIDS pandemic but were observable long before HIV/AIDS.

The long history of the rise and use of similar restrictive “avoidance strategies” in colonial Africa gives an opportunity for us to reconsider the historical context within which contemporary forms emerge (Becker & Geissler, 2007). Attentiveness to this historical context also reflects the postcolonial perspective which impacts how individuals make meaning of HIV/AIDS. In the next section I engage such debates, again using specific participant narratives. I focus on some of the meaning-making struggles that participants’ narratives suggested.
Postcolonial Subjective Resolutions for an Old Conflict

The multiple, fragmentary, and often contradictory ways through which individuals struggle to achieve some sort of understanding of HIV/AIDS has long been identified by Paula Treichler (1988). She illustrates this complex process in her article, “AIDS, Homophobia and Biomedical Discourse: An Epidemic of Signification.” In this piece, Treichler does not argue we must take both the social and the biological dimensions of HIV/AIDS into account but asserts that the social dimension is far more pervasive and central than we are accustomed to believing. In agreement, I use research participants’ statements to argue that the very knowledge systems available in postcolonial social contexts render HIV/AIDS as an ambiguous reality.

After closely reading participants responses I realized that whereas some participants’ remarks may suggest clear and definite understandings of HIV/AIDS, other participant narratives hint otherwise. A rigorous reading of such incongruent commentaries indicates the subjective struggles participants engage in as they resolve conflicts and contradictions the meaning-making process presents. Therefore, in exploring the narratives, I identify the necessary work individuals engage in as they attempt to understand – however imperfectly – the complex, puzzling, and quite terrifying phenomenon of AIDS (Treichler, 1988).

In my experience talking to research participants, I realized that within the postcolonial Ghanaian context, participants’ make meaning of AIDS drawing on different knowledge systems. On the one hand, they explain the disease using biomedical discourses acquired partly through development-oriented campaign messages. For instance, in an attempt to explain what AIDS is NB, a college student explains that “AIDS is a human immune deficiency virus that gets into our system. We acquire it through indiscriminate sex and the use of blade or any kind of sharp tool.” Akiti, a female data entry clerk, also shared her knowledge about AIDS explaining
that, “When someone has AIDS you don’t have to reject that person. You can talk to them. It is sharing sharp objects with them that is dangerous.

Their explanations are reinforced by another male participants’ statement. Muhammad said: “The medical experts gave us this understanding that the ways that you can contract it are through syringe, sex …. you can prevent it by not engaging in such activities.” Obviously, all three interpretations of AIDS draw on objective, medical, and scientific discourses that articulate and imagine AIDS as a disease fully knowable, explainable, and preventable. When applying these medical discourses participants do not mince words in their explanations of what AIDS is, as well as its modes of transmission.

Although such explanations are widespread, Ashforth (2002) contends the precise mechanism by which HIV infections occurs is not well understood, neither do we fully understand why some people exposed to the HIV virus do not become infected (Ashforth, 2002). And it is such arguments for the inexplicable and uncertain parts of the disease that make us reconsider alternative interpretations of AIDS in postcolonial contexts. Through participants’ responses it becomes clear they are living in a context where alternative, traditional, and spiritual disease interpretations are also plausible. Whereas biomedical explanations project definite interpretations, alternative interpretations are clouded in uncertainties. Consider, therefore, the ambiguities contained in the following statements made by some research participants:

There was this woman that a pastor revealed to her that her husband’s relatives don’t like her and they have given her the disease in spirit, and if she doubts she can go to Korle Bu to check her blood and she will find out that she has the disease…. there are other people they are told they have the disease meanwhile their husbands don’t have it. (Kwadwo, salesman)
A cousin of mine contracted the disease and some of my cousins attributed it to witchcraft and all sort of things. They pointed fingers at some of our uncles as being the cause. While her health was deteriorating they wouldn’t listen to anybody’s advice to take my cousin who had AIDS to hospital. She was there and they were preparing concoctions. The worst of it they were just cutting her with blade and putting herbs into the skin. Witchcrafts, particularly, one of our uncles was the wizard in all these. Everybody was pointing fingers at him. (Reba, batik seller)

I know some pastors will pray for you and tell say you will be healed of AIDS. I have not seen anybody who has been to a pastor for prayers and gotten healed, but I have been hearing it on radio. I know God is a Supreme Being, I believe God can heal but in fact there are certain things that I find it hard to believe. (Afua, petty trader)

I have heard some people say they have been healed. It was one of the pastors from Nigeria. I watched it on the TV. He prayed and the man went and he tested negative. (Ama, unemployed)

From the above statements we realize that the mystery surrounding the disease makes individuals and communities range far and wide in their search for explanations (Becker & Geissler, 2007). According to Ashforth (2002) the HIV/AIDS pandemic is fundamentally
different from a plague or famine that afflicts all equally. Because HIV/AIDS singles out its victims within intimate social networks this lends to the suspicion that malicious individuals are pursuing secret evil work in the society (Ashforth, 2002). Therefore we find individuals calling upon their knowledge of different views on disease, health, and healing (Becker & Geissler, 2007) to make sense of the inexplicable aspects of the disease.

Apparently, within the postcolonial context, individuals employ and develop different derivations –Western medicine, Christian beliefs (introduced during colonial encounters) and, witchcraft, – to make sense of AIDS and also live in its presence (Becker & Geissler, 2007). It is important to note that witchcraft and other religious discourses represent modes of posing and answering questions about the beings, powers, forces, and modes of action responsible for causing suffering in the world (Ashforth, 2002). In this regard, for my participants, AIDS can be anything from a “disease which used to be there in the past, named Ghost disease,” or a disease which is acquired through spiritual forces.

Even though some research participants try to cast the notion of witchcraft, faith, and spirituality as beliefs held by others, this still reflects available knowledge systems possibly used to make meaning of AIDS. Therefore, by sharing these stories, participants in no small way endorse the meaning-making mechanism of the disease as a pervasive struggle/dilemma; a contestation long identified in colonial African contexts, albeit differently. HIV/AIDS, which represents the fears and anxieties of the African society, better resonates this old contestation. As in contemporary times, during the colonial era Africans were faced with healing options that emerge from different disease interpretations. However, overt differences between African interpretations of disease and Western explanations make choices difficult (Worboys, 2001).
What we find in participants’ narratives is a re-enactment of uncertainties, conflicts, and contradictions in the diverse interpretations these distinct knowledge systems present.

Considering the similarities in how Africans made sense of disease during colonial times and contemporary interpretations of AIDS, Becker and Geissler, (2007) argue that AIDS must be seen as one of the most recent in a long line of African struggles with adversity. Like other historical struggles, making meaning of AIDS calls for different frameworks of understandings, practices, and explanatory narratives. In this regard, the interaction between faith and AIDS becomes bound up with the wider context of suffering within which the epidemic is set. Also, the context of suffering makes relevant old strategies that are used to deal with struggles. Consequently, African responses to AIDS are embedded both with much older debates on the ways African lives have been changing, and with the experience of these changes themselves (Becker & Geissler, 2007). Unfortunately, these changes have been forceful and often contradictory since colonial occupation began, and, at best, ambiguous in the contemporary era (Becker & Geissler, 2007).

Conclusion

So far I have used this chapter to discuss how people perceived to be carriers of the disease are subjected to specific micro-practices of discipline. It also highlights how concerns about the possible decay of the “self” leads participants to subject their own bodies to disciplinary actions, as well. In addition, I delved deep into the panic stories participants shared highlighting the important role the bodies of AIDS patients play in the meaning-making process.

The discussion in this chapter indicates that disease is externalized unto “an-Other.” It is this interpretation that leads participants to acquire specific modes of disciplinary measures to protect their social fabric and self-boundaries. Like Bancroft (2001), I conclude that the
boundaries between spaces and between communities are increasingly contested. Also, I use participants’ narratives to argue that, although public spectacles of regulating the body during epidemics are less visible today, the body continues to be a site to be watched over and supervised. I also believe that in contemporary times it is hard to imagine any other contemporary disease, than AIDS, that calls for such bodily subjection, infinitesimal power, and uninterrupted codification suggested by Foucault’s observation of techniques of constraints, prohibitions, and obligations. The AIDS epidemic highlights such disciplinary measures because during its outbreak the body continues to be interpreted as a potential threat to social order, particularly public health (Varas-Diaz, Toro-Alfonso, & Serrano-Garcia, 2005). Therefore, to ensure its conformity, to certain measures the body is targeted and constantly regulated.

In addition, I focus on how interpretations of HIV/AIDS demonstrate an old meaning-making struggle for postcolonial subjects. The struggle of using different knowledge systems to make meaning of an ambiguous entity is discussed as an old experience that existed during the colonial era. With this analysis I make the argument that African experiences need to be considered in a continuum, but not in isolation. It is only through such acts that we can identify how specific forms of tradition continue to remain in colonial and postcolonial discourses. In this context, HIV/AIDS is better understood as another site of cultural anxiety.

As a site of cultural anxiety AIDS discourses are also used to engage tensions related to issues of gender, sexuality, and power. As such, the next chapter focuses specifically on notions of sexuality as suggested by my research participants’ reading of three HIV/AIDS TV commercials.
Chapter Four: Interrupting the Classic AIDS Script

A Cultural Reading of Sexuality in HIV/AIDS Communication Materials

The implied association between AIDS and sex profoundly binds popular AIDS representations with sexual discourse (Gilman, 1989). Therefore, this chapter provides a cultural reading of three specific HIV/AIDS television advertisements in Ghana that perform sexuality in different ways. These scripts are, “Boys’ Night Out,” “Sorry, No Sex,” and “In the Dark.” This chapter starts with a theoretical discussion on sexuality and then moves to narrate these three scripts. This is followed by a comprehensive analysis of sexuality using participants’ interpretation of these advertisements. It explores how the scripts simultaneously conform to, and also deviate from participants’ sexual experiences and ideologies. In so doing it plumbs the cultural relevance AIDS discourses hold by suggesting the wider social context within which sexuality takes on meaning. In addition, it uses participants’ sexual experiences to understand gendered power relations that accompany heteronormative sexuality. It also uses experiences regarding patriarchal domination to explore the ambivalences in heterosexual power relations that sometimes challenge established dichotomies.

Holland, Ramazanoglu, Scott, Sharp and Thomson (1990) see sexuality as “practices, but also what people know and believe about sex, particularly what they think is natural, proper and desirable” (p. 339). Whereas Holland and her research associates emphasize sexual practices and belief systems, Dowsett (2003) broadens the definition to suggest sexuality as an organized body of thought. He categorizes sexuality not only as a structure of ideas but also as an array of discourses, sensations, embodiment of pleasures, formation of sex-object choices, and the endless unfolding of categories of desire (Dowsett, 2003). By suggesting the complexity of
sexuality, Dowsett’s explanation can unequivocally be aligned with Foucault’s (1978) cultural and ideological conceptualization of the same.

In Volume 1 of the series, *History of Sexuality*, Foucault (1978) offers a wider theoretical context for understanding the development of sexual beliefs and values including their cultural and historical dimensions. He relates the emergence of contemporary sexual discourses to power considerations observing that:

> Sex was a means of access both to the life of the body and the life of the species …. this is why in the nineteenth century sexuality was sought out in the smallest details of individual existences; it was tracked down in behavior, pursued in dreams; it was suspected of underlying the least follies.

(p. 146)

In addition, Foucault disputes the neutral position sexual beliefs and ideas assume by arguing that issues relating to sex are vehicles through which access to individuals are gained in the society.

Foucault (1978) continues to posit that pursuing sexuality in such a detailed manner positioned it as the theme of political operations, economic interventions, and ideological campaigns. Therefore, the technology of sex became a whole series of different tactics (Foucault, 1978). Drawing from these arguments, analyses in this chapter perceive sexuality not only as a network of practices, values, and belief systems but also as social structures that enable or disable specific practices and knowledge systems. Furthermore, I believe embodied structure of a society’s sexual thoughts and beliefs can be accessed through verbal, visual, and other popular performances of HIV/AIDS representations. I also believe participants’ responses and reactions to carefully organized sexual discourses can potentially broaden our understanding of sexuality.
Before exploring some of these broad sexual meanings, I narrate below the three HIV/AIDS television advertisements this analysis focuses on.

“Boys’ Night Out”

The scene opens with three young men busily preparing for a night out. In the background music is softly playing. Then the following conversation begins.

Young man 1: I will chill tonight, (Slipping his shirt on)
Young man 2: I am with you, brother (Combing his hair)
Young man 3: Ok, guys… I have got the love thing, (Hands one packet of condoms to each friend,)
Young man 3: But you paaaaa, look it is not about what you wear, it is about how you mmm (wiggles his waist to the admiration of the others)
Young man 2: Oh yeah.
Young man 3: As for me I dey fear AIDS papa so anytime I dey walk if this thing no dey my body I no dey venture self.
Young man 1: Look at what they are saying
Young man 2: But the girls sometimes complain.
Young man 3: They say what?
Youngman 2: That it is not the same.
Young man 3: As for me I tell them say if is not on, then it is definitely not in.

The scene ends with the three young men giving a high five to endorse condom use.

Then a voice-over comes in to conclude saying, “Stop AIDS, love life.”

(Source: Lintax, Ghana and GSMF, International)

“Sorry, No Sex”

The scene opens with a teenage boy and a teenage girl standing at a gate. Then the following conversation ensues:

Girl: I will see you tomorrow, OK?
Boy: OK. (Proceeds to hug the girl, attempting to stroke the girl’s bottom. The girl brushes the boy’s hands off trying to move)
Boy: (Interrupts) Ehhh! But do you still love me?
Girl: Of course, since we started moving together two years ago.
Boy: But if you do then why can’t we?
Girl: Look, just because I don’t want to have sex with you does not mean I don’t love you. Do you understand?
Boy: I do
Girl: Are you sure?
Boy: Yes, I think we can wait.
(Boy and girl hug to end the scene. Voice-over: “Stop AIDS, love life”)
(Source: Lintax, Ghana and GSMF, International)

“In the Dark”
The scene opens in the dark. Man and woman walks pass the camera. Their images appear dark. They enter a building and lights go off. The two start to moan. Then the following conversation follows.

Man: Do we have to…
(Woman walks out of the room.)
Man: No wait, please, please, please.
Woman: What is it?
Man: I will wear the love thing, I will wear the condom.
Woman: You will wear the condom?
Man: Yes, I will.
Woman: You will (smiling.)
(They move away from the camera with hands around each other’s neck. Voice-over: “Stop AIDS, love life.”)
(Source: Lintax Ghana and GSMF, International)
Discourse of Desire and Sexual Politics in the AIDS Script

Even though these narrated commercials speak to specific HIV/AIDS protective measures, research participants use the performances to draw attention to an entire sexual culture. Their responses suggest distinct ways through which HIV confronts sexuality as a symbolic structure invested with diverse sociocultural meanings (Lear, 1995; Varga, 1997). Overall, participants used these scripts as entry points to engage broad conventional sexual beliefs, practices, and discourses. Their interpretations reference diverse sexual norms, but their consistent identification of heterosexual relations as a meaning-invested process stands out. They employ their personal experiences and knowledge of broad cultural norms as interpretive frameworks.

In the “Boys’ Night Out” commercial, for instance, the entire conversation takes place among three young men. Their discussions are used to represent diverse heterosexual experiences with condom use. There is the first man who does not believe it is right to use condoms. He does not use condoms because he is “no undercover lover.” Second, is another gentleman who is in a limbo regarding condom use. He is unsure of himself because whenever he uses condoms the girls complain that it is not the same. However, the third man believes there is the need to always use condoms. Therefore, he has come up with a definitive answer for the girls. He always tells the girls, that “if it is not on, it is definitely not in.”

During conversations, participants did not only identify these perspectives but also isolated such experiences as meaningful sexual encounters. To elucidate this I focus at length on my conversations with one male research participant, I have named Koosei. I let his thoughts and experiences put into perspective the complex dimensions heteronormative sexual relations can assume. Koosei is a high school teacher. The first time I met Koosei he was chatting with a
group of friends. On that day I talked to Koosei and his friends for about an hour and half. After my first conversation with this group of friends, Koosei agreed to meet with me for further conversations. Even though during my first interactions with this group of friends I identified Koosei as outspoken, it was during my second visit with him that he shared some of his personal experiences with condom use. During this second meeting, I asked Koosei if he had something more to say about our previous discussions. For a while Koosei was quiet, trying to recollect some of the issues we had discussed previously. He then proceeded to share the following experience:

Last time when we talked about condoms something was triggered in my mind. I don’t think people have been using the condom consistently. I don’t think somebody will go for a new girl and will use condom continuously for six months. Maybe when the person goes for a new girlfriend the girl may have some virus but I don’t think the guy who has gone for the girl will stay with her for year and continue to use condom for the whole year. May be he will use condoms for the first one month but after that he will not use [it] anymore.

I am talking from my personal experience. Because when I am talking with some of my friends I bring this issue up asking them if they can use condom for one year with a lady and they say after a few months you stop .... after I said that then they were like yes after you have used that for may be one month the following month you may think that now the girl has been coming to my place and she is my girlfriend so now I can put the condom aside. Also, sometimes you want to go extra and see something for yourself
and you will ask yourself why do I have to use condom anymore. Some of the girls also complain. After you have used condom for the first one month they will question why. They will ask why you still want to use condom on them. They say, “what do you think of me? Do you see me as a bad person or what?”

In Koosei’s sentiment, we realize that the various elements of the sexual act are not just pleasurable activities but a process rendered with symbolic meanings significantly read by all partners involved. At the beginning of the relationship, condoms are seen as a protection used by partners who might still have reservations about each other. Therefore, Koosei is not bothered about how his female partner will read condom use. However, as the relationship progresses, symbolic meanings assigned to condom use, particularly issues of trust, are brought to the forefront. In this sense, a decision to continuously use condoms in long-term relationships can potentially undermine trust, which is fundamental for establishing commitments. And it is this understanding that leads Koosei’s female partners to question his intention to use condoms. Obviously, the decision to use, or not to use, has become a struggle for Koosei, as well as the first young man in the “Boys’ Night Out” commercial.

These two young men’s experiences suggest condoms are not neutral preventative objects about which straightforward choices are made (Lear, 1995). Their arguments impute condoms as a meaningful material object that is equally read like any other sexual act or practice. By regarding sex as a meaning-oriented process, sexual partners are required to be conscious of all possible interpretations associated with their actions or inactions. In addition, this research participant’s experience draws attention to the sexual negotiation process as an ongoing struggle.
Even though the statement, “if it not on, it is definitely not in” used in the “Boy’s Night Out” advertisement sounds definite, Koosei’s experience explains sexual negotiation as an ongoing process, especially for those engaged in long-term relationships.

Such endowed meanings of condom use have been previously established by Manuel (2005). In a study focusing on obstacles to condom use in Maputo in Mozambique, Manuel (2005) argues that young people believe it is not necessary to use condoms in relationships built on love and trust. He believes such notions are usually reinforced by stereotypical images of risk groups presented in the media with which few young people identify (Manuel, 2005). Usually people feel that they do not need to use condoms in steady relationships because they are in love and trust each other (Manuel, 2005). However, in sexual relations with people with no commitment to each other, condoms are more likely to be used because partners do not feel they have guarantees about the other partners’ sexual activities (Manuel, 2005).

In addition, participants realize meanings of a sexual act are not separable from gendered power relations and sexual hierarchy; they acknowledge power is active in shaping sexual interaction (Holland, et al., 1990). Research participants unequivocally observe heterosexual relations as a process socially located in gendered power relations. Within this context, sexual encounters have become sites of struggle between the exercise and acceptance of male power and of women’s ambivalence and resistance (Lear, 1995). Therefore, the decision to use condoms or abstain from sex is not a rational choice made by either party but an outcome of negotiation between potentially unequal partners (Lear, 1995). Participants, understanding of these power-related dynamics particularly emerge as they interpret and compare the three HIV/AIDS messages (“Boy’s Night Out,” “Sorry, No Sex,” “In the Dark”).
Whereas the entire “Boy’s Night Out” conversation ensues among three men, their interpretations hint at inter-gender sexual negotiations. In this script we note the centrality of the male voice in the negotiation process. However, the other two narratives (“Sorry, No Sex,” “In the Dark”) place a woman at the center of the negotiation process. For instance, in the “Sorry, No Sex” commercial it is the girl who suggests they abstain from sexual activity. Even though a little argument follows, the boy finally agrees to wait as well. Similarly, it is the woman who suggests condom use in the “In the Dark” script.

Although all three television commercials depict heteronormative sexual relations, research participants interpret them differently. By placing males at the center of the negotiation process, the “Boy’s Night Out” script resonates more with participants than the other two. After watching the “Sorry, No Sex” advertisement, participants find it hard to believe a female partner can easily convince a male partner to abstain from sex. They realize the negotiation process scripted in the “Sorry, No Sex” commercial does not conform to their cultural knowledge of male domination. For instance, David, one participant, believes the suggestion from the girl can break up a relationship. In his own words, David believes the boy in “Sorry, No Sex” “will avoid the girl.”

Also, two other participants, Joojo and Koosei, brought this male attitude close to home by sharing how they would react to such a proposal from a woman. Joojo makes us understand he does not think any girl can convince him to wait. This is endorsed by Koosei, who does not “believe in abstinence because as human beings we have some sexual instinct in us.” The men’s attitude suggests females find it difficult convincing male partners on sexual issues. To endorse this difficulty, Mina, expressed doubts about the girl’s initiative in the “Sorry, no Sex” commercial. She thinks this is “too artificial” since no guy can be convinced to do that.
In deciphering issues of gender, power, and sexuality from AIDS discourses, participants reject notions that deviate from their personal knowledge and social norms, while accepting those that conform. Despite the diversity of concerns, both female and male participants, like Giffin (1998), acknowledge power differences are intrinsic to heteronormative sexuality. Participants’ attentiveness toward gendered displays of power clearly gives meaning to Holland et al.’s (1990) assertion that negotiation of desires and practices occurs in social contexts in which power is embedded. Particularly significant in the negotiation of safer sex in heterosexual encounters is the power that men can exercise over women.

Research participants also believe this power imbalance manifests in other distinct forms of sexual gestures they personally experience. Below I capture remarks by some male participants that elucidate distinct male sexual experiences:

> For us [men] the mentality of being in a relationship is all about sex. To be honest with you, to be in a relationship you just want to be *kpa kpa kpa* (quick, quick) and that is it. And maybe when the other person says let us wait for sometime the other person will take it to mean that you don’t love me or something and will shun the relationship all together and go for another person and it is the same mentality and it will continue. (David, elementary school teacher)

> But with men they will like to come out with the kind of women that they have conquered. To say that yes I have put this one down and I have put that one down. Just to show that he is a warrior when it comes to womanizing. I think that is the reason why. But me I have changed a lot.
Now I don’t take much interest in ladies again. Sometimes I think when you are in school and you are not working, that is when you think about all these things. But when you get to a situation where you have other things to be thinking about you stop thinking about these things. (Koosei, high school teacher).

I know of some guys, anytime…. they get a girl they will go and inform their friends to come and peep for them to know what they are doing. But I think as you grow you become more responsible. (Richie, unemployed).

When I was in senior high school I had these friends and any time there was inter school competition they come to an agreement. Someone would like to set a record in terms of the number of girls he is going to sleep with during the interco (inter college sports competitions). And they will be betting on it. (NB, college student).

These narratives reinforce previous research that emphasizes male desire and insistence for sex; male sexual ego and adventurism; male availability for sex; males as sexual actors; male initiation, and dominance and control of sexual relationships (Karlyn, 2005; Measor, 2006). These narratives do not only highlight such gendered male sexual experiences but also demonstrate acceptance of the superior position assumed by males.

Whereas past research consistently suggests female objectification and conformity to such inter-gender sexual dynamics (Gyimah, 1999; Karlyn, 2005; Manuel, 2005; Measor, 2006), I will emphasize diversity the of heterosexual experiences using participants’ conversations. I
identify differences in women’s sexual experiences and the politics that accompany these experiences. I focus on narratives that show inter-gender sexual interaction as a struggle that sometimes destabilizes male subject position and dominance. To do this, I follow Spronk’s (2005) suggestion for using sexual biographies to understand “male power as a set of relations that do not simply dominate women, but also forms the conditions of being dominated and possibility of modifying domination” (Spronk, 2005, p. 270). In this context, the distinct details of participants’ personal sexual experiences can elucidate the fluidity of power and show how it potentially shifts between inter-gender sexual partners.

In a response, Ben, hints about this complex possibility. Explaining why the female in the “Sorry, No Sex” commercial is pushing for abstinence, Ben speculates “maybe, she is in her menses.” He also claims he can easily relate to the scripted interaction in the commercial. In comparing the commercial with his personal experience, Ben states:

I am going through a similar experience. The girls will tell you that they are in their menses, or say when they have sex they might get pregnant or something like that. They just not ready for that. That is another way they use to avoid sex. Or they might say they are about to …. maybe they are not but it is just an excuse to avoid it. So when they tell you that you will understand because you don’t also want to be a parent. So you just agree.

In the above narrative, Ben acknowledges females sometimes reject male sexual advances with excuses. This understanding speaks to two distinct issues. First, there is a demonstration of conditions that enable possible shifts of power between males and females during sexual negotiations. Second, it shows Ben’s female partner does not only identify gaps in Ben’s male privilege, but she intelligently uses these slippages as points of resistance against
Ben’s male sexual dominance. Her excuses are effective because they are rooted in an apprehension held by most unmarried men in sexual relationships. Ben makes it clear he yields to female excuses because he is not ready to be a parent yet. Similarly, another participant, alerts us to such fears. He says:

Sometimes you are concerned more about pregnancy than AIDS, because the person you are going out with may not the one you want to spend the rest of your life with as your wife. So if the person comes to say they are pregnant then it will create a problem for you. (Richard, Unemployed)

In my conversations it was obvious that young female participants are not ignorant of their male partners’ fear of unwanted pregnancies. If anything, they show clear understanding of the inherent ambivalences this apprehension can present to the sexual politics they engage in. Clearly, women are aware of the dominant sexual position their male counterparts assume culturally. However, they also remain conscious of their male partners’ fear of unwanted pregnancies, a fear that destabilizes the power that males hold during sexual negotiations.

Akosua, a young female participant, elucidates this contradiction in her response. She knows, despite men’s presumed dominance and love for sex, that “they are the ones who are afraid of sex.” She explains, that although males “want to have fun all the time,” they are also “scared of the consequence.” Therefore, men “always have condoms on them …. but still they think the ladies are ignorant.” After closely reading Akosua’s responses and Ben’s narrative, it is clear females translate their profound knowledge of young men’s fears into strategies that effectively destabilize male power and privilege during sexual negotiation. This is exactly what Ben alludes to when he explains the different ways his female partners try “to avoid sex.”
In essence, the above narratives address distinct issues worth highlighting. First, they emphasize participants’ consciousness of social ambivalences regarding accepted notions of heteronormative sexuality that ideologically separates women as sexual agents from women as sexual objects or victims (Lear, 1995). In other words, women do not always respond to male sexual advances as objects or victims but sometimes act as sexual agents playing an active role in the negotiation process. In participants’ responses we find women actively engaging in and celebrating their sexuality in ways that challenge male power. Second, we realize that in doing so females are able to break down specific gender roles and privileges accorded to the various genders. They defy the passive sexual space and role accorded women in society. Third, the active role played by females also demonstrates sexual negotiations as a reciprocal venture. Here, both men and women equally determine the final decision.

Based on these alternative perspectives, I argue, contrary to notions that only emphasize singularity of women's [African women’s] experience of inter-gender relations (Karlyn, 2005; Measor, 2006; Manuel, 2005). By focusing on nuances and contradictions inherent in research participants’ sexual experiences I argue that women are aware of dominant heterosexual cultural practices, yet there is no uniformity in their responses to these practices. This means, that although the terrain of mainstream heterosexuality within which women negotiate sex assumes many common patterns, women’s experiences, as well as the strategies they adopt, might differ considerably. Therefore, I believe that the issue of power relations in inter-gender relationships cannot be categorized in linear/hierarchical or in either/or dichotomies. We cannot constantly place one gender in a fixed superior position while locating the other in a predetermined inferior position.
**Conclusion**

In order to bring a fresh perspective, this chapter combined the theoretical and critical capacities of postcolonial feminist analysis to strengthen our understanding of the discourse of desire and heterosexual politics. As the above discussions suggest, sexuality, gender, and power are prominent among a plurality of contested issues raised by the HIV/AIDS pandemic. Conversations with research participants elucidate the ideological meanings that underline notions of sexuality scripted in HIV/AIDS campaigns. Participants’ responses speak to Holland et al.’s (1990) argument that sexual acts and discourses, as they are currently socially constructed, cannot simply be understood as a pleasurable physical activity. On the contrary, sexual acts and discourses are redolent with symbolic meanings (Holland et al., 1990).

HIV/AIDS commercials analyzed in this chapter demonstrate diverse heterosexual perspectives. However, it is participants’ interpretations, endorsements, and rejections of these scripts that allow the exploration of intersections between sexuality, gender, and power. The scripts demonstrate the gendered contradictions and paradoxes that heterosexuality presents. Even though these gendered sexual norms may have existed previously, it is important to note that dynamics surrounding the HIV/AIDS epidemic give renewed momentum to this reality. I therefore believe that awareness of such wider sociopolitical contexts helps to envision HIV/AIDS not just as another disease plaguing African populations but also as a cultural force that reinvigorates wider social problems that are associated with human sexuality. It is such recognition that led Dowsett (2003) to argue that AIDS is not just a simple epidemic related to gender as difference or division alone but to intersecting patterns of human sexual expression and other complex social forces that are enabled or disabled by these gendered differences.
I now move to the final chapter which provides my reflection, not only on the findings of this research but also on the entire ethnographic process. It combines my fieldwork summaries with my personal epistemological, methodological, and political considerations of feminist ethnography. It confronts isolated fieldwork experiences that led to a rigorous post-fieldwork self-questioning.
CHAPTER Five: Reflecting on the Ethnographic Journey

Post-Fieldwork Self-Questioning: Envisioning Alternative Possibilities

“If there could be a feminist ethnography, it would be a reflection of how the research and writing emerges from concrete engagements with, and clarifications of struggles…in all their diversity.” (Enslin, 1994, p. 560)

I began this dissertation journey with the quest to understand how HIV/AIDS is known within a specific Ghanaian context. My main purpose was to use this knowledge to not only theorize processes and mechanisms through which HIV/AIDS meanings emerge but also to provide a new focus for mapping how individuals symbolically structure their own HIV/AIDS meanings. Therefore, this final chapter provides a reflection, not only on the findings of this research but also on the entire ethnographic process. It combines my fieldwork summaries with my personal epistemological, methodological, and political considerations of feminist ethnography. It confronts isolated fieldwork experiences that led to a rigorous post-fieldwork self-questioning.

During the defining stages of this research I struggled with the choice of an appropriate methodology for exploring the HIV/AIDS phenomenon within a non-Western context. My initial choice was discourse analysis. However, discussions with and advice from other scholars led me to feminist ethnographic methodology, a way of knowing that has led me to rethink what research is, as opposed to what it ought to be. At the beginning of this dissertation, I argue that the mysterious and life-threatening nature of HIV/AIDS compels us to attempt to make sense of it. I also believe, in postcolonial contexts, such as Ghana, that HIV/AIDS campaign messages interact with particular beliefs and past experiences to become ideas in the practice of everyday life.
Therefore, in November 2007 I started making contacts back home with organizations that design, produce, and circulate HIV/AIDS communication materials in Ghana. I contacted five organizations in Ghana that purposely focus on addressing the problem of HIV/AIDS in Ghana. These organizations are Ghana AIDS Commission (GAC), Ghana Social Marketing Foundation International (GSMF), Ghana Sustainable Change Project (GSCP), Ghana Education Service, and Lintax, Ghana. I requested HIV/AIDS communication materials developed and circulated in Ghana by these organizations. During fieldwork, I used these HIV/AIDS communication materials as a means to understanding what HIV/AIDS means to participants. I had the privilege of interacting with 39 participants living in the city of Accra. These included senior level officers from four organizations – Ghana AIDS Commission, CARE International, Ghana Social Marketing Foundation and West Africa AIDS Foundation – that focus on addressing the problem of HIV/AIDS in Ghana.

The entire research process was guided by my understanding of current theories of ethnography. Using this lens I believe knowledge I produce through this process is based on my subjective human experience. Therefore, it is not total but a partial knowledge produced through my personal perspectives, values, and interpretation of specific local forms of knowledge in the Ghanaian context. Also, arguments made in this dissertation consider the time, place, and history within which I was situated during the fieldwork. I also believe the embodied nature of this research process did not only offer me the privilege of closely looking at crucial issues and attitudes expressed and contested on the field, but it also placed upon me, the researcher, a responsibility that requires a critical reflection on the various ethnographic interactions I was engaged in.
Negotiating Difference and Points of Affinity

I returned from the field over a year ago and my main concern was with the interpretation of the raw material I had gathered. However, my concern with the phenomenon this project set out to explore easily constricted a possible focus on the problematics the research process itself generated. With such an overwhelming task, I only imagined this research in terms of output, ignoring the process through which the outcome is generated. However, at this final stage, as I try to reflect on both output and process, I am confronted with the philosophical and critical questions that both the process and the outcome pose for me, as a feminist ethnographer.

Like Lengel (1997), a feminist ethnographer, I wonder if my interest in returning home to Ghana was solely motivated by the need to obtain raw material to be used for my own purposes as an academic. I also question if I can simply highlight the interpretations I generate from this raw material without considering critical and problematic moments during fieldwork that impact the ethnographic process. To these questions, I echo the critical need for both fieldwork and post-fieldwork reflexivity. I believe there is the need for a careful consideration of fieldwork experiences that can prompt researchers to constantly consider the meaning of what they are doing and why they are doing it, or as my advisor puts it, a self-questioning of what is at stake.

From my fieldwork experiences, I believe continuously questioning the “Self” about what we perceive as the importance of the research is one possible means through which we begin to constantly imagine research participants as human beings. Because such a process enables me, the researcher, to envision participants as people who have their own agendas and realities that, in most cases, are different from that of a researcher. However, these fieldwork processes can also caution the researcher to realize there are situations within which connectivity between the researcher and the participants can be found. And it is the constant negotiation of these instances
of difference and affinity in the field that allows the researcher to see participants as cultural producers in their own right, people with whom interactions are worth exploring and pursuing. The ability to hold such notions about participants, in most cases, requires extreme researcher attentiveness both on and out of the field. This is because fieldwork problematics are often revealed through the little interactions on the field. Therefore, extreme focus only on the overt subject matter of the project can render such important moments invisible.

As I reflect on the entire fieldwork process I am reminded of specific ethnographic interactions that reinforce the constant negotiation of class, cultural, and educational differences (i.e., material, social, political power differences) between me, the researcher, and participants. Perhaps my interaction with one male participant, Gerald, can help elaborate these issues and also appropriately speak to difference as an ethnographic concern. I had the privilege of talking to Gerald twice. I first met Gerald during my early days on the field. During the first meeting he was hanging out with a group of friends I approached for an interview. Following a short introduction about the study and its purpose, this group of young men agreed to grant me an interview. After this first meeting I requested individual interviews, and Gerald was among those that agreed.

On the following Saturday afternoon, I met Gerald at a local bar located close to his home. We each ordered a bottle of Coke and then proceeded to continue our conversation. Gerald started by sharing his personal opinion on many of the issues his friends raised during the first interview. We then moved to other HIV/AIDS concerns that Gerald wanted to discuss for about an hour. Just as we were about to part, I asked if he had any questions for me. He replied, “yes.” Without much hesitation, he asked: “I would really like to know where you are coming from.” Even though I was a little surprised, considering he had a copy of my consent form in his
hand, I answered saying: “I am a student in the United States pursuing my Ph.D. in Communication Studies. This project is my dissertation and it is a part of the Ph.D. program I am pursuing. I decided to come back home and do this study on HIV/AIDS.” Then he responded: “Initially, I thought you belong to an organization….So I now know that you are a Ghanaian.”

Whereas this short introduction seems ordinary, it became one of the fieldwork moments that continually defined and also reminded me of my subject position as a researcher. This interaction made me realize participants wanted to know more about me beyond the short introductions I had on my consent form. In addition, I understood, for my research participants, as well as myself, the question of “who I am” is crucial and needed to be continually negotiated during the entire ethnographic interactions. However, the daily, chaotic process of continually interacting with different people poses potential threat to the need for this constant re-negotiation of the researcher’s position.

Nonetheless, in the middle of all the chaos of constant interactions Gerald’s question consistently reminded me to critically examine my class, race, culture, gender, assumptions, and beliefs (Harding, 1997) in the same vein as I examine the meaning of HIV/AIDS within Ghanaian society. In my answer to Gerald, I use two distinctive identity markers. First, I mention my links with Western academy. Second, I describe myself as a Ghanaian who has come back home to conduct this research project. As stated earlier in this dissertation, one challenge of returning to do research at “home” is the researcher’s constant negotiation of her native/outsider and self/other subjectivity.

Such problematics of postcolonial feminist research have been raised by Third World women in the Western academy who return home to study their own cultures (Gajjala, 2004; Khan, 2001; Minh-ha, 1989; Narayan, 1997; Ong, 1995; Parameswaran, 2001; Spivak, 1994).
Their arguments speak to the split identity I held while in the field. In many ways my baggage from Western academia made it difficult for me to assume the total native persona my participants have. Initially, I mistakenly ignored this dual identity thinking I appeared much like Gerald and the other participants I interacted with. I overlooked the advantageous class positioning my access to Western education gave me. But as I closely read Gerald’s profile, I understood why such a question would be of interest to him.

Gerald is a native of Saltpond, a small town in the Central region of Ghana. He moved to Accra in search of a job and now works as a part-time tutor for junior secondary school students. He is single and likes to hang out at the Mallam Ata Market (local market) where he enjoys the company of Kayayei (women who carry goods/wares for money). Within Gerald’s social space, my link with the Western academy remains alien. Therefore, the research process that allowed a contact between these two different worlds demonstrates the class differences that exist between me and participants. I was reminded that in walking the streets of Accra with my backpack and digital equipments, Gerald did not see me as the average Ghanaian he encounters in his everyday experiences. In distinct ways I saw the differences between me and participants fleshing out to place me in a hierarchical position. There were instances in which participants didn’t feel comfortable addressing me by my first name; many referred to me as “madam.”

Whereas these differences granted me access to and respect from participants like Gerald, I must state for other potential participants, it had the opposite effect. A few people refused to speak to me for reasons such as these. In specific cases, especially with men, it was clear gender was an issue. They were not comfortable speaking to a woman, whose educational and class status was higher than what they possessed. Also, there were others that simply felt intimidated by my educational and class background and, therefore, declined to speak to me.
Despite these differences, I could still find several affinities I share with participants. My literacy in specific social relations and local languages in the Ghanaian setting offered me a subject position that partially connected me with participants at various levels of the ethnographic interaction. This was a subject position that simultaneously enabled me to recognize that which strongly binds me with participants and that which disconnects us (Enslin, 1994). Even though the points of affinity I shared with participants could not gloss over crucial economic and power differences, they provided a somewhat common ground for debate and conversation in the field.

For instance, my knowledge and understanding of Ghanaian culture, as well as my ability to speak the native language, made it easy for me to gain the trust of participants. Most participants welcomed me into their homes offering a seat and water. I remember one participant sitting down and gradually taking me through her photo album to make me feel welcome. It was an act that also provided an extraordinary access into the most intimate aspects of this participant’s life stories. In addition, the connection that I struck with this particular participant became the foundation for a relationship that we have both been able to sustain even beyond the fieldwork. It is been over a year since I returned from the field, but I continue to communicate with this participant through e-mails and phone calls.

I must say the sense of affinity I shared with these participants should not be taken to mean my assumption of epistemic privilege nor my ability to provide authentic native accounts. I recount these instances of connectivity together with the differences to demonstrate the complexity of the subject position I occupied during fieldwork interactions, but not to indulge in the twin senses of “speaking for” and “making present” (Natrajan & Parameswaran, 1997). This dissertation by no means purports to speak “for” the participants I engaged neither does it seek to
perpetuate neocolonial representations of Third World subjects. I emphasize this because the knowledge produced through this research occurs within a complex and fluid ethnographic research process embedded within broader social relations. I believe this is a complex dynamic that simultaneously blurs and elucidates the affinities I share with participants and also the differences between us. For me, personally, this also distorts the boundaries between home and field.

Therefore, my findings should always be seen as interpretive and partial, yet making visible stories that are often untold about issues of HIV/AIDS, sexuality, power, and gender as they pertain to broad postcolonial contexts. In addition, I hope that through this dissertation the Western reader and researcher will become conscious of Third World peoples as active subjects who resist subordination and create a social space for themselves (Lengel, 1997; Natrajan & Parameswaran, 1997). For this purpose, my analysis does not enable or encourage dominant and stereotypical images of Africa as a region with high HIV/AIDS prevalence.

On the contrary, I analyze the stories of research participants highlighting the contexts, histories, and everyday political struggles they engage in to understand HIV as a phenomenon. For instance, my analysis of the discourse of sexuality evident in HIV/AIDS communication material acknowledges how women in their own ways resist male sexual domination. Here I explore participants’ interpretation and experiences of sexuality to confront subjective experiences that speak to the gendered power relations that accompany heteronormative sexuality. More importantly, I use participants’ stories to theorize ambivalences in these heterosexual power relations that sometimes challenge established norms of sexuality. This finding not only suggests the fluid nature of the power position men occupy in heterosexual relations but also the various ways through which women use their femininity to challenge this
dominant male position. I therefore, conclude that HIV/AIDS has become a cultural force that reinvigorates wider social problems associated with gender, sexuality, and power. AIDS should be seen as phenomenon that has given a renewed impetus to complex social forces that are enabled/disabled by them.

What is at Stake for Ethnographies in Post-Colonial/Development Contexts?

Drawing from her experience in conducting fieldwork in international contexts, Sultana (2007) proposes that ethnographic projects conducted in postcolonial contexts must be attentive to the histories of colonialism and development. This is important because, as Enslin (1994) states, “there is no “inside” untouched by an ‘outside’” (p. 556). In this regard, I discussed earlier in this dissertation some colonial discourses that help clarify the context within which current HIV/AIDS discourses emerge in Ghanaian society. I argue that contemporary references accompanying HIV/AIDS are suggestive of broader cultural norms that can be understood in relation to both colonialism and postcolonialism. This is because these angles provide a prominent lens through which we can explore social, cultural, and historical dimensions of disease and also emphasize issues of power and resistance. Thus, a close engagement of the theoretical and critical with the historical in the African context means looking at how disease has been approached during colonial times.

During Africa’s colonial days, the overwhelming presence of a colonial power that constantly positioned, scrutinized, and distributed colonized bodies - both sick and healthy- highlights the historical contexts that simultaneously enable contemporary attitudes of power and vulnerability toward the disease. In addition, the historical context explains many of the complex social and economic dimensions of contemporary problems such as HIV/AIDS. Therefore, by remembering them we are able to portray participants’ stories and experiences as lived
consequences of such challenges. For instance, in chapter 3 I argue that the process whereby my research participants continually localize HIV/AIDS in the “Other’s” body reverberates with well known binary tropes that accompany colonial discourses. Through such a lens, the study makes an interesting finding which suggests a neat tie between colonial disease outbreak contexts and contemporary stories shared by research participants.

Also, the study finds that the past-present connection also allows for a rehearsal of particular disease reactions that inadvertently target the “Other’s” body. In this case, we cannot overlook participants’ observation that HIV/AIDS patients are either “kept indoors” or “in isolation” as isolated cases. But as this study remembers similar colonial situations it makes it understandable how current attitudes regarding AIDS entered participants’ imaginary, and the kinds of material practices they both encourage and enable.

Similarly, this study couldn’t disregard ambiguities contained in HIV/AIDS meanings participants are accustomed to. The study finds that participants draw on mainstream medical discourses that articulate and imagine AIDS as a knowable and explainable disease. However, a close reading of their stories indicates alternative traditional and spiritual disease interpretations that highlight the inexplicable aspects of the disease. Overall, this demonstrates the contradictory nature of the diverse philosophical and ideological interpretations postcolonial subjects draw on to explain disease, health, and healing. The unusual combination of objective Western medical discourses, together with ambiguous traditional explanations, enables us to better see participants as both producers and products of a colonial social system; and as people implicated in the present transmission and perpetuation of past colonial struggles (Odamtten, 1994). Therefore, this postcolonial reading of these meanings of HIV/AIDS in an African context perceives the disease as essential to a broader historically informed understanding of Africa’s political present.
In this regard I argue that meaning-making of HIV/AIDS is context specific. Hence, the meanings that my participants bring to the disease are informed by a specific context that has a long history of colonial rule and recent experiences with issues of development.

Besides colonialism, the study finds that the issue of development is also closely linked with HIV/AIDS discourse in postcolonial contexts. Scholars reasonably see “underdevelopment” as a crucial determinant of AIDS due to its rapid spread in developing countries (Altman, 1999; Poku, 2002; UNAIDS, 2007). To account for uneven patterns of development, the development concept recommends solutions that address “underdevelopment” (Tucker, 1999). In this regard, there is a constant supply of specific solutions to address “underdevelopment” problems such as HIV/AIDS. What is entirely clear in such practices is the dominant position assumed by development practitioners who control HIV/AIDS projects and other development programs in Third World contexts.

The study identified that past and present experiences with development practices lead participants, the state, and development practitioners to define expert knowledge and expertise as external. Therefore, community members continually look for answers not within their society but from numerous NGOs and other outside organizations. This experience encourages a development process whereby external interventions in the lives of participants have been seen as the inevitable and expected answers to the HIV/AIDS problem in Africa. I realized that this understanding of the development concept, coupled with my blurred native/outsider subject positioning, created a perfect opportunity for participants to identify me as a representative from an NGO.

On several occasions, participants asked if I worked for an organization. However, it did not take long for me to realize such questions and perceptions are linked with specific
expectations participants had. During interviews, participants made it clear they either expected to receive free condoms from me or thought I would introduce them to an HIV/AIDS cure. There was even an instance where one participant asked if she could organize an HIV/AIDS program for a group of women and have me come in to educate them about the disease. When I asked participants why they have such expectations, one respondent said that is what usually happens when they attend HIV/AIDS programs. Most often at the end of HIV/AIDS programs, organizers hand out male condoms to attendees. Also, most of the HIV/AIDS programs they attended in the past were educational.

From these interactions it was obvious that participants had direct and tangible expectations from me, a researcher who in many ways bears a resemblance to the many NGO workers they have become accustomed to seeing. Also, upon reflection, I have come to understand that embodied interactions characteristic of ethnographic research practice provide a perfect opportunity for participants to look forward to immediate material benefits from the process. However, I was in no position to either provide condoms or introduce participants to a cure. Thus, I used statements on my consent form that clarified my position as a student. I made it clear to participants I was a Ph.D. student and that this research is a part of my academic work. Overall, this became a convenient excuse that allowed me to continue with my fieldwork and safely ignore participants’ expectations. However, as I do this intense self-questioning I am beginning not only to grasp the full power in participants’ perceptions and expectations but also understand the politics of my response and reactions to these expectations.

First, such participant expectations clarify some key problematics of feminist ethnography. “Although feminist ethnography is considered to be an ideal methodology for feminist research” (Lengel, 1997, p. 235), the fieldwork situations I described above suggest a
crucial disjuncture between theory and practice. From my experiences I wonder why this research process privileges the need for collecting raw material over the material benefits and expectations of research participants. I also wonder how this process easily allows me to ignore the possibility of contacting an organization for packages of condoms that could be handed to participants free of charge. Why did I overlook the opportunity to combine my research agenda with the provision of material benefits? Why did I encourage the disconnect between theory/academia, on one hand, and practice/activism, on the other by ignoring participants’ expectations? Why and how I was able to conveniently dissociate myself from a section of civil society popularly known for activism and taking a political stance is a philosophical question that continues to plague me.

Second, questions raised by participants’ expectations led me to begin re-envisioning a new and different direction for this research project. To help deal with these dilemmas, during the next steps of this project, I plan to build upon knowledge gained through this research by adopting a methodological approach that emphasizes praxis, a process that creates a space where theory and practice are constantly clarified through critical engagement (Enslin, 1994). I believe such a dialectical and critical engagement can ensure important positive and pragmatic shifts in the way I work as a researcher, and the products I am able to produce for various audiences.

Even though I am considering a praxis-oriented approach, I am also conscious of the specific constraints such methodological engagement can enable. For instance, Enslin (1994) deliberates on how structural requirements of the academic pursuit can inhibit similar processes. As a postcolonial feminist researcher, however, I am more concerned about how my personal involvement in participants’ struggles can emphasize unequal power relations between me, the
researcher, and participants. Lengel (1997), after studying Arab women in Tunisia, speak of the potential problematics of such methodological engagements.

Lengel (1997) believes a researcher can actively offer assistance in the field, but must not ignore the reality where researchers can become “donor gods and goddesses, furthering the dependence of the powerless on the powerful” (Lengel, 1997, p. 239). Lengel’s (1997) emphasis is not on the researcher’s involvement in participants’ struggles per se, and she is not concerned with the benefits the researcher can offer. However, her apprehension stems from the superior subject positioning often accorded to and assumed by the donor and the unequal power relations it perpetuates between the donor and the recipient. In such relations, local forms of knowledge and expertise can be stifled, whereas outside provisions are perceived as superior skills needed to ensure desired social change.

In the field I realized it was not only participants’ expectations of donations that set this unequal relation in motion. My conversations with professionals who work for organizations addressing the AIDS problem in Ghana suggest a similar understanding. For instance, their solutions to the problem usually focused on external expertise that needs to be presented to local communities to ensure change. They often disregard ambiguities in participants’ understanding of the disease as naïve or ignorant. This attitude explains why many HIV communication materials in Ghana disregard the histories, stories, and struggles of the local communities but emphasize the expertise of development practitioners.

At this point I would like to problematize what is at stake here by broadly conceptualizing the implications that alternative meanings of HIV/AIDS can have for HIV/AIDS communication practitioners, communication scholars, as well as medical doctors who are confronted with the problem of HIV/AIDS. Considering the struggles in the meaning-making
process, I believe a gap is created either way, whether practitioners acknowledge the ambiguities that alternative meanings of HIV/AIDS bring, or disregard it as naïve and ignorant. On one hand, the disregard of alternative meanings by HIV/AIDS practitioners creates a gap because they do not address different forms of disease interpretation that AIDS generates within that space. In this case strategies are partial because meaning-making is not considered comprehensively. On the other hand, even if these alternative forms of meaning are considered, there will still be a gap that is created by the fundamentally different and irreconcilable epistemologies within which these forms of interpretations are rooted. In this sense, practitioners would have to design strategies that can potentially bridge the gap.

To address this conundrum, I suggest that associated practices of modern/development responses to AIDS in Ghana must work with local knowledge systems. Practitioners need to adopt Western responses that can positively dialogue with traditional interpretations of disease and healing. I believe that through dialogue, responses to the AIDS problem can weave both local and external forms of expertise to adequately address the problem of HIV/AIDS in Ghana. Also, practitioners must realize that this collaboration between external and internal knowledge systems can happen only when the state, practitioners, as well as individuals think positively about internal knowledge systems. Getting the society to think positively about traditional ways of knowing is important because many have become accustomed to a “development” concept that consistently blames traditional practices as hindrances to progress. Unfortunately, this attitude makes the collaborative effort challenging because even though traditional interpretations are deeply rooted in societies individuals continue to distance themselves from it.

Considering the limitations of the research approach together with participants’ responses, I also re-imagine the next steps of this project as a long-term venture that engages the
struggles of participants but does so cautious of the possible power relations. Finally, I must state that I am not presenting my final thoughts on the project and the visions I hold as a new model for feminist ethnography. Rather, I hope they use these discussions to demonstrate the complexity of such an approach. Also, I am considering such new methodological engagements because I hope it can not only situate my knowledge and praxis but also enable me to participate in particular conversations, share certain visions, and be held accountable for seeing and knowing in various spaces of struggle (Enslin, 1994, p. 560).
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APPENDIX A

Consent Form

My name is Phyllis Dako-Gyekye, a doctoral student in the School of Communication Studies, Bowling Green State University, Bowling Green, Ohio, USA. I am conducting this research on how people interpret HIV/AIDS media campaign messages. I am specifically interested in understanding how people make meaning of the disease. I have selected you to participate in in-depth interviews. I will be seeking the help of approximately 30 adults like you to volunteer to participate in in-depth interviews. The interviews will last for approximately two-three sessions with each session lasting about 90 minutes. All participants will be in the age group of 18-49 years who live in the city of Accra. The risks associated with this study are no greater than those encountered in daily life.

During the interviews, you will watch, listen and read different forms of HIV/AIDS media campaign messages that are in circulation in Accra. After watching, listening to, or reading these campaign messages we will enter into a conversation where you will share your understandings of HIV/AIDS. The interview will be audio-taped. Also, note that all information that you give to me will be confidential and used only for the purposes of this study. In Ghana, all information will be locked in drawers at my residence at Bubiashie. Upon arrival at the United States, information will be locked in drawers at my academic advisor’s office at West Hall, Bowling Green State University. I will be the only one who has the keys to access information in these drawers. To ensure confidentiality, I will use a pseudonym when I am quoting you in my report. All electronic information will be password protected. If you agree to participate, you do not have to answer any question that you are not comfortable with. You may also choose to withdraw from the interview at any time.

Potential benefits of this project include the creation of a space where you can air your thoughts and opinions about this deadly disease. This study will open avenues for participants to make positive contributions to future HIV/AIDS interventions. Through this study the Ghanaian society will also expand its knowledge about why the disease continues to persist. These understandings can inform the numerous HIV/AIDS intervention programs that are implemented in Ghana every year. Please know that the activities I observe during my meetings and your responses to interview questions are for my educational purposes. You have the right to have all questions concerning the study answered by me.

You will be provided with a copy of this consent document for your records. I am also providing you with my contact information so that you can ask me any question regarding your rights as a research participant at any time. My personal e-mail address is phyllid@bgnet.bgsu.edu. You can also reach me by phone on 021-240-798. If you need more clarifications about this study you can also contact my academic advisor, Dr. Gajjala, 419-372-0528 or radhik@bgnet.bgsu.edu. In case you have further questions about the conduct of this study please contact the chair of Human Subject Review Board, Bowling Green State University, (419)372-7716 or hsrb@bgsu.edu. Please indicate if you grant permission for me to audio-tape the interview by checking one of the choices mentioned below.
Check One
Yes, you may audio-tape the interviews
No, you cannot audio-tape the interviews
Signature--------------------------------------

Date-----------------------

School of Communication Studies
302 West Hall
Bowling Green, Ohio 43403
419-372-8349
fax: 419-372-0202
http://scs.bgsu.edu
APPENDIX B

Pre-Interview Questionnaire

My name is Phyllis Dako-Gyeke, a doctoral student in the School of Communication Studies, Bowling Green State University, Bowling Green, Ohio. I am conducting this research on how people interpret HIV/AIDS media campaign messages. I am specifically interested in understanding what meanings people attach to the disease. Can you spend 5 minutes with me whilst I go through this pre-interview questionnaire with you? I want to know if you will be eligible to participate.

Date:

Name:

Gender:

Age (Circle One): (1) 18-25 (2) 26-35 (3) 36-49

Occupation:

Highest Level of Education:

Contact Information:

Appointment Date, Time and Venue
Unstructured Interview Guide

1. Can you please introduce yourself?

2. Tell me the story you just heard/seen/read in your own words.

3. Have you heard other stories about HIV/AIDS before?

4. What other stories have you heard about HIV/AIDS?

5. Are the other stories you heard similar to these stories?

6. Are the other stories you heard about HIV/AIDS different from these stories?

7. How different or similar are those stories?

8. What do the narratives you just heard/seen/read say about HIV/AIDS?

9. Tell me something about the first time you heard something about HIV/AIDS.

10. What is HIV/AIDS?

11. How do you define HIV/AIDS to someone who doesn’t know what the disease is?

12. Are you aware of any disease that is similar to HIV/AIDS?

13. How did you get to know about HIV/AIDS?

14. What are your personal thoughts/ ideas on HIV/AIDS?

15. What is your understanding of HIV/AIDS as a disease?

16. What do you think about HIV/AIDS when you hear/see/read such messages?

17. What do you think about HIV/AIDS as a disease?

18. What comes to your mind when you hear the word HIV/AIDS?

19. Why do you associate these meanings with HIV/AIDS?

20. Is there anything you want to say about HIV/AIDS that I have not asked?
Structured Interview Guide


2. Some background information on your organization. Your organization’s role in providing care, support and treatment for people living with AIDS in Ghana.

3. What are some of the objectives of your organization which are related to HIV/AIDS?

4. What is the relationship between your organization and the Ghana AIDS Commission?

5. What is the relationship between your organization and other organizations actively involved in HIV/AIDS campaigns in Ghana?

6. What kind of treatment does your organization currently offer people living with AIDS?

7. Is it highly patronized? Why?

8. What are your impressions about HIV/AIDS treatment in Ghana?

9. Would you say treatment is widely available to people living with AIDS?

10. Do you think the government is adequately funding the treatment of AIDS patients in Ghana?

11. Any ideas on the state of HIV/AIDS in Ghana.

12. What would be your suggestions for future directions as far as AIDS treatment in Ghana goes?

Thank You.
HIV/AIDS Campaign Posters

He didn’t JUDGE YOU?
Why should YOU?

Judging people with HIV is not Christ-like

Stop AIDS Love Life
Abstain & Be faithful & Condom use
The Choice is in Your Hands
He didn’t JUDGE YOU?

Judging people with HIV is not Allah’s will

Who are YOU to JUDGE?

People living with HIV are JUST LIKE YOU

Pharmacist
Likes to play football
Loves fufu
Has HIV

Accountant
Likes reggae music
Enjoys working on his old car
Does NOT have HIV

*Disclaimer: The models used in this production are professionals. Use of their photos does not suggest their HIV status.*
Who are YOU to JUDGE?

People living with HIV are JUST LIKE YOU.

*Slogan: The models used in this production are professionals. Use of their photos does not suggest their HIV status.

Stop AIDS Love Life

Abstain Be faithful Condom use
(From sex) (Together) (Everytime)

The choice is in your hands.