"Making it personal": ideology, the arts, and shifting registers in health promotion

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ABSTRACT
In South Africa, health promotion related to HIV/AIDS has been characterised as a component of public health prevention. It has heavily utilised global health ideology to construct promotional messages that rely on neoliberal models of individual, responsible health citizenship. However, after nearly 30 years of public health messaging, there have been only minor shifts in the country’s HIV prevalence rates; it has become apparent that there is disconnect between policy, programmes, and target audiences. Debates about where this disconnect occurs tend to focus on the role of problems in biomedical knowledge translation or with structural inequalities that lead to health inequity. As debates increase, artists involved in health have emerged to address an additional reason: audience interpellation. In this article, I interrogate relationships between health promotion ideology and processes of interpellation. I suggest that disconnect between the two has roots in the tone of programming, the ways sociality is constructed within health promotion, and the kind of subject which global prevention programmes seek to constitute. Using a case study, I illustrate how public health ideology is made actionable through arts practice. While conventional health promotion programmes address populations in a way that allows individuals to distance themselves, members of South Africa’s arts sector have worked to integrate prevention and care in a way that bolsters interpellation through making messages personal. The case study presents one performance but is informed by my broader research with over 20 theatrical groups conducted during 18 months of fieldwork. Analysis of the production reveals that artists act as mediators between population-level public health messages and individuals through the embodied technologies of applied theatre. However, I argue that artists also create space for participants to reimagine configurations of care, responsibility, and intimacy within health practices.

Introduction
While public health is a highly politicised endeavour globally, its deeply political roots in South Africa are reflected through the mobilisation of people across government and civil society to address the country’s staggering burden of HIV. Around 6.8 million people of a total population of 54 million are HIV positive, and South Africa has the highest number of people living with HIV in the world. Despite recent advances in antiretroviral rollout, increases in HIV testing, decades of health promotion campaigns, and a strong history of AIDS activism, the country’s adult HIV prevalence rate remains around 16–20% nationally and an estimated 39.5% in provinces such as KwaZulu-Natal (UNAIDS, 2012).

From 2010 to 2011, I spent a year conducting ethnographic fieldwork in South Africa with artists involved in HIV/AIDS initiatives. As HIV became an increasing topic of public discussion, it was incorporated as a social issue of importance in applied theatre. I asked the artists with whom I worked what they thought about the discrepancy between decades of intervention and the persistent transmission of HIV. Without exception, they expressed their confusion, raising questions that became a kind of mantra within health intervention circles: “Why? How can this be? What is going on?” Lisle,1 a senior theatre-maker and artistic scholar, invoked messaging in her discussion of the shifts that have occurred in HIV intervention styles:

In the beginning, they were all information based because in the mid-80s, AIDS was quite new. A lot of HIV work was a matter of getting across information about HIV and AIDS and ABC – abstain, be faithful, condomise. That seemed to be the message for quite a long time. The next message that came up was “know your status”. So, the importance of being tested and the kind of self-knowledge, self-care, and control over one’s life that being in a position of having knowledge would give. After years of information giving and voluntary counseling and testing, there was still a problem, so...
now everyone’s begun saying, “Why is there still a problem?”

Now in her 60s, Lisle has witnessed major changes in the country. She lived through apartheid and the shift to democracy, and she has observed 30 years of national public health intervention policy as the government struggled to manage the country’s AIDS epidemic. What Lisle alluded to above is that Knowledge-Attitudes-Practices approaches to health promotion, on which many past programmes were based, rarely conform to people’s lived experiences. The correlation between knowledge about HIV and safe sexual practices is not as simple as often constructed in national and global health campaigns (Parker, 2001; Pigg, 2001; Rossiter et al., 2007). Most health practitioners I met observed with frustration that knowledge rarely equates directly with action among the populations they served.

After decades of direct, targeted, and robust health promotion campaigns, urban HIV literacy in South Africa is high, but HIV prevalence rates remain elevated. Health promotion messages tend to be didactic, normative, and underscored by neoliberal agendas to create responsible health subjects who invest heavily in notions of self-care and regulation. This constitutes intervention in what I suggest is an imperative register; in such contexts, targeted populations cognitively process the information but then set it aside as inapplicable or non-actionable in their lives (Middelkoop, Meyer, Smit, Wood, & Bekker, 2006; Parker, 2001; Parkhurst & Lush, 2004).

While this discrepancy between instructive messaging and personal action is well documented, questions remain: why does disconnect happen, where does it occur, and how can it be addressed? In response, in contrast to imperative forms of health promotion, some artists have advocated a more embodied form of intervention that encourages participants to think about the relevance of messages to their own lives and speculate about what their future actions might be. Through this more speculative and participatory register, theatre-makers attempt to intervene in the gap between conventional health promotion ideology and the ways everyday people experience the worlds in which they live, the realities of their lives, and their relationships to healthcare.

In this article, I interrogate key questions concerning South Africa’s arts sector, national public health programming, and the processes through which health ideology becomes relevant to individuals. In it, I consider how theatre-makers take up the normative directives for care of the self that are implicit in public health approaches to HIV/AIDS and explore how artists interpret, incorporate, or challenge these directives. I draw on Louis Althusser’s understanding of interpellation (1971) and Michel Foucault’s writings on governmentality and subjectification (1977, 1982, 1988). I also develop the concepts of imperative and speculative registers as analytics to think through differences between modalities of interventions and shifts in intervention agendas. Using a case study of a performance at a major national annual arts festival, I illustrate how artists use applied theatre to give public health messages personal meaning and highlight processes of interpellation that occur in the arts. I illustrate how, through participatory theatre processes, applied theatre acts as a technology of governance by aiding the interpellation of public health messaging.

Simultaneously, I argue that theatre opens a space of embodied enactment that renders visible fissures in conventional public health messaging. The speculative register of theatre interventions allows participants to reject, contest, or reimagine the configurations between care, intimacy, and responsibility that have historically underpinned national health promotion projects. In particular, I show how theatrical practices trouble the models of sociality on which much public health messaging rests. Instead of drawing on rigid boundaries between self and other, theatre-makers increasingly incorporate national ideas about ubuntu to create different ways for people to engage with and act on public health messaging.

Methods

Study population and data collection

In this article, I draw on data generated during 18 months of fieldwork conducted from 2008 to 2011 within Johannesburg (12 months) and Cape Town (6 months). I administered and audio-recorded in-depth semi-structured interviews with 81 theatre-makers (Johannesburg n = 56, Cape Town n = 25) who produce HIV/AIDS-related performances, and 30 audience members who had seen HIV/AIDS-related theatre in South Africa. The artists belonged to 20 theatre organisations in the country, but I primarily interviewed members of seven theatre groups and five individual theatre-makers (n = 67). In addition, I conducted participant-observation at the following levels of theatre: training organisations, institutionalised theatre groups, private individual projects, and community theatre groups. I also attended and collected filmed footage of 55 health-related plays in Johannesburg, Cape Town, and the National Arts Festival in Grahamstown.
**Data analysis**

Written field notes from participant-observation, interview transcripts, scripts, and collected public media documents were entered into and organised with MaxQDA 11 qualitative data analysis software. I coded the data for major emergent themes and conducted qualitative inductive comparative analysis of the goals, ideology, communication strategies, performance aesthetics, and self-reported impact of the theatre groups represented. Quantitative analysis within this project was largely confined to audience demographics and cultural domain analysis. I recorded the results of cultural domain analysis using MaxQDA and ran basic statistical operations to reveal patterns in domain construction (HIV/AIDS-related health issues identified as relevant by theatre-makers and by audience members).

**Background**

The First International Conference on Health Promotion was held in Ottawa, Canada, in 1986, in response to growing expectations for a new movement that would better attend to population health, the social determinants of disease, and issues of health equity, in contrast to the more clinical, individual, and technological foci of biomedicine (World Health Organization [WHO], 2015). It resulted in the Ottawa Charter for Health Promotion, prior to which health education dominated popular ideas about this field (Coulson, 1999; WHO, 2015). The Charter clarifies the place of education as one component among many within health promotion and recognises the links between individual actions, socioeconomic conditions, the physical environment, politics, policy, and health. Health promotion is defined as “the process of enabling people to increase control over, and to improve, their health” (WHO, 1986, p. 1) through manipulating the determinants of health and their own actions (Nutbeam, 1998). It is presented as a comprehensive approach combining politics, legislation, fiscal measures, organisational change, attention to physical environment, and individual or community actions. Consistent with this, the Charter sets out three basic strategies for health promotion: political advocacy for health, enabling individuals and groups to improve their own wellbeing, and mediating between different interests in society in the pursuit of health (Nutbeam, 1998; WHO, 1986). These are supported by five priority action areas: building healthy public policy, creating supportive environments, strengthening community action for health, developing individual skills, and reorienting health services (Nutbeam, 1998; WHO, 1986).

The Ottawa Charter policy was incorporated into South Africa’s health system in 1990 (Coulson, 2000; Onya, 2007). With the turn to democracy in 1994, primary health care (PHC) became a focus of the newly elected African National Congress government to address the deep health inequities caused by policies of the former apartheid regime. Health promotion was considered a pillar of PHC and remains so today (National Planning Commission, 2011; Onya, 2007). Although South African health policy conforms to the Charter’s multi-strategy approach in some areas, health promotion continues to be understood narrowly as health education in other contexts, including in HIV interventions (Bunton & Macdonald, 2002; Coulson, 1999; WHO, 2015). Health promotion has historically been relegated to prevention activities, but promotion efforts related to HIV focus almost exclusively on individual skills, including health information, education, and communication (IEC) strategies (Ndlovu et al., 2013; South African National AIDS Council, 2013; WHO, 2005). This is partly because HIV interventions were structured post-democracy; the implementation tactics for prevention, treatment, and care modalities have been deeply shaped by early economic policy, in particular the 1994 Reconstruction and Development Programme (RDP) and the 1996 Growth, Employment, and Redistribution Plan (GEAR).

The RDP was designed to improve service delivery to the impoverished and support human rights, justice, and development (Lodge, 2002). It set forward PHC as the means to address health inequity, but this was quickly undermined by the introduction of GEAR two years later, which emphasises economic growth, deficit reduction, and privatisation in all sectors of the economy (Onya, 2007). GEAR privileges neoliberal economic stabilisation and is structured in favour of capital instead of national spending on social and health services (Lodge, 2002). It led to the privatisation of healthcare, a tacit redefinition of the AIDS epidemic in monetary terms, and significant budgetary constraints on HIV/AIDS interventions. This encouraged policy makers to look for cheap, quick-fix solutions to the country’s increasing HIV prevalence rates (Wouters, van Rensburg, & Meulemans, 2010). With neoliberal reform, health promotion privileged education and awareness campaigns over structural interventions, which are more costly and difficult to implement. While education encompasses information about the social determinants of health, this focus is rarely at the centre of HIV/AIDS awareness. More often, as elsewhere in the world (Abdul-Quader & Collins, 2011), individual risk factors and behaviours comprise the core messaging components of national HIV/AIDS education programmes.
Conceptual framework

To analyse the relationship between neoliberalism and health promotion, I begin with Michel Foucault’s notions of “subjectification” and “governmentality”. Subjectification is the process of forming oneself as a subject, and it indexes both the production of subjects and their subordination to power, norms, or authority (Bergschmidt, 2004; Besley, 2005; Davis, 2012; Foucault, 1982). Because such processes are socio-historically situated, it is important to examine the forms of subject to which an individual is encouraged to aspire, the ideology on which those forms are built, and how and why people subject themselves to particular political-economic rationalities. A related concept is governmentality, defined by Foucault and scholars of his work as the ways in which humans have come to govern themselves and others, or “the conduct of conduct” (McNay, 2009; Rabinow & Rose, 2003; Rimke, 2000). The concept allows us to analyse modern forms of power and their political rationalities, including all modalities of the social control of populations (Lemke, 2000, 2001). In applying Foucault’s concepts to examine health promotion as a technology of governmentality, I illustrate how neoliberal ideology positions particular ideas of health and the routes to attain it as correct and moral, while others are marginalised. As a result, technologies of neoliberal governmentality seek to produce a form of health subjectivity that not all people recognise as relevant, resulting in disconnect between health promotion aims and effectiveness.

One explanation for this disruption is what French philosopher Louis Althusser calls processes of “interpellation” (1971): the constitutive process through which individuals recognise, respond to, and internalise ideology (Althusser, 1971; Nguyen, 2015). In order for the subject positions promoted by ideologies to be occupied, individuals must accept them. Althusser’s classic example is of a policeman yelling “Hey, you!” in public and an individual turning in response. In the embodied process of turning, the individual recognises the authority of the policeman and his or her own subjugation to it, thereby constituting the individual as a subject of the law (Althusser, 1971). Health promotion operates similarly through privileging certain ideology to construct norms that guide how people understand themselves and their practices (Coveney, 1998). Although disruption in interpellation processes can be caused by many factors, I focus on two in relation to HIV health promotion: the tone of programmes and the subject they seek to construct. Both tend to be at odds with the ways people experience their lives. Hence, artists argue, conventional health promotion often misses its mark. In response, some artistic groups have taken up IEC objectives, but they seek to more effectively invest audience members in the ideological commitments of health promotion through participatory processes designed to make programme messages personal. In the process, artistic interventions concomitantly open spaces for questioning the ideology on which much health promotion rests, thereby shifting from an imperative to a speculative register. I illustrate this below.

Findings: Scrutinize workshop

As I walked into a classroom, a woman in her late 20s addressed the small, gathered group, “Have any of you ever played Roll Call?” It was August 2010, and I was at a nine-day theatre festival built around the theme of capacity development in HIV/AIDS education, activism, and therapy.4 I had arrived a little late to a two-hour workshop called “Scrutinize” that was being run by a non-profit organisation, Drama in AIDS Education (DramAidE). Founded in 1992, DramAidE’s main goals are to use participatory drama for HIV/AIDS, life-skills, and sexuality education through communicating public health messages to a wide audience (Dalrymple, 2005). The workshop was organised around a national animated public health campaign called “Scrutinize”.5 This campaign, much like the workshop, targeted people aged 16–24 and asked them to interrogate whether and how their actions contributed to increased risk of contracting HIV, including in relation to multiple concurrent partnerships, substance use, condom use, and transactional sex.

Aside from Thembeka, the facilitator, six of us were present. Thembeka explained: “The game’ll help you learn names, but it’s actually about the rhythm of sexuality in South Africa.” Roll Call is a chant-based game premised on maintaining a steady beat as participants call out their names and describe their likes and dislikes. Thembeka began clapping her hands, invited us to join, and opened with “My name is Thembeka clap clap and I like to party.” Everyone dutifully kept the rhythm and chanted her name. As we introduced ourselves in turn, we periodically lost rhythm or forgot to clap altogether, causing much laughter. Afterwards, Thembeka suggested that the rhythm of Roll Call is similar to the rhythm of avoiding HIV. She said:

See? There’s a rhythm in this game, and to keep the game going, we have to keep the beat steady. Sometimes, you make a mistake and lose the rhythm for awhile – this is like the mistakes we make in life. ABC6 is the rhythm of how we keep away from HIV, and we all know this rhythm. We’re taught it. But sometimes, we mess up. It’s like condom use, ne? You use them but sometimes forget.
Continuing, she said that most people knew the common public health messages but failed to align actions with knowledge. She urged, “Scrutinize! Take a closer look at yourself. People are too quick to blame things on others but don’t look at their own actions.” Thembeka asked for responses. We generally agreed with her: most people know, understand, and remember common public health directives but do not act on them consistently. Thembeka then stood and declared we would spend the rest of the workshop scrutinising ourselves and using Forum Theatre to think about how our actions contribute to our chances of contracting HIV. In particular, we would examine how alcohol might affect our sexual encounters.

Forum Theatre is a dramatic technique pioneered by Brazilian theatre-maker Augusto Boal and used in his participatory Theatre of the Oppressed. In Forum Theatre, actors perform a scene of some kind of oppression or problematic engagement between characters. In scene replay, audience members are invited to eschew the spectator role and become agentive “spect-actors” by shouting “Freeze!” to halt the scene when an alternative action is possible. Once the scene is halted, the audience member is invited to tap out an actor, take his or her place, and resume the scene by acting out an alternative. The improvised scene continues until the facilitator intervenes and initiates a discussion of the changes. Thembeka explained:

When we go to communities, we work to contextualise public health issues. We pose problems and let the audience give us solutions. Things like Freeze Frames, they empower the kids and make the issues personal for them – it’s their life, ideas, and actions.

Thembeka outlined a scenario for us: a man and woman go on a first date. Both are nervous, so they share a bottle of wine to loosen up. At night’s end, the man walks the woman to her house, she invites him inside, and they embrace. Although the woman wants to use a condom, she fails to ask the man. He says nothing, so they end up having unprotected sex. As Thembeka finished, a 20 year-old female, Bongi, immediately said, “So, wait. What? No. Why did she not ask him to wear a condom? Did she have one? Was she afraid he’d say no? And why was she having sex with him on a first date, anyway?” An older woman interrupted: “She can have sex on a first date if she wants. She probably likes sex. I like sex. He would have to wear a condom, though.” Thembeka asked if anyone would like to act out the scene and change the story. A man volunteered, and the second of the women who had spoken joined him.

Before the new scene began, Thembeka asked the volunteers some questions to prompt speculation about their lives: “What would you say to get him to wear a condom if he didn’t want to?” “What would you do if a woman pulled out a condom and asked you to put it on?” “What if you had only one condom, but it broke when you put it on? Would you stop?” Encouraging the volunteers to assume the character roles, Thembeka said, “Okay, you’ve just come home and you’re making out and being sexual, and the issue of condoms comes up – now go!” The volunteers improvised the scene and introduced a broken condom to the story. However, no sex occurred after the condom broke; the two parted ways respectfully after saying goodnight. Perhaps predictably, the volunteers had reenacted the scene in accordance with public health guidelines to avoid unsafe sex.

Thembeka smiled: “Okay great, but what would you really do in that situation? Really? You’re turned on and this other person wants you just as bad. Pretend it’s been a year since you last had sex. How would that change things?” After some discussion, the workshop participants agreed they might not have sex, but would probably do more (physically) than say goodnight and walk away. Thembeka continued:

What do you think you would do if your partner had two more bottles of wine and became really pushy? Or what if the guy has a second girlfriend? Who wants to play the other woman? How would you react to finding out your boyfriend was sleeping with someone else?

Thembeka let the participants discuss each situation and then asked for volunteers to act out what they would do.

By the end, some participants were obviously invigorated by the process, but others struggled. Bongi in particular had trouble with the scenes related to alcohol consumption, as she explained:

Look, first I wouldn’t drink that much alcohol. And even if I did, I definitely wouldn’t have a man over because I know how that would end. The situation wasn’t like my life. But, yeah, it made me think. About my values and what might happen if I were ever put in that situation even if I wasn’t the one drinking.

As the workshop concluded, Thembeka reiterated that our participation in Forum Theatre-style processes was meant to encourage us to think about public health messages and how they relate to our own lives.

Not all applied theatre employs participatory techniques like those in the “Scrutinize” workshop, but many do. Involved artists often suggest that theatre is a medium of health intervention that affects its audience in ways other media formats do not. The definition of “audience” differs among artists and is contested within literature (Radbourne, Glow, & Johanson, 2013; Seale, 2003). However, a commonality of theatre audiences is that they are comprised of particular people attending
live performance in specific contexts. Audiences of theatre related to HIV tend to be composed by certain communities, including health clinic attendees, primary school children, university students, members of disadvantaged municipalities, or prisoners. Applied theatre differs significantly from radio, TV, and print media campaigns both in tone and how it addresses individuals as subjects. Print campaigns in contrast rely on direct, instructional slogans targeted to a mass audience that is often faceless, nameless, and invisible. For many theatre-makers, such common public health campaigns fall short: they fail to make things personal.

Discussion
“Making it personal”: tone, subject, and embodied enactment

According to artists working in or commenting on this style of intervention in South Africa, breakdown in the effectiveness of public health promotion has to do largely with disrupted interpellation of public health messages. Through conventional public health campaigns, knowledge about HIV is distributed but not made to matter to people; its relevance is not linked to people’s intimate lives – their particular interpersonal relationships, experiences, feelings, and activities. Most theatre-makers with whom I spoke suggested that elucidating this relevance for individuals was important for encouraging people to invest in health messages. Asked how to make topics matter, artists suggested that theatre offers three productive routes that differ from other forms of health communication: it is speculative, personal, and experiential. Anya, a university lecturer in applied drama, elaborated on this:

Look, I find most HIV work either very prescriptive, like sort of assuming what’s best for people or fact-based, which is valuable. People need to know the facts. But personally in those kinds of interventions, I’ve never learned anything that I didn’t know before. But theatre is different.

Emma, a practicing dramatherapist, expanded:

There’s something about the live aspect, the immediacy of theatre that I think is very powerful. If you think about our country, if you think about our psyche, we love to live in denial. Especially in relation to HIV! Just think of Thabo Mbeki’s denialism. I heard someone once call it “conscious amnesia”; we like to quickly forget what’s happened and get into that disconnected space. I think film and TV allow you to do that quite easily, whereas theatre pulls you back from that. It pulls you to the present. You can’t deny what’s happening in front of you. You have a real person in front of you, and there’s something very alive, immediate, and present in that. Also, when you are a participant either through being a performer or taking part in a drama process, there is nothing more immediate and powerful! It’s about embodiment, feeling it in the body. It’s about mind, body, and feelings connecting. You can’t dissociate then! You can’t just intellectualise or just be in the body. To really understand these topics, you have to have an immediate experience. It anchors you in the topic.

Anya and Emma reference the early years of HIV/AIDS intervention in South Africa where even the government, under President Thabo Mbeki, hesitated to formally acknowledge the etiological link between HIV and AIDS. This denialism by government representatives led to a concerted effort, spearheaded by civil society organisations led by the Treatment Action Campaign, to generate and publicise explicit, direct forms of public health knowledge in the 1990s and early 2000s. However, these early forms of didactic messaging led to widespread AIDS fatigue. Anya and other artists posit the immediacy, embodiment, and participatory components of theatre as routes to re-engage disconnected publics with conversations about HIV.

Nathan, a senior director of an academic programme that explores the relationship between HIV and theatre, expanded on these components and his interest in theatre:

I suppose what makes theatre unique is what happens between the actors and the audience. You know, the experience. Theatre directors are trying to explore the performer in the space in relationship to the audience. In that embodied environment, there’s a transformation that takes place. If I’m trying to speak to something that is transpiring within a culture here and now, then I want to open that space in order for the audience and the performance to engage on a deeper level or to raise questions of why. How do we change people’s thinking? Well, we’ve gotta give them a sense of there is an alternative. Imagine that there’s something else.

For Nathan, as for many other artists, theatre is a transformative space where audience members are not only exposed to public health messages but internalise them in meaningful ways. This is accomplished by having audience members move from being passive listeners to active participants in theatre processes. These processes enable audience members to contemplate the relevance of messages to their own lives, speculate through discussion how they would react to those messages in daily life, and enact situations in which they put to practice the tenets of public health instruction.

The “Scrutinize” workshop illustrates how this style of theatre draws on experiential, embodied, and participatory action, which are integral aspects of “making it personal” within theatre as a form of health communication.
In the workshop, the main goal of the facilitator was to prompt participants to internalise public health imperatives to practice safe sex and avoid compromising situations created by substance use. As illustrated in the case study, the workshop uses theatre to teach people how to conceive of alternatives to their daily practices and to change the worlds in which they live. Within scenes, volunteers connected risk-avoidance messages with contemplation of their own sexual practices, and public health principles were realised through a process of embodied enactment.

Forms of theatre like this one act as a technology of governmentality through mirroring the content of dominant HIV/AIDS health promotion efforts in the country, which tend to cluster around ideas about safe sex practices. These ideas are organised around a specific relationship between subjectivity and healthcare, implicit in which is the directive for people to assume responsibility for their own sexual health and actively manage how they interact with others in their intimate lives. However, while programmes like the “Scrutinize” workshop retain core values related to HIV/AIDS health promotion, they differ significantly in tone, shifting from an imperative register, with its concomitant instructives, to a register that is more speculative and geared toward considerations of alternatives to routine practices. The speculative register of theatre allows participants to relate their knowledge of HIV and AIDS to their own lives.

At the same time, participatory theatre addresses another major disruption in both biomedical and public health interpellation processes: the subject of intervention. Because health promotion in South Africa tends to be implemented as IEC activities targeting individual actions, subjectification becomes problematic because the architecture of health promotion is ill equipped to reach individuals: it speaks at the level of populations, but people experience their everyday lives uniquely. With its distanced messaging style, most HIV/AIDS IEC campaigns have historically missed engaging members of a population as socially embedded human beings with particular life experiences. Through theatre, health education content is made to matter by personalising it—instead of simply listening to the recitation of generic messaging about biomedical aspects of HIV risk, people are invited to speculate on their own actions and relationships. Artists therefore act as mediators between the public health workforce, the messages they convey, and the audiences they seek to engage by creating a subject for those messages. Within workshops like “Scrutinize”, a face is given to messages—the participants’ own faces reflected back to them. Through this extra step, cracks in the interpellation process are patched, and messages become harder to ignore.

Finally, theatre enlists audience members as participants through embodied enactment. For Louis Althusser (1971), interpellation is the process where individuals recognise themselves through ideology and thereby become complicit in their own subjugation. As Althusser (1971) presents it, along with Foucault (1961/1973, 1963/1975, 1977) in his earlier works on technologies of domination, individuals submit to ideology through either coercion, disciplinary power, or everyday actions structured to produce self-regulating subjects. Although individuals in these theorisations of subjectification engage in actions that reinforce their relationship to particular ideologies, this is nonetheless a passive form of subjectification (Davis, 2012; Ecks, 2004). Applied theatre, in contrast, is a strongly active form of subjectification. Audience members recognise, submit to, or engage with the underlying ideology of the health intervention, but they also enact it in a participatory, experiential, and embodied way. This takes processes of interpellation one step further into embodied enactment and more strongly resembles the forms of self-governance that Foucault (1988) later in his life coined “technologies of the self”. Workshops like the “Scrutinize” campaign of DramAidE thus act as a Foucauldian technology of governmentality that combines cognitive processing with embodiment and practice. Theatre interventions provide space for enacting the ideological—a space that bridges domains of thought and action, personal and collective, individual and interpersonal, and citizen and subject.

The “Scrutinize” workshop by DramAidE is illustrative of many participatory action health interventions in South Africa. Other groups also use participatory theatre techniques within educational or development frameworks, following Theatre in Education (TIE) or Theatre for Development (TfD) conventions to implement public health communication campaigns.7 Strong normative agendas underscore the aims of this style of theatre, which has long tradition within health media programming in South Africa. DramAidE, along with other well-known TIE theatre NGOs, communicates national public health messages to targeted populations in a way that surpasses generic messaging and moves toward personalising health promotion topics. However, partly because they work with national, provincial, and district departments of health or education, they tend to reflect conventional public health messages. They are limited to narrow HIV health promotion ideology informed by neoliberal notions of responsible health citizenship. DramAidE and similar organisations formed an early wave of multi-media HIV programming that began in the late 1980s and provided an alternative to conventional models of messaging. Although this wave peaked in the early 2000s, many TIE and TfD groups
are still active. This trend endures and continues to form the basis for a range of health communication efforts in the country, despite other styles of artistic HIV intervention gaining popularity in the mid-2000s.

**Fissures in health promotion: troubling models of sociality and care**

Central to South Africa’s most recent national public health policy is the mainstreaming of a cultural model of health seeking subjects as rational, responsible, enterprising, and self-interested neoliberal individuals. For Foucault, neoliberal influence on health programming leads to practices and values that promote an ethic of self-care, a technology of self-regulation that includes the actions people perform in everyday life to maximise their life opportunities and improve their health, safety, and wellbeing (Besley, 2005; Ecks, 2004; Kickbusch, 1989; Samuelsen & Steffen, 2004). This kind of subjectivity, premised on ideological mandates for responsible self-care, supports the goals of the National Strategic Plan on HIV, STIs, and TB (2012–2016) and the government’s agenda of distancing itself from responsibility for the plateauing of high HIV prevalence rates. Reflecting this, the official National HIV Counselling and Testing Campaign Strategy was unveiled in 2010 under the campaign theme “I am responsible” and followed on the heels of President Jacob Zuma’s call for all South Africans to take individual and collective responsibility for reducing HIV prevalence in the country. The official “HIV – your responsibility” campaign is based on the principles of the neoliberal subject and positions HIV testing as an entry point to responsible health behaviour. In addition to national governmental campaigns, other recent HIV/AIDS NGO and media efforts implore people to take responsibility primarily through testing and male circumcision. Campaigns declare things like “Play Your Part for a Better South Africa”8 “Get wise. Get tested. Get circumcised,”9 and “I am responsible!”10 All three campaigns are designed to foster a culture of responsibility that hinges on an ethic of self-care.

Theatre interventions like the DramAidE workshop also operate as a technology of the self and shore up neoliberal forms of health subjectivity. However, because of its participatory approach, both interpellation of ideology and resistance to it occur in performance spaces. By using embodied enactment, artists implement health directives but also create opportunities for contestation. In the “Scrutinize” workshop, for example, Bongi questions the scene outlined by the facilitator. When Thembeka tells Bongi to improvise the scene as though she were intoxicated while having to negotiate condom use dynamics, Bongi resists, then reflects: “The situation wasn’t like my life. But, yeah, it made me think. About my values.” Bongi underscores that the narrative of the scene did not speak to the way she understands herself, her daily realities, her relationships, or her needs. Even as the workshop operates as a form of governmentality that takes up normative directives of health promotion, it renders visible critical fissures in contemporary approaches to HIV/AIDS health promotion.

One important fissure revealed through the “Scrutinize” workshop is in the way health promotional messages have historically constructed sociality in relation to HIV. Because such messages underscore the importance of care for the self, rigid boundaries are constructed between self and other in this ideology. Indeed, health promotional messages related to HIV/AIDS tend to bring the edicts of governmentality and neoliberal self-regulation into the domain of sexual and interpersonal conduct; they instruct individuals to protect their health and wellbeing from potentially dangerous others through condom use or avoidance of risky practices. This kind of subject is, at times, focused on self-care at the expense of care for others, which is incommensurable with how many people see themselves – as socially embedded beings in webs of relationships of care.

A major national philosophy of importance in South Africa is ubuntu, the idea that people gain humanity through interrelationships with others. Ubuntu is a national ideal promoted by the democratic government and is taken up by both the media and individual citizens as a banner for the country (Metz & Gaie, 2010). It translates roughly as, “I am because we are” and acknowledges that humanity is interdependent. Because health promotion ideology has historically privileged independence versus interdependence of selves, neoliberal forms of health subjectivity are fundamentally at odds with other important types of subjectivity in the country. As a result, interpellation of health messages related to HIV is uneven. In some cases, like Bongi in the “Scrutinize” workshop, it is outright rejected by target populations.

In noting these disruptions in interpellation, artists have begun to alter the tone of their performances to reflect wider conceptions of what health subjectivity can be, including more nuanced understandings of responsibility, care, and intimacy. This was demonstrated when I attended a performance in the same festival by Themba Interactive Theatre, another major HIV/AIDS-related arts NGO. While much of the performance also addressed the idea of responsible citizenship, near the end, Themba departed from typical self-care directives. The facilitator explained that it was important to realise everyone in the country is now affected by and implicated in dealing with HIV. He had us do a call-
and-response refrain. He called out, “I am HIV positive,” and the audience responded with “And we care about you!” He then reversed the call, and audience members all said, “I am HIV positive,” to which he and the other actors responded, “And we care about you!”

Through the DramAidE and Themba workshops, understandings of care, intimacy, and responsibility are reconfigured in subtle but important ways. First, self-care becomes linked to care for others. While care continues to be demonstrated, much like conventional health promotion programming, through an ethic of responsibility, this moves toward a responsibility for self and others. Second, this ethic of care is interpellated within theatre through participation rather than simple messaging – it is care enacted. Next, the tone of this wave of HIV/AIDS-related theatre is more speculative than imperative. Through its focus on future actions, care becomes partly understood as an investment in thinking about the future. Finally, intimacy has a double meaning within theatre. While productions about HIV continue to highlight sexual intimacy, theatrical intimacy also means the fostering of experience characterised as personal, close, and familiar to individuals and between participants.

While this first wave of applied theatre related to HIV parallels conventional health promotion ideology in certain ways, the forms of engagement it enables, particularly embodied enactment, provide opportunities for expanded interpellation experiences by audience members. Taken together, these additional conceptualisations of responsibility, intimacy, and care also relate more productively to widely held national sentiments on sociality, such as ubuntu.

**Conclusion**

This switch within theatre to considerations of interdependence and interrelationship is particularly important in the third decade of global HIV/AIDS intervention because it is conducive for thinking about prevention in the contemporary context. In South Africa, a large percentage of the population is already HIV positive, which means primary prevention no longer suffices as a single modality of intervention. In a context where the starting premise cannot be that most people are unaffected by HIV, secondary prevention becomes important and no longer indexes simply care for the self but also care for others. Messages expand to include protecting sexual partners of people who are HIV positive, as well as broader ideas about treating those affected by HIV with respect and consideration, as seen in Themba’s call for audience members to affirm their care for HIV positive individuals. Finally, this call to trouble the very notion of care that underscores health in the imperative register is not limited to South Africa but has important policy implications in any global context where HIV education or communication continues to inform national intervention strategies. It is about a global call to better understand subjective life experience: it is about asking not just how to protect individuals from HIV, but rather – who are we in relationship to other people and this particular epidemic?

**Notes**

1. All names in this article are pseudonyms to protect the anonymity and confidentiality of interviewees.
2. I use “ideology” to refer to a set of standards, including ideas, morals, values, ethics, and assumptions that shape people’s understanding of the society in which they live and their relationship to it.
3. Although DramAidE was not one of the organisations with which I conducted extensive fieldwork, several key informants had worked for or with DramAidE.
4. The “Sex Actually” festival is a multi-disciplinary, public annual festival begun in 2008, and its goal is to engage and promote dialogue around sex, relationships, and HIV/AIDS globally and in South Africa. It is hosted by the Drama for Life (DFL) programme at the University of the Witwatersrand, which is an accredited programme offering degrees in applied theatre. While DFL hosts the festival, a multitude of theatre groups from around the country converge during festival time to showcase their artistic contributions to national HIV/AIDS efforts.
5. “Scrutinize” is a campaign that relies on animated advertisements (cartoon-like graphics) to follow the exploits of a taxi-driver character named Victor as he promotes public health messages. It is funded by USAID and PEPFAR and issues from collaboration between DramAidE, Johns Hopkins University’s Health and Education in South Africa programme, marketing company Matchboxology, and other South African stakeholders (scrutinize.org.za).
6. In South Africa, the “ABC” slogan of public health is colloquially referred to as “Abstain, Be Faithful, Condomise.”
7. The groups employing these techniques span community theatre, non-governmental organisations (NGOs), governmental projects, corporate social responsibility efforts, and industrial theatre.
8. “Play Your Part!” is a national campaign to encourage civic participation and is driven by Brand South Africa to “inspire, empower, and celebrate active citizenship in South Africa” (http://www.southafrica.info/playyourpart/faq.htm#.U26dlvlWOs0ixzz31Ls42aOL). Its HIV/AIDS branch encourages all citizens of South Africa to contribute to positive change in the country through recognising the power of individual responsibility in testing and that “neither government nor business can solve South Africa’s challenges alone. Play Your Part” (http://www.southafrica.info/playyourpart/faq.htm#.Vu7y8uj97IU).
9. The 2014 World AIDS Day theme was “Get Wise. Get Tested. Get Circumcised.” World AIDS Day 2013 and 2014 were dedicated to launching a drive to encourage South Africans to embrace medical male circumcision as a prevention measure (http://www.health-e.org.za/wp-content/uploads/2014/02/SANAC-NEWS-6-Feb-Mar-2014.pdf).

10. The “I am Responsible” campaign has also made its way into the business sector. Led by the South African Business Coalition on HIV and AIDS, companies have worked together to develop a strategy to mobilize the resources within the business sector to support the government in its National Strategic Plan objectives, including a focus on personal responsibility and testing (http://www.sabc.co.za/htc-campaign/).

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References
Abdul-Quader, A. S., & Collins, C. (2011). Identification of structural interventions for HIV/AIDS prevention: The concept mapping exercise. Public Health Reports, 126, 777–788.

Althusser, L. (1971). Ideology and ideological state apparatuses (notes towards an investigation). In B. Brewster (Trans.), Lenin and philosophy and other essays. New York, NY: Monthly Review Press.

Bergschmidt, V. B. (2004). Pleasure, power, and dangerous substances: Applying Foucault to the study of “heroin dependence” in Germany. Anthropology & Medicine, 11(1), 59–73.

Besley, T. (2005). Foucault, truth telling, and technologies of the self in schools. Journal of Educational Enquiry, 6(1), 76–89.

Bunton, R., & Macdonald, G. (Eds.). (2002). Health promotion: Disciplines, diversity, and developments (2nd ed.). London: Routledge.

Coulson, N. (1999). Chapter 21: Health promotion. In The South African health review (pp. 289–300). Durban: Health Systems Trust.

Coulson, N. (2000). Health promotion. Health Systems Trust. Retrieved from http://www.healthlink.org.za/uploads/files/chapter21_99.pdf

Coveney, J. (1998). The government and ethics of health promotion: The importance of Michel Foucault. Health Education Research: Theory and Practice, 13(3), 459–468.

Dalrymple, L. (2005, April). DramAidE: An evaluation of interactive drama and theatre for HIV/AIDS education in South Africa. Paper presented at the 5th International Conference on Researching Drama and Theatre Education, University of Exeter, UK.

Davis, N. (2012). Subjected subjects? On Judith Butler’s paradigm of interpellation. Hypatia, 27(4), 881–897.

Ecks, S. (2004). Bodily sovereignty as political sovereignty: “Self-care” in Kolkata, India. Anthropology & Medicine, 11(1), 75–89.

Foucault, M. (1961/1973). Madness and civilization. New York, NY: Vintage Books.

Foucault, M. (1963/1975). The birth of the clinic. New York, NY: Vintage Books.

Foucault, M. (1977). Discipline and punish: The birth of the prison. London: Penguin.

Foucault, M. (1982). The subject and power. In H. L. Dreyfus (Eds.), Michel Foucault: Beyond structuralism and hermeneutics (pp. 208–226). Brighton: Harvester Wheatsheaf.

Foucault, M. (1988). Technologies of the self. In L. H. Martin, H. Gutman, & P. H. Hutton (Eds.), Technologies of the self: A seminar with Michel Foucault (pp. 16–49). Amherst: University of Massachusetts Press.

Kickbusch, I. (1989). Self-care in health promotion. Social Science & Medicine, 29(2), 125–130.

Lemke, T. (2000, September). Foucault, governmentality, and critique. Paper presented at the Rethinking Marxism Conference, University of Amherst, MA.

Lemke, T. (2001). “The birth of bio-politics”: Michel Foucault’s lecture at the College de France on neo-liberal governmentality. Economy and Society, 30(2), 190–207.

Lodge, T. (2002). Politics in South Africa: From Mandela to Mbeki. Bloomington: Indiana University Press.

McNay, L. (2009). Self as enterprise: Dilemmas of control and resistance in Foucault’s The Birth of Biopolitcs. Theory, Culture, & Society, 26(6), 55–77.

Metz, T., & Gaie, J. (2010). The African ethic of Ubuntu/Botho: Implications for research on morality. Journal of Moral Education, 39(3), 273–290.

Middelkoop, K., Meyer, L., Smit, J., Wood, R., & Bekker, L. B. (2006). Design and evaluation of a drama-based intervention to promote voluntary counseling and HIV testing in a South African community. Sexually Transmitted Diseases, 33(8), 524–526.

National Planning Commission. (2011). National development plan, department: The presidency. Pretoria: Republic of South Africa.

Ndlovu, N., Vilakazi, M., Majozi, M., Sithole, F., Mbatha, K., & Guthri, T. (2013). Trends in national and provincial health and HIV/AIDS budgeting and spending in South Africa. CEGAA Occasional Paper 2013–1. Retrieved from http://cegaa.org/resources/docs/healthbudget2014.pdf

Nguyen, C. (2015). Interpellation. The Chicago School of Media Theory Online Resource. Retrieved from https://lucian.uchicago.edu/blogs/mediatheory/keywords/interpellation/

Nutbeam, D. (1998). Health promotion glossary. Geneva: World Health Organization. Retrieved from http://apps.who.int/iris/bitstream/10665/64546/1/WHO_HPR_HEP_98.1.pdf

Onya, H. (2007). Health promotion in South Africa. Promotion & Education, 14(4), 233–237.

Parker, R. G. (2001). Sexuality, culture, and power in HIV/AIDS research. Annual Review of Anthropology, 30, 163–179.

Parkhurst, J., & Lush, L. (2004). The political environment of HIV: Lessons from a comparison of Uganda and South Africa. Social Science & Medicine, 59, 1913–1924.
Pigg, S. L. (2001). Languages of sex and AIDS in Nepal: Notes on the social production of commensurability. *Cultural Anthropology, 16*(4), 481–541.
Rabinow, P., & Rose, N. (2003). Foucault today. In P. Rabinow & N. Rose (Eds.), *The essential Foucault: Selections from the essential works of Foucault, 1954–1984* (pp. vii–xxxv). New York, NY: New Press.
Radbourne, J., Glow, H., & Johanson, K. (Eds.). (2013). *The audience experience: A critical analysis of audience in the performing arts*. Chicago, IL: University of Chicago Press.
Rimke, H. M. (2000). Governing citizens through self-help literature. *Cultural Studies, 14*(1), 61–78.
Rossiter, K., Kontos, P., Colantonio, A., Gilbert, J., Gray, J., & Keightley, M. (2007). Staging data: Theatre as a tool for analysis and knowledge transfer in health research. *Social Science & Medicine, 66*, 130–146.
Samuelsen, H., & Steffen, V. (2004). The relevance of Foucault and Bourdieu for medical anthropology: Exploring new sites. *Anthropology & Medicine, 11*(1), 3–10.
Seale, C. (2003). Health and media: An overview. *Sociology of Health and Illness, 25*(6), 513–531.
South African National AIDS Council. (2013). *South Africa national AIDS spending assessment summary brief*. Retrieved from http://sanac.org.za/resources/aids-spending/cat_view/6-aids-spending
UNAIDS. (2012). *Global AIDS response progress report: Republic of South Africa*. Retrieved from http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/ce_ZA_Narrative_Report.pdf
World Health Organization. (1986). *The Ottawa Charter for health promotion*. Presented at the First International Conference on Health Promotion, Ottawa, Canada. Retrieved from http://www.who.int/healthpromotion/conferences/previous/ottawa/en/
World Health Organization. (2005). *Summary country profile for HIV/AIDS treatment scale-up*. Retrieved from http://www.who.int/3by5/support/june2005_zaf.pdf
World Health Organization. (2015). *Health promotion*. Retrieved from http://www.who.int/healthpromotion/en/
Wouters, E., van Rensburg, H. C. J., & Meulemans, H. (2010). The national strategic plan of South Africa: What are the prospects of success after the repeated failure of previous AIDS policy? *Health Policy and Planning, 25*, 171–185.