Health Subjectivities in a Diabetes Clinic in Ghana

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Abstract

This article discusses how biopower is exercised in a public health clinic in Ghana. By looking at the clinician-patient encounter in a diabetes clinic as an instance of a state-citizen encounter, the expectations for and the development of expert patients as ideal citizens emerges. Clinicians play an important role in forming patients’ health subjectivities, through the subtle shaping of assumptions, bodily practice, and attentiveness (Whyte 2009). In the diabetes clinic, health subjectivities are shaped by clinicians in order to ensure patient compliance with a diabetic routine against the backdrop of a self-responsibility model of care and shrinking government support. The patients often adopt these expectations for managing their own illness as best as they can, such as changing diets, adhering to strict drug regimens, and increasing exercise, yet the wider contextual causes of and barriers to controlling diabetes are left unaddressed. However, as clinicians shape health subjectivities in the diabetes clinic, they also create the opportunity for patients to adopt health identities, through which they are able to contest or alter these expectations and demand additional social support from the state.

Keywords: Biopower; diabetes; health identities

Introduction

Scholars have examined how the implementation of neoliberal policies – namely the creation of open markets and cuts in state services – requires citizens to behave in economically rational ways (Brown 2005; Foucault 2010; Harvey 2005). This expectation for rationality and calculation emerges in different domains of life, even in one’s own body, and is reinforced in the health clinic. The public health clinic is a site where the state and the citizen meet and expectations are exchanged. For a chronic illness such as diabetes, citizen-patients are directed to self-manage many aspects of daily life, from sleep and exercise to diet and drugs. This serves to alleviate financial responsibility for health from the state while encouraging citizens to behave in health-investing ways. In order to achieve patient compliance, clinicians shape patients’ subjectivities to make room for a new diabetic reality, against the backdrop of the state’s wider neoliberal milieu. Patients are disciplined to be knowledgeable, diligent, and in control of their bodies. In this article, I examine the ways that biopower shapes health subjectivities and how these are formed, accepted, and challenged in and out of the health clinic, including in the adoption of health identities, which is a way to take marginalization and use it to call for recognition, rights, and social justice (Whyte 2009). The public health clinic is a productive arena to examine the subtle processes of biopower insofar as it is a setting that does not seemingly prioritize the market and purports to be a site of
utmost care. I engage with the literature on biopower, health subjectivities, and biological citizenship to think through eight weeks of ethnographic fieldwork conducted in the diabetes clinic of a regional public hospital in southern Ghana. I argue that the state exercises biopower in the diabetes clinic as clinicians shape patients’ neoliberal health subjectivities. Patients who come to embody these subjectivities gain the opportunity to adopt health identities, challenge the way that the state treats the ill, and make demands for further social support.

Methods and the Clinical Context

I conducted participant observation in the waiting room of a diabetes clinic in southern Ghana. I attended three times per week, starting in the early morning when patients began arriving to wait in line. I sat as the patients waited hours to see the doctor and observed their conversations, reactions to the news on TV, and their interactions with the Head Nurse during the health talk. I recorded notes on my observations and had informal conversations with patients about their experiences managing and troubleshooting diabetes as well as issues of everyday life. I built rapport with the nurses as they explained their processes, motivations, and frustrations to me. With the help of an interpreter, I conducted one-on-one, semi-structured interviews with thirty diabetic patients, two nurses, and the Head Nurse. I also conducted participant observation at the diabetes support group held monthly at the hospital. The interviews consisted of open-ended questions about experiences managing diabetes in everyday life and about the resources for and the barriers to complying with prescribed regimens.

Ghana is a middle-income country that the World Bank regards as a development success story (Chalfin 2010; Opoku 2010). Open markets and increased involvement in the globalized economy have contributed to lifestyle changes and shifts in diet, leading to a greater prevalence in obesity and disorders like hypertension and diabetes (Oggioni et al. 2014). Diabetes has affected up to nine percent of the population of Ghana (Tagoe 2012). However, state efforts to combat diabetes are lacking, as public health programs often reflect the priorities of foreign-based donors and NGOs, which upon observation, largely focus on malaria, tuberculosis, and HIV/AIDS. A visit to the district Ministry of Health office confirmed that there is no public health program in place to address or prevent diabetes. The existing public health campaigns for diabetes are largely spearheaded by international pharmaceutical companies, such as Novo Nordisk and Merck.

I conducted my study in one of the only hospitals in the Central Region that has an official diabetes clinic. There are other large diabetes clinics in the Greater Accra and Ashanti Regions, among others. It is in an urban location, but attracts patients who travel moderate distances from the surrounding rural areas. The clinic operates on Mondays, Wednesdays, and Fridays, and sees anywhere from 30–60 patients each day. After being initially diagnosed and referred by a general practitioner or emergency doctor, patients are instructed to regularly attend the clinic. The diabetic patients were primarily in the 50–70 years age range and women accounted for about 75 percent of the attendees. Most of the patients spoke Fante and many of them spoke or understood Twi, though many spoke various other languages as well. They were about two-thirds Christian and one-third Muslim. Patients’ income levels ranged from very low to middle, considering that the poorest would not be able to afford the National Health Insurance Scheme nor the cost to travel to the clinic, while more affluent patients would be more likely to attend a private doctor’s office.

The diabetes clinic meets daily throughout the week, beginning at 6:00 a.m. and lasting until all patients are seen, generally by noon. Patients whose blood sugar is under control are usually told to come to the clinic every two months, though it could be more or less frequent depending on the severity of their illness. The clinic is staffed by several nurses and a Head Nurse in addition to one of the doctors from the hospital, who spends part
of his day in the clinic to examine patients before attending to his other duties elsewhere in the hospital. Patients arrive before 5:00 a.m. to wait in line to get their fasting blood sugar levels tested by a nurse and then move to another area where they wait to see the doctor. It is during this waiting period that the Head Nurse delivers a lecture on managing diabetes, called a health talk, intended to educate patients about their condition and offer means to control it. I conducted interviews for my research during this time.

Biopower in the Health Clinic

In thinking about the role of the clinic in shaping health subjectivities, it is helpful to consider the theory of biopower. According to Michel Foucault, biopower is a technology of power for the control of the bodies of entire populations (Foucault et al. 2009). Biopower consists of “modes of subjectification through which individuals are brought to work on themselves, under certain forms of authority [...] in the name of their own life or health, that of their family... or indeed in the name of the life or health of the population as a whole” (Rabinow and Rose 2006: 197). Citizens’ health, welfare, and conditions of daily existence become objects of knowledge and appropriate targets of intervention (Collier 2011). It concerns itself with the wellbeing of a population for the goal of economic productivity. Governing a healthy population requires both biomedical care and the cultivation of individual, health-promoting behaviors (Shaw 2012). Medical expertise and state power combine to create categories that patients come to inhabit, such as the category of “diabetic” (Shaw 2012). The exercise of biopower shapes subjectivities and requires the disciplining of one’s own body, the regulation of desire, and the cultivation of a responsible self (Dilger 2012).

Citizen-patients are expected to let every action be in the service of prevention, in constant surveillance of “likely occurrences of diseases, anomalies, deviant behavior to be minimized, and healthy behaviors to be maximized” (Rabinow 1999: 187). Biopower today manifests through neoliberalism, the enduring method of modern governmentality (Foucault et al. 2010). In a neoliberal climate, individual freedoms are extolled in order to serve the interests of the market, and a citizen is expected to be an entrepreneur of herself (Foucault et al. 2010). Individual freedom and the control of the population are intertwined, as citizens are morally obligated to utilize their freedom in financially prudent ways.

Biopower emerges in the health clinic through the self-management, training, and discipline taught to and required of patients to control chronic illnesses. This is inherent in the design of the health clinic itself. Health clinics are intended for outpatients not needing overnight or urgent care from clinicians, and who after leaving the clinic will provide their own follow-up care. Public diabetes clinics in Ghana were founded both to detect more cases of diabetes and to provide a space to enable effective self-management. The therapeutic goal for most chronic illnesses including diabetes is for patients to learn how to become “physicians unto themselves” (Ferzacca 2000: 29). Though it may appear the state is taking more responsibility for its citizens’ health and wellbeing by setting up a diabetes clinic, via the health clinics’ screenings and trainings, the state relieves itself of responsibility for prevention and care once it endows the patient with self-management duties. Moreover, health policies, educational materials, and clinicians often use moral language to describe self-management and patient noncompliance, as if they were disobedient children or foolish adults, and to imply that a patient is to blame for her diabetes or complications due to her lack of self-control (Broom and Whittaker 2004).

The procedures, instructions, and relationships in the clinic serve to discipline and shape rational and compliant health subjects. These rational health subjects adopt and form diabetic identities to various degrees. Whyte (2009) explains that biopower, in the formation of health identities, points “toward the much more subtle shaping of subjectivity, of
assumptions and bodily practice and attentiveness [...] knowledge, technologies, and control are the watchwords" (Whyte 2009: 10). Knowledge of the disease, technologies for managing it, and control over the body are indispensable in a diabetic's life. Subjectivities are thus “the ensemble of modes of perception, affect, thought, desire, fear, and so forth that animate acting subjects...as well [as] the cultural and social formations that shape, organize, and provoke these modes of affect, thought, etc." (Ortner 2005: 31). These subjectivities become intertwined with patients' identities. I argue that one significant way in which these subjectivities are formed is through the health talk. While they are waiting to see the doctor, the Head Nurse gives the patients what they call a health talk, which touches upon different topics about diet, exercise, and drug regimens, including troubleshooting different issues that arise in self-managing diabetes. For example, one morning during the health talk the Head Nurse discussed "hypo," or hypoglycemia, a condition in which blood sugar level drop dangerously low, which can cause fainting or even death. Hypo can happen when a patient takes too high a dosage of metformin(3), skips a meal, or does not eat a meal before taking the drugs. Often a patient will improve their diet or increase physical activity, naturally lowering blood sugar levels, but keep the same amount of metformin, leading to dangerously low blood sugar. He warns them about the dangers of hypo, reiterates the proper way to take the drugs, and urges them to continue coming to the clinic regularly to get their blood sugar levels checked so that the doctor can make adjustments to medication if necessary. He insists that it is their responsibility to do these things correctly and that the clinicians cannot force them to do so. Later he explained to me that he tries hard to make the health talk interesting and engaging so that they can learn as much as possible. Most of the patients I interviewed could recite accurately the definition of diabetes, what they should eat, how they should exercise, and how and when to take their drugs. They described the different methods for integrating these responsibilities with the other duties of everyday life. They shared how the diagnosis changed their lives forever and how their self-management responsibilities were a life or death matter. This illustrates the power and effectiveness of the subtle shaping of subjectivities. As part of the greater project of managing the population, the exercise of biopower trains these citizen-patients to manage themselves.

**Clinicians as State Actors**

Clinicians represent the state to patients, therefore the health clinic is a location of a government-citizen encounter in which the state exercises biopower. When asked if the government helps diabetics, most of the patients I interviewed identified their clinicians as the major form of government help. As one interviewee said:

Oh, the government helps. The government helps because if you look at what we are doing here, we start coming here around 4:30 a.m. By 6:00 a.m., the nurses are here, so they are here with us. With the doctors also, by 6:00 a.m. to 7:00 a.m., they are already here and I know that in all the other teaching and regional hospitals, the stories are the same... when we go to the hospital, they will come and meet us and give us a lot of teachings plus other things, so in addition to the drugs, they are helping us.

Because doctors and nurses are viewed as "the government," I consider clinicians to be the “effective sovereign” (Weber 1995), where the abstract idea of the state becomes tangible for everyday people. Chalfin (2010) has similarly considered customs agents in Ghana as the effective sovereign. She argues that because customs is “the state agency most deeply embedded in the history of Ghanaian state formation, catalyst of political economic change, and of Ghanaian statehood and sovereignty,” customs agents both enable and exercise state sovereignty (9). The effective sovereign interpret and enforce state policy and shape ideal citizens accordingly, so clinicians’ interactions with patients are a telling site in which to observe the formation of health
subjectivities. The clinicians’ main goals are education and compliance (Ferzacca 2000). Several of the nurses shared their frustrations with getting the patients to comply. They noted that many of the patients claim they follow the diabetic diet and exercise, but that they are not being truthful. The nurses struggle with ridding them of trust in traditional medicine. One nurse said that she deeply believes in the work she does, has a lot of compassion for the diabetic patients, and truly wants them to learn and follow the directives. This is what motivates her to wake up so early and to continue her work at the diabetes clinic, despite the many challenges of imparting a biomedical conception of diabetes to patients and encouraging their compliance.

The knowledge and beliefs of these clinician state actors are rooted in and reflect both Ghanaian ways of knowing, class hierarchies, and global power flows that are shaped by the postcolonial legacies of international development and global health. In this sense, biomedicine can be understood as a “form of social control and cultural authority, perpetuating dominant-class interests by detaching human suffering...from the socioeconomic systems that produce it” (Wendland 2010: 12). According to Dilger (2012), “the production and dissemination of biomedicine in societies worldwide has become inseparably intertwined with the social hierarchies, cultural mechanisms and moral, ethical and legal priorities prevailing in local and global power relations” (501). Starting in colonial times, the introduction of biomedicine to the colonies was a moral project: “Colonial bureaucrats and medical doctors propagated the idea that the acceptance of biomedically defined ‘healthy’ lifestyles had become the necessary precondition for the social, moral and economic advancement of the colonized societies and for establishing a civilized and stable social order” (Dilger 2012: 501). This orientation has been maintained in modern global health agendas, as “promoting health abroad is also a critical aspect of foreign policy, and indeed, of national security” that offers the Western states and private entities an opportunity to promote their core values and interests (Wendland 2010: 9). Clinicians’ knowledge and procedures are derived from research, policy recommendations, and corporations in the Global North, whether or not this knowledge is compatible with the cultural lifeways of patients. The Head Nurse explained that he gets his updated information about diabetes and clinical recommendations from Western journals, whose research subjects and target audiences are patients and physicians in the United States and Europe. This is how recommendations like “fill half of your plate with vegetables” and “don’t eat too many starches” made their way into the diabetes clinic in southern Ghana, where vegetables are commonly a small portion of the meal and starches are a substantial part. Individualism is also a value that is preached and required for successful self-management (Seligman et al. 2015), which may not be a cultural value for many older Ghanaians. Additionally, the significant class difference between clinicians and patients at the public hospital presents a disparity between perceptions of resources available to self-manage and notions of authority and expertise. The health clinic is a site for subject formation according to the knowledge hierarchies of an increasingly globalized world.

One of the major manifestations of this knowledge hierarchy is the opposition created between biomedicine and traditional medicine. Warnings against traditional medicine are highly visible and widespread in Ghana, in posters on the hospital walls, in discussions on the news, in teachings from nurses, and in stories shared in the diabetes support group. Labels for non-biomedical treatment such as “traditional,' 'backward' and 'superstitious’... [are] often promoted not only by governmental and nongovernmental bodies and their representatives, but also by those parts of populations which identify themselves with ‘more educated' and ‘modern' worldview” (Dilger 2012: 501).This biomedicine–traditional medicine binary is reinforced by clinicians and expert patients in the support group.
The support group, known as the Welfare Group, meets in a lecture room in the hospital on the last Sunday of every month. It is headed by a diabetic patient who is particularly motivated and willingly embraces a diabetic identity. She chairs the sessions along with several other diabetic patients and one of the diabetes clinic nurses. During one of the Sunday meetings, during the question and answer portion, a thin woman stood up to ask for advice. She explained that she visited a traditional healer who told her that the only starch she could eat is plantain, which would help to cure her from diabetes. She had been trying this diet for several months but was losing a lot of weight and felt sick and weak. The expert patient panelists in the front of the room each took turns addressing her. They told her, “you have been deceived,” and she became distraught and cried. They gave her a lengthy scolding about her mistake of going to a traditional healer and the importance of getting any and all medical information from the hospital alone. This is a very explicit shaping of health subjectivities in the form of health identities, as allegiance to one medicinal-cultural system places a person in opposition to another system (Whyte 2009). Clinicians are at the forefront of rehearsing this rhetoric of biomedicine as the only legitimate form of medical knowledge.

**Pharmaceutical Hegemony**

This medical hierarchy bolsters the legitimacy, demand, and use of pharmaceutical drugs in Ghana. In fact, in addition to their clinicians, patients often cited the fact that the National Health Insurance Scheme provides drugs for free or at low cost to them as evidence of the government’s effort to help diabetics. Prescribing drugs for chronic illness inherently requires increased and more precise self-management, therefore the government provides diabetics with tools of self-management, not with a cure or tools for prevention, as patients often asked for. However, the Welfare Group and the National Diabetes Association of Ghana has criticized the rising costs of drugs and lack of insulin and other supplies, and patients lamented that they often could not get their free drugs because the hospital pharmacy runs out. So pharmaceutical companies create access to and reliance on these drugs, transferring the responsibility from society to the individual, and obligating people to this responsibility despite the fluctuations in drug availability and affordability. Meanwhile the cultural and global influences on rising diabetes rates are left unexamined. This process of pharmaceutical hegemony encourages and adheres to market logics rather than states’ capacity to care. Therefore, diabetic subjectivities serve the market, as self-managing citizens create opportunities for corporate profit.

Pharmaceutical companies also have a strong claim on legitimate knowledge. Whyte explains that in China, “a liberalizing political economy where multinational drug companies play an important role in providing information about diabetes, patients become consumers and are rather left to their own devices to manage their condition. They feel unjustly treated, and they carry a heavy economic burden in having to finance their own treatment” (2009: 9). In Ghana, Novo Nordisk, a multinational Danish pharmaceutical company that founded the World Diabetes Foundation, plays this role. In two hospitals I visited, the diabetes clinics had Novo Nordisk informational posters on the walls in the waiting rooms educating patients about diabetes. In another hospital near the capital of Accra, Novo Nordisk donated an entire new diabetes wing. The wing has wall-sized posters advertising their brand and the importance of their contribution to addressing diabetes in Ghana. Photos, videos, and stories decorate their website detailing the difference it has made in people’s lives. Their stated goal is to screen more people for the disease and give them access to life-saving drugs. One video shows an interview of a woman who explains how she was previously unable to get to a hospital due to poverty and lack of safety, but now that they have put a clinic in her neighborhood, she is able to control her diabetes. Clinics that are sponsored by...
states, global pharmaceutical companies, or nongovernmental organizations shape subjects, define facts about health and illness, and reify legitimate lifeways. The diabetes clinics are thus “islands of biopower” (Dilger 2012: 511). The sponsored clinic’s main achievement is widening the scope of surveillance to more corners of Ghana, diagnosing more patients, and finding more people who need its product. This is all achieved under the stated goal of humanitarianism.

With diabetes, as in the case of HIV/AIDS, patients are “required to ‘make a lifelong contract’ with medications that have transformed the life-threatening disease into a chronic condition” (Dilger 2012: 511). By creating global awareness about diabetes, Novo Nordisk may genuinely seek to save lives, but it is also increasing the number of patients with a lifelong need for the company’s diabetes products and therefore increasing its profits. Thus, “health and illness are ‘political’ categories, [having] as much to do with the physical and cultural possibilities and constraints surrounding a person’s body as with any characteristic of the body itself” (Fox and Ward 2006: 462). This process neglects the structural and economic causes of diabetes and barriers to managing diabetes according to clinicians’ orders. In Ghana’s neoliberal atmosphere, patients’ understandings of themselves, their illness, and their world are profoundly shaped by the expectation that they take care of themselves rather than be taken care of.

**Health Identities and Activism**

Health identities emerge from the possibilities and constraints of biopower, encompassing all of a body’s physical and social relations (Fox and Ward 2006). In confronting the challenges to self-management that arise in everyday life, diabetic patients often stray from prescribed lifestyles and drugs and instead assemble their own approaches to controlling and making sense of their illness. For some, this manifests by embracing a health identity to collaborate and petition for increased social support. This is often viewed by clinicians as noncompliance rather than a legitimate and necessary adjustment due to inequalities, stigma, or lack of access (Ferzacca 2000). However, for patients, selfhood has more to do with how competing demands are managed than by complete biomedical compliance (Seligman et al. 2015). Health identities echo notions of identity politics, such as with gender, sexual, and indigenous identities. Health identities are “values and ideas that have emerged in the context of a globalized health response under the concept of therapeutic citizenship: a transnationalized form of biological citizenship, which makes claims on the global economic and social order based on a ‘shared therapeutic predicament’” (Nguyen 2007: 126). Biological citizenship is a way of delineating difference as individuals and groups and demanding recognition from society, state, and global entities as citizens entitled to services. Petryna (2013) describes how victims and healthy citizens alike must make a claim of bioinjury from the Chernobyl disaster to receive basic welfare provisions from the state. Shaw (2012) explains that in community health settings, biosociality extends beyond genes or physical disease and describes the ways people understand and act on health issues to bring marginalization to light and make claims on the state. Health identities provide new opportunities for the sick to reclaim social support for a disease that is otherwise presented as their responsibility to manage.

In Ghana, these identities are expressed and developed in the diabetes support group as well as in the Diabetes Association of Ghana. Advocates of the Welfare Group at the hospital believe it is important to embrace the reality of being a diabetic in order to best self-manage and to rally together for recognition, support, and funding, not just from the state, but from international entities as well. The president of the group, a veteran diabetic patient at the hospital, explained to me that the government is cutting the National Health Insurance Scheme’s coverage and adding a tariff to diabetes drugs such as insulin, and that it was imperative that they make their demands known. In the meeting, she implored members to write two letters to
to request donations to fund their operations. When I visited the president of the Diabetes Association of Ghana, also the head nurse at the Novo Nordisk-sponsored clinic, she insisted that the government was not doing enough to ensure that diabetics received their drugs. In fact, I first learned of her from a newspaper article in which she called upon the government to decrease tariffs on drugs to make them more affordable for patients who desperately need them.

To be clear, not every patient liked the idea of embracing a diabetic identity. During every health talk in the clinic, a nurse would remind the patients about the opportunity to join the Welfare Group and explain its importance. For various reasons, the ratio of group members to total patients remains extremely small. One week, a spokesperson for the group announced that they would be making and selling t-shirts to wear together in the upcoming yearly parade in town. The rest of the patients in the waiting room reacted with contempt and disagreement. I asked a patient later in an interview why he felt this way. He explained that he does his best to eat the right foods, exercise, and take his drugs on time, and can afford the expense of coming every two months for the checkup, so he just wants live his life when he leaves and sees no need to proclaim to the world that he is a diabetic.

This sentiment suggests that support groups are tools of governability and serve as an important site in which biopower is exercised. HIV/AIDS support groups, often sponsored by nongovernmental organizations, similarly turn sexuality into a "site of rational, individual choice and agency, an opportunity for empowerment and 'healthy positive living'" (Dilger 2012: 512). This parallels diabetes groups, which bring lifestyle into that same domain of rationality. Dilger explains that "it is through these extended conversations that people with HIV/AIDS (ideally) learn to accept their illness and to acquire a future-oriented and self-conscious approach to dealing with HIV" (2012: 509). It is not only a way for patients to come together under a shared identity to demand services and supplies from global entities, but also an opportunity for another layer of state disengagement. The fact that many patients were turned off from the idea of convening as a group of diabetics demonstrates a resistance to having this expectation of personal responsibility take over other domains of one’s life and identity. Their health subjectivities were still being molded by the clinician–patient encounter, but conscious shifts in identities were up for debate. Patients both conform to and contest biopower as it is disseminated throughout the health clinic.

**Concluding Discussion**

Scholars have questioned how far market logics can penetrate the realm of health care, raising important questions about the implications that this has for the lives and wellbeing of patients. In this case, it seems there is a breaking point, as diabetics in Ghana refuse to accept all of the responsibility for their care and demand that their government do more. As chronic illnesses become increasingly central to the focus of global health, it is also worth asking how many different health identities will be recognized by the state. In fact, despite the cries from the Welfare Group and the president of the Diabetes Association of Ghana, a chapter of the World Diabetes Foundation, diabetes is not on the radar of government or public health efforts. Neoliberal capitalism encourages turning to the market to address health needs and continues to remove responsibility from states. This is especially true in postcolonial contexts where sovereignty and responsibility are negotiated and contested.

For individuals suffering from diabetes who do not attend the clinic, perhaps the notion of a longer life due to medical advancement in exchange for a regimented body and lifestyle is not really worth the disruption to their identity and lifeways. Yet embracing the expectation of self-management works for some people, and they use it to survive while living their lives as “normal” as possible. This small case study highlights the nature of agency in a neoliberal health milieu, suggesting that
market logics intersect with notions of desirable lifestyles in ways that generate complex health subjectivities. People negotiate under the reality of their situations and cope based on barriers they experience once they leave the clinic and every day for two months until they come back. They also use the expectations of neoliberalism for their benefit. The exchanges in the health clinic inform, and are shaped by, local, regional, and global processes, including the fight for global health, shifting identities and lifeways, and the global economy.

The neoliberal ethos in Ghana requires citizens to behave in economically rational ways, even when it comes to their bodies. The health clinic houses a state-citizen encounter where patients are disciplined to discipline themselves. The state, via clinicians, seeks to shape patients' subjectivities to be compliant with the neoliberal logic of self-management and relegates state responsibilities to the individual. Patient education endows diabetics with self-management responsibilities and bolsters Western knowledge in legitimacy, at times muting the lived experiences of Ghanaians of varied socioeconomic status. Pharmaceutical corporations ensure they remain a fixture of the global health scene as they widen their scope and surveil more of the population, leading to higher profit margins. However, the health clinic creates a space for patients to embrace a diabetic identity, contest or alter subjectivities, and demand additional social support.

Notes
1. I received IRB approval from my institution and was granted permission to conduct research in the clinic by the hospital administration.
2. The interpreter and I worked out the translation and wording of the interview questions before conducting the interviews. Given the age and cultural differences between us and the patients, there were some issues with the wording of a few of the questions that led to answers that missed what I was trying to elicit. We edited the questions for understanding as we progressed. There are two questions that I have not yet figured out how to appropriately translate; one is about gender differences and the other is about diabetes stigma.
3. Metformin is a commonly prescribed drug for type 2 diabetes that controls blood glucose levels.

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