A Tale of Two "Cultures": HIV Risk Narratives in South Africa

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There has been a tendency for many researchers and health professionals examining HIV transmission in South Africa to focus on explanations that specifically implicate culture as a primary vector affecting the prevalence of high-risk sexual behavior, such as multiple partners, unprotected sex, and dry sex. In contrast, the residents of Orange Farm, a former informal settlement south of Soweto, portray culture as seldom, if ever, motivating actions that are associated with HIV transmission or prevention in the community. Comparing and contrasting these differing conceptions, we comment critically on the use of ideas regarding culture in explanations addressing the HIV/AIDS pandemic in sub-Saharan Africa.

Key Words: culture; HIV/AIDS; South Africa

INTRODUCTION

Currently, sub-Saharan Africa has the highest number of AIDS cases in the world, while South Africa has the distinction of being the African country with the largest population of HIV-positive people. An estimated 5.4 million of 48 million South Africans are infected with HIV, a total population

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prevalence rate of 11 percent (Dorrington et al. 2006). Consequently, a great deal of work has been undertaken to determine and document the main factors that contribute to the spread of HIV in South Africa. Sex with multiple partners, unprotected sex, transaction sex, violence, and poverty structure individual’s vulnerabilities to HIV infection (Gilbert and Walker 2002; Harrison et al. 2001; Hunter 2002; Jewkes et al. 2003; Kaufman and Stavrou 2002; MacPhail and Campbell 2001; Wojcicki 2002). When postulating explanations for the existence and continuation of these behaviors, ideas of culture are often utilized by medical professionals and public health researchers. Since the onset of the HIV epidemic, behavioral accounts have tended to stress the ubiquitous and pathological influence of “African” culture on health status (Stillwaggon 2003).

As anthropologists working in the context of a large clinical trial evaluating the efficacy of a vaginal microbicide gel—Pro 2000—in preventing HIV and STI infection,¹ we were struck by the differing ways in which medical researchers and trial participants used the word “culture.” While many researchers cast culture as a barrier to gel and condom use, trial participants did not explain these actions in terms of culture. Trial administrators asked if the gel was “culturally appropriate” but local individuals asserted that community residents no longer possessed culture. Although the same word was used by both groups, it clearly had very different meanings.

Reviewing the literature, we discovered that although a great many publications have been dedicated to examining African cultural beliefs that are assumed to assist in the spread of HIV, there are very few that examine the ideas and attitudes of people living in sub-Saharan Africa regarding the link between culture and HIV prevalence. In an effort to redress this imbalance, we explored the views of residents living in Orange Farm, a peri-urban township south of Soweto, regarding culture and its link to HIV/AIDS. As part of the larger clinical trial, we conducted a series of 42 focus groups,² formal and informal interviews, and participant observation as well as analysis of an Nvivo database of 384 interviews with 178 women enrolled in the clinical trial and 30 interviews with 18 male partners. We discovered that concepts of culture in Orange Farm closely resemble South African colonial and apartheid ideas that situate culture in rural areas. Orange Farmers stated that an urban existence had caused them to “lose” their culture, just as the apartheid Bantustan policy had argued years before.

This article seeks to contextualize “culture” and provide a critical examination of the ways in which these notions are utilized. By comparing local ideas of culture to HIV/AIDS publications, we intend to augment existing research regarding biomedical understandings of culture (Bibeu and Pedersen 2002; Briggs 2005; Gausset 2001; Stillwaggon 2003). Adopting a reflexive approach to culture within a medical context illuminates issues
important to anthropology and public health. On one hand, examining different iterations of culture demonstrates the ways in which colonial and medical authorities conceived and constructed ideas of the “African” other as well as the longevity and tenacity of these ideas. On another, given the almost omnipotent role that culture is often accorded in designing and evaluating HIV prevention programs and technologies, it is important to understand its meaning for local populations.

We begin by reviewing the differing ways in which Orange Farmers and health researchers portray the characteristics and role of culture in HIV transmission. Because ideas about culture can differ widely, we refer to culture only in an emic sense—either from the perspective of Orange Farmers or the perspective of health researchers. We do not wish to muddy the waters by proposing yet another inventory of cultural characteristics and then debating who possesses them and who does not. Instead of trying to provide a single comprehensive definition of what culture “is,” we believe it is more important to understand what these differing emic ideas of culture “do.” Examining the social and historical context of these views, we assert that although people may hold contrasting ideas and definitions of culture, in most instances these beliefs create boundaries between groups that appear to be natural and permanent. Culture provides a vehicle through which social attitudes regarding difference can be expressed. This is particularly true of HIV/AIDS risk narratives.

CULTURE AND HIV/AIDS IN ORANGE FARM

Established on former farmland, Orange Farm lies 40 kilometers south of the Johannesburg city center in Gauteng Province. The community first began to take shape in 1988 when a number of impoverished residents from Soweto built informal houses in the area. Many of the early settlers were tenants and sub-tenants who previously lived in crowded backyards of Soweto homes, renting structures such as prefabricated sheds. Other migrants to Orange Farm included homeless people from the townships of Vereeniging and Vanderbijlpark, major industrial centers in the province. The open spaces of the rural site allowed individuals with little or no money to claim and eventually own parcels of land. Initially, new residents were allowed to build homes without the government harassment experienced by “squatters” in similar “squatter camps” closer to Johannesburg since the 1940s. For several years after its establishment, Orange Farm was characterized by endemic violence, poverty, and political resistance to the apartheid regime. Residents recall with great fondness how Chris Hani, the popular ANC leader, visited Orange Farm on several occasions in the
early 1990s and openly identified with their struggle for better living conditions in what residents then called “Palestine” or the “Promised Land.”

Today, despite being officially part of Johannesburg, Orange Farm continues to be effectively isolated from the rest of the city due to its distant location and lack of local economic opportunities. Nevertheless, Orange Farm has grown to become a peri-urban settlement of approximately 170,000 people. The population continues to hail from other regions of Gauteng, particularly Soweto, as well as rural areas of South Africa. These individuals often come attracted by the prospect of work in the province’s urban centers. But with regular employment difficult to find and high transport costs to Johannesburg, poverty, underemployment, and unemployment abound in Orange Farm. Residents continue to live in houses that they built themselves, although the government has begun to implement a housing construction project. Electricity is widely available but few people have access to potable water inside their homes, relying on external taps and pit latrines. Recent development projects have contributed a multipurpose community center, which includes an Olympic-size swimming pool, an information center with Internet access, and the Nike Chris Hani Sports Complex, yet many residents continue to live below the bread line.

Because Orange Farmers have migrated from all over South Africa, individuals with whom we spoke identified themselves as belonging to one of several ethnic groups, including Xhosa, Zulu, Sotho, or Tswana, and each of these groups was said to have its own culture.² Although ethnic groups shared some cultural elements, residents asserted that there were important differences. For instance, one trial participant identified herself as Zulu and commented that Zulu men were not circumcised while Xhosa men were. Another woman present, identifying herself as Xhosa, agreed, remarking that it was a different culture. A third trial participant expressed confusion when her husband’s family, who she said were of a different culture, made certain requests of her saying, “I do not know why but, it is their culture.”

Even though Xhosa culture, Zulu culture, and Sotho culture were mentioned regularly and often contrasted with “Western” culture, Orange Farmers were adamant that because of differences there could not be a single South African or African culture. As one trial participant succinctly noted, “The only thing we all have is black skin.”

Most of the trial participants discussed culture in terms of specific actions that individuals performed. Examples included having a large family, virginity testing, talking to elders respectfully, refraining from intercourse during menstruation, kneeling when serving food to men, initiation, polygamy, demand sex within marriage, and brewing beer for the ancestors. These cultural practices were often described as static and immutable. When asked
if culture could be changed or altered, the response was invariably "no." An older trial participant noted, "We found it like that so we must leave it like that."

Although some women did discuss performing cultural practices in Orange Farm, many residents believed that these traditions were followed more rigorously in rural areas that were composed of a single ethnic group. A trial participant in her 30s detailed how, after returning to visit her family in KwaZulu-Natal, she would kneel when serving food to her husband. She said, "When you are in the rural areas you can't just say, 'Here's your food Mike.'" However, in Orange Farm she reported that she did not follow these proscriptions. An older woman remarked, "When you get married your parents ... say you must respect your husband and do whatever he wants you to do. I have never seen things like that here in Johannesburg." Because not all Orange Farmers consistently engaged in practices that are considered to be traditional, residents would often describe individuals or families by their adherence to culture. For instance, one woman asserted, "There is culture in some families where the girls in those families still go back to the villages for virginity testing." While a few households were seen to continue to practice cultural traditions, thereby "having" culture, many more were thought to ignore or suspend the enactment of these customs. When this occurs, individuals, families, and even communities are said to lack culture. We were told repeatedly that there was "no culture" in Orange Farm. Consequently, culture is not something that all residents inevitably practiced on a daily or even yearly basis. Culture, as portrayed by Orange Farmers, is not an essential or compulsory component of their lives.

While culture is cast as dependent on the performance of specific actions that are considered to be traditional, ethnic identity is not. Orange Farmers routinely spoke of ethnicity as independent from the enactment of culture. For instance, residents who identified themselves as Zulu, Sotho, Tswana, or Xhosa also acknowledged that they did not participate in their culture. Men who reported that they were Zulu admitted that they had never visited their natal home or had claimed to regularly engage in cultural practices that they considered Zulu. A lack of culture was never used to challenge ethnic affiliations. In fact, it was the multi-linguistic and multi-ethnic population of Orange Farm, coupled with its peri-urban location and recent establishment, which was believed to encourage and exacerbate the paucity of culture in the community. One woman remarked, "There is no culture because it is mixed up culture." The intermingling and intermarrying multi-ethnic population of Orange Farm caused individuals to either forget or ignore their unique culture in favor of an urban lifestyle without culture. As the boundaries between cultures are erased, ignored, or forgotten, culture was not said
to be changed, adapted, merged, or deployed in a new way to fit the urban multi-ethnic surroundings, but lost.

Given the local conception of culture, many Orange Farmers viewed it as peripheral to the transmission or prevention of HIV/AIDS. Although cultural factors were thought to play a role, this was only in instances where individuals still participated in traditional practices. Furthermore, culture was thought to be able to play both a positive and negative role in the HIV/AIDS pandemic. For instance, cultural traditions that encouraged virginity were praised as an effective tool against HIV. A 42-year-old informal trader who identified himself as Zulu remarked that in Zulu culture women were expected to remain virgins until they were married, thereby preventing the transmission of HIV. Virginity testing, which aims to monitor the sexual status of adolescent women, was similarly praised as a cultural practice that could protect the health of individuals. For instance, one participant remarked, “[Culture] helps, because if virginity testing was still done religiously, it would help in stopping the spread of HIV.”

In contrast to virginity testing, polygamy was often given as an example of a cultural practice that encouraged the spread of HIV. One young woman remarked, “There is one [wife] who is the favorite one so those ones who are not the favorites will not have time for the man and they will have affairs.” However, this view was challenged by a trial participant who commented, “My father has two wives and then he went with them to test for HIV, so it is not all men who have many wives are ignorant.” This view was not unique. Other participants noted that while polygamy could spread HIV, this was not inevitably the case: “It depends on the conduct of both the woman and the man; if they are faithful to each other ... there is no reason why HIV will be spread.”

Although Orange Farmers asserted that culture played a role in the HIV pandemic, this was mitigated by a variety of other factors. Many people discussed transaction sex, prostitution, and lack of condom use without reference to cultural beliefs, traditions, or practices. For instance, the most frequently cited risk factor for HIV transmission was lack of condom use, and this trend was not considered to be the result of culture. Orange Farmers, both male and female, repeatedly asserted that they did use condoms because of trust. Trial participants explained that if both partners tested negative and agreed to be monogamous there was no risk of contracting HIV. Orange Farmers commented that they were more likely to use condoms with sexual partners whom they suspected of promiscuity. One trial participant remarked that after suggesting condoms to her partner, he replied, “Why do you suddenly want us to use condoms, we are faithful to each other or are you cheating on me?” Because partners can engage in clandestine affairs and as a result contract an STI, if one partner suggests
condom use after a period of abstaining, the other will often suspect infidelity.

Furthermore, Orange Farmers agreed that overall, women were more likely than men to insist on condom use but many women reported that men were reluctant to wear condoms. Instead of blaming men's reluctance to wear condoms on cultural attitudes, women used other explanations. Women stated that a variety of issues such as trusting your partner, love, unfamiliarity with condoms, and lack of information concerning condoms all influenced male attitudes toward condoms. Although women highlighted a number of factors that they believed affected condom use, overall there was general agreement that it was impossible to know whether a man would choose to engage in protected sex. An older woman commented, "We cannot classify and say rich men will behave like this and poor men will behave like this, people are different and circumstances in which they find themselves are different also."

Infidelity, transaction sex, and prostitution, unlike polygamy, were practices not associated with culture or cultural practices. A male resident told us that he believed that the inability of women to access financial resources—poverty—was the primary reason that women engaged in transaction sex. A number of women enrolled in the trial echoed this statement. Neither prostitution nor transaction sex were linked to polygamy. In fact, prostitution was actually viewed as a consequence of not having culture. A male informal trader asserted that prostitutes had lost their culture, either forgetting or ignoring traditional teachings and values. Other members of the community, who stated that women who followed traditional cultural values would not become sex workers, confirmed this view. Female trial participants were adamant that women who engaged in transaction sex or had several "boyfriends" were rejecting cultural norms.

Like Orange Farmers, researchers and health professionals also employ the concept of culture. In much of the literature relating to HIV on the continent, African culture has been considered—either explicitly or implicitly—to exert a profound influence on the behavior of individuals. In most cases, African culture is cast as either contributing to, or the primary cause of, high rates of HIV/AIDS on the continent. While there has been variation in the way in which ideas of culture are employed in health research, we wish to highlight a set of themes that while not universal can nevertheless be found through a range of publications.

Culture has been cast as contributing to the spread of HIV/AIDS since the beginning of the epidemic. In the 1980s, when researchers were seeking the origin of HIV, both Africa and Haiti were considered possible environments that fostered and spread HIV. In each case, theories explaining the mechanism through which the virus "jumped" from animals to humans tended to
focus on cultural practices. Karpas (1987) asserted that sexual practices involving the use of monkey blood in the Rift Valley region could be responsible. It was even suggested that perhaps Africans had sexual intercourse with monkeys (Sabatier 1988:50). In Haiti, tales of exotic voodoo rituals, such as drinking animal blood, were theorized as yet another way that the virus could have entered the human population (Farmer 1992; Shannon et al. 1990). Although initially there was little scientific data to support these claims, they were disseminated in both the scientific and popular publications.

As the years have progressed and medical and epidemiological data regarding HIV became better understood, culture continued to feature in behavioral explanations regarding the high prevalence of HIV in sub-Saharan Africa (Marshall 2005:2520). While some researchers examine the role of witchcraft (Boahene 1996; Yamba 1997) or traditional healers (Peltzer et al. 2006), much of the literature focuses on sexuality. For instance, documented risk factors for HIV infection that are considered to be culturally influenced include a widow having intercourse to remove her dead husband’s spirit (Campbell and Kelly 1995; Chipfakacha 1997), levirate and sororate (Sow and Gueye 1998), polygamy (Cleland and Ferry 1995), and an indifference to chastity (Caldwell et al. 1989). The assumption that Africans have a tendency to engage in higher rates of multi-partner sex can also be found throughout HIV/AIDS research (Stillwagon 2003). In many cases, this behavior is claimed to be the result of culture.

Culture is also thought to promote unsafe acts of sexual intercourse. For instance, writers assert that African men have a preference for dry sex, which can cause the vagina to tear and thereby become more susceptible to HIV infection (Brown et al. 1993; Runganga and Kasule 1995; van de Wijgert et al. 1999). Lack of condom use has also been explained as the result of cultural attitudes that encourage female submission to male sexual desire (Campbell 1995; Wood and Foster 1995). Macdonald (1996:1327) writes, “In particular, the legacy of these cultural traditions is important for an understanding of the contemporary position of women in society and its connections with the transmission and rapid spread of HIV.” A further barrier to condom use appears to be the cultural importance of fertility and child bearing in African societies (Lachenicht 1993). Finally, myths regarding the contamination of condoms with HIV are also blamed as a cultural barrier to condom use (Tobias 2001).

Throughout literature relating to HIV/AIDS in South Africa, culture, sex, and risk behavior have also been linked. For example, LeClerc-Madlala (2001:41) wrote that “Zulu sexual culture” is characterized by:

- gender inequity, transaction sex, the socio-cultural isoka ideal of multiple sexual partnerships, lack of discussion on matters of sexuality in the home
and between sexual partners, the conditioning of both men and women to accept sexual violence as “normal” masculine behavior along with the “right” of men to control sexual encounters, and the existence of increasingly discordant and contested gender scripts.

Each of these characteristics can be cast as factors that could potentially contribute to the spread of HIV. Cultural practices such as virginity testing, lauded by some residents of Orange Farm as a cultural solution to HIV, have been asserted to be ineffective by LeClerc-Madlala (2002).

Recently, health researchers have begun to move away from views that focus exclusively on culture. Instead social, economic, political, and biological factors are being examined in greater detail. Nevertheless, culture still remains an important topic in HIV research. For instance, the United Nations Economic Commission for Africa recently published a report stating that culture plays a “major role” in the following behaviors: “gender inequalities,” “wife inheritance and widow cleansing,” “polygamy,” “domestic violence including marital rape,” and “harmful practices like female genital mutilation” (Commission on HIV/AIDS and Governance in Africa 2008:18–20). Like earlier sentiments, the report specifically focuses on risky sexual practices, their link to culture and the need to change cultural practices to reduce the spread of HIV on the continent. The belief that African culture promotes male domination has influenced the way in which new medical technologies such as microbicide gels are viewed. Volker (2006:753) suggested that the gels are one way of giving women “control over their health in cultures that deny them control over their bodies.” Internet discussion forums are also replete with statements regarding the role and effects of culture in Africa. On the Africa Microbicide Advocacy Group e-forum, culture continues to be viewed as an important factory in the spread of HIV/AIDS. For instance, a recent posting was titled “Cultural factors influencing the spread of AIDS specific to Africa.” These are but a few examples of current attitudes toward the negative role of culture in the HIV/AIDS pandemic.

Throughout the literature, ideas of culture tend to stress four main features. The first is that of a single “African” culture that is applied as if the region were an undifferentiated whole (Stillwagon 2003:812). For instance, writing about HIV/AIDS, van Dyk (2001:61) stated, “Despite the differences between Africans from different cultures in terms of geography, linguistics, religiosity and ways of life, there is a dominant socio-religious philosophy shared by all Africans.” Secondly, medical researchers tend to view culture as both static and homogenous (Kleinman and Benson 2006:835). Another important tendency is to cast culture is an almost inflexible force that is difficult if not impossible to alter. As Volpp (2000:94) noted, when analyzing “communities of color,” culture is often
seen as “a fixed monolithic essence that directs the actions of community members.” Finally, culture is believed to act as a barrier to substantial behavior change. Consequently, from a biomedical perspective, culture is generally viewed as limiting rather than empowering health outcomes (Fox and Swazey 1984; Gordon 1988a; Taylor 2007).

CULTURE AND DIFFERENCE

Ideas about what culture is and the effects that it has on behavior have been influenced by a history of social relationships between peoples (Spiegel and Boonzaier 1988). From the popularization of the German word *kultur* in the 19th century, concepts of culture have stressed not the similarities but rather the variations between people (Kuper 1999). Although championed by Boas to bring an end to racial theories, culture became a new medium through which differences could be justified. By providing a way of explaining unchanging human difference, culture could be used as a homologue for earlier notions of race (Malik 1996; Stocking 1982). In a South African medical context, Macleod and Durrheim (2002:788) commented, “In the place of biological ‘scientific’ racism, we have a ‘new racism’ in which ‘culture’, ‘tradition’ and ‘ethnicity’ perform the work previously achieved by the category of ‘race’.”

Within the context of HIV/AIDS research, culture continues to be a marker of difference (Bibbeau and Pedersen 2002; Briggs 2005). Many cultural explanations highlight risk behaviors, notably sexual practices, which are believed to be practiced in populations of color. There has been a long tradition of associating sub-Saharan Africa with deviant sexuality and disease (Gilman 1985). Throughout the Victorian era, African sexuality was described as wild, animal-like, exotic, irrational, and immoral (Gaussset 2001:510). Sexual aberrations were seen to be symptomatic of the social and physical afflictions that were believed to plague an entire continent and its people. Black bodies were associated with “degradation, disease, and contagion” (Comaroff 1993:306). Mirroring earlier views of Africans as sexually deviant and diseased, explanations that focus on culture as one of the leading contributors to the high rates of HIV marshals scientific and medical evidence do demonstrate that African culture is not only different, but it is pathological. As Briggs (2005:276) writes, “Using liberal languages of multiculturalism, cultural features are pathologized by linking them to notions of biomedical causation.” Through HIV/AIDS research publications and a health discourse of risk behavior, social categories that are based on historical and ideological representations become naturalized and accepted as scientific fact. The portrayal of African culture as dangerous and biomedical intervention, such as condoms or anti-retroviral therapy, as efficacious, both constructs
and reinforces ethnic and racial boundaries. Consequently, while it is possible to medically identify the risk factors involved in HIV transmission, the way in which these factors are portrayed—in terms of individual behavior that is the result of culture—are far from neutral.

In South Africa, the association between race, culture, and disease has a long history and was used to reinforce not only conceptual boundaries between whites and blacks but also physical ones. The Public Health Act (1919), South Africa’s first national health measure and one that would remain until 1977, advocated racial segregation as a means of arresting the spread of disease (Phillips 1990). Throughout the interwar years, as black migration to white urban centers reached a new high, health officials continued to argue that a large metropolitan black population would lead to poor sanitation and increased illness rates, resulting in stricter influx controls (Comaroff and Comaroff 1992:229). After the Second World War, concerns about the rapid spread of venereal disease were merged with anthropological notions of culture. Jochelson (2001:123) noted that in South Africa, anthropological ideas encouraged people “to view Africans and African society not as a less developed version of themselves, but as intrinsically different on cultural rather than biological grounds.” It was argued that Africans living in cities were at much greater risk for contracting and spreading syphilis because the native population was “culturally unsuited” to urban living (Jochelson 2001). In contrast to much of the literature relating to HIV/AIDS, cultural norms were believed to control the natural sexual impulses of Africans. Once Africans migrated to urban centers, these cultural safeguards would be lost, leading to increased rates of promiscuity and syphilis.

In South Africa, ideas of culture and difference were also employed to justify mass segregation and disempowerment of non-whites during years of apartheid. Volkekunde, a form of anthropology promoted by the government and Afrikaans-speaking universities, conceived of culture as bounded and distinct (Gordon 1988b; Kuper 2002; Sharp 1981, 2001). Using ethnos theory, volkekundiges argued that each cultural group had its own traditions, which could be corrupted or destroyed after coming into contact with the traditions of other cultural groups. African culture, they believed, was only intact in rural areas and could be quickly lost after people migrated to urban centers. Segregation, they claimed, was the only effective way to ensure the preservation of culture. This argument was used to justify the creation of rural homelands for each of South Africa’s major ethnic groups and the forced resettlement of Africans into these Bantustans. As homelands were given flags, national newspapers, and radio stations, and eventually “independence,” volkekunde ideas of culture and identity were disseminated and entrenched among the black population (Harries 1991).
Despite the advent of majority rule in South Africa, colonial and apartheid notions of culture continue to permeate the country. In Orange Farm, residents conceptualize culture as bounded and discrete despite some similarities that might occur between ethnic groups. Regardless of the mutual intelligibility of the Zulu and Xhosa languages, Zulu and Xhosa cultures are considered to be distinct and separate. Furthermore, Orange Farmers discuss culture as being strongest in rural areas, the former homelands. In an urban setting, culture is likely to be lost. Instead of conceptualizing culture as adapting to new circumstances, it is thought to be abandoned. These views influence the ways in which Orange Farmers view HIV risk behaviors. Just as many of the behavior theories suggested by health researchers resemble earlier notions of Africa as immoral and diseased, so too do views of Orange Farmers reflect earlier notions of culture loss as an effect of urban living.

CONCLUSION

While the concept of culture is employed and essentialized by both health researchers and residents of Orange Farm, there is not agreement on the role that culture plays in HIV transmission and prevention. For the former, culture is portrayed as possessed by all Africans and is thought to exert a profound influence on the way in which they behave and live their lives. Culture is often given as the primary vector motivating risk behavior, thereby casting culture as pathological. These narratives of HIV/AIDS in research literature resemble earlier European views of Africans as possessing deviant sexuality and pathological culture. In the context of HIV/AIDS research, culture provides a way of linking concepts of disease and sexual deviance in sub-Saharan Africa. In contrast, Orange Farmers spoke of culture as a series of actions that individuals could choose to either follow or ignore. Consequently, culture did not automatically influence the lives of every resident. Believed to be a primary vector for HIV transmission, prostitution was stated to be the result of a loss of culture. These narratives of HIV/AIDS in Orange Farm resemble earlier colonial and apartheid views of culture, which were used to promote segregation.

Examining the ways in which concepts of culture are used by HIV/AIDS researchers and Orange Farmers demonstrates that while on the surface these might appear to be very different usages, in fact, they are both situated within a social and historical context. In both cases, ideas of culture can be employed in illness etiologies to construct and entrench ideas of difference. Through medical discourse, difference becomes naturalized, justified through ideas of risk and risk behavior. Consequently, it is important not
to understand history in terms of culture but rather culture in terms of history (Thornton 1988). Instead of explaining risk behavior in terms of culture, one should instead look at how medical ideas of risk have been used to entrench identity and difference. Instead of debating what culture “is” we should instead look at how it is used.

Understanding and contextualizing concepts of culture should not be confined to anthropological arenas. Given the ubiquity of cultural and behavioral explanations, medical professionals and researchers are often informed by these models when developing, conducting, and evaluating intervention programs, as is the case with vaginal microbicides. Popular views of culture can also impact how new medical technologies to fight the spread of HIV are developed and marketed. Consequently, public health professionals and medical researchers should be aware of the way in which they employ ideas of culture.

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NOTES

1. Ethical permission to conduct the study was granted by the University of the Witwatersrand Committee on Research Ethics (Medical).
2. Fourteen of the focus groups were with community residents not participating in the trial.
3. In SeSotho and IsiZulu the words Setso and Insinitu were respectively translated into English as culture.

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