Published in final edited form as:

Camb Q Healthc Ethics. 2008 ; 17(2): 195–205. doi:10.1017/S0963180108080225.

Key Conceptual Issues in the Forging of “Culturally Competent” Community Health Initiatives: A South African Example

Christian Simon and Maghboeba Mosavel

Many cultural competency efforts in healthcare stress the importance of cultural diversity and difference. This emphasis is necessary and well justified. It has helped sensitize healthcare systems to the differences among people and their health-related attitudes, preferences, and behaviors. However, the emphasis on diversity and difference has, unfortunately, also detracted from serious consideration of the things that cultures have in common and the possibility that socioeconomic differences are today far more important than cultural ones in determining healthcare outcomes.

This paper attempts to deepen current conceptions of cultural competency in health by exploring the twin elements of cultural commonality and socioeconomic difference. Given our background in community-based health promotion (CBHP),¹ we focus our discussion on the need for “culturally competent” CBHP. The broad aims of CBHP are similar to those of many preventive public health initiatives and rest on the perceived value of positively changing people’s health-related attitudes, preferences, and behaviors. Recent trends in CBHP emphasize community understanding and capacity over service delivery and consumption.² Our paper considers the case of Masidaal, a community in South Africa where we have been conducting formative research aimed ultimately at educating and mobilizing women to get screened for cervical cancer. We present data that clearly challenge stereotypes about “African culture” as markedly different and exotic when compared, for example, to European, American, and other urban cultures. Our data also illustrate how profoundly unemployment, poverty, and related socioeconomic forces affect our research community and that it is through consideration of these forces that the differences among people and their communities are revealed. Finally, we argue for conceptual balance between the similarities and differences among people and cultures in our efforts to forge culturally competent health promotion initiatives. We suggest that “class competence” deserves a place alongside “cultural competence,” and that this form of competency requires respecting the capacity of communities for self-determination and action. One useful strategy here is to conduct “participatory research,” in which community members are invited to critique and work alongside healthcare researchers. This strategy may help bridge the disparities in position, power, and access to resources between different people, communities, and countries. Future discussion will need to address other possible ways of acknowledging the effects of socioeconomics alongside those of culture.

Background

Any discussion of cultural competence must be rooted in a clear understanding of the concept of “culture.” What is culture? How unique or consistent are cultural beliefs, attitudes, and practices? Where does one culture begin and another end? Unfortunately, these questions have no easy answers, in large part because of the difficulty of pinning down what we mean by “culture,” exactly. According to the classic anthropological view, expressed by Edward Burnett Tylor in his *Primitive Culture*, in 1871: “Culture ... is that complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society.”³

This definition was widely adopted in the 19th and early 20th centuries and supported by anthropological “discoveries” of new, exotic, and “primitive” cultures around the world. However, anthropologists in the 20th century began questioning the definition and meaning of culture, in part as a result of modernization, progress, and rapid cultural contact. In the 1960s, predictions of “culture loss” and Marshall McLuhan’s vision of a “global village” amounted to a rejection of the idea that cultures were unique, distinctive, and easily told apart.⁴ Globalization added fuel to the fire. The creation of new and lucrative global markets for goods such as Coca Cola and McDonalds, popular television shows such as *Dallas* and *Dynasty*, and other Western cultural artifacts led scholars to theorize the emergence of a global marketplace in which cultural differences and boundaries were fast eroding and disappearing altogether.

Not all scholars agreed, however. Tamar Liebes, for example, questioned the idea of “Western cultural imperialism” sweeping the world and blotting out other cultures. Liebes conducted research in Israel and showed that the message imparted among viewers of the television show *Dallas* depended on their prior values and varied according to the experiences of the particular group to which the viewer belonged.⁵ The implication of this research was that cultures were a great deal more flexible and accommodating of outside influences than theorists of cultural imperialism presumed.

Efforts to understand culture grew more nuanced as a result of this debate. At the end of the 1980s, Herbert Schiller, once a staunch believer in the idea that cultures were being wiped out by Western influences, wrote:

The transfer of cultural values is a complex matter. It is not a one-shot hypodermic inoculation of individual plots and character representations. It involves the much more difficult to measure acceptance of deep-structured meanings that may not even be explicitly stated. Can the transfer, for example, of acquisitive or consumerist perspectives be simply quantified?⁶

Recent efforts to understand what culture is and how cultural change occurs have led to the idea that culture is not a concrete, objective phenomenon, but something that is collectively imagined, socially constructed, and constantly reshaped and renegotiated. This idea has been extended to mean that “culture” is subjective and not something that simply exists “out there.”⁷ At the same time, it is starkly evident that people and their attitudes, behaviors, and material cultures are changing and changing rapidly. A present-day trip to Africa, for example, quickly reveals the extent of this change. Instead of finding ancestor worshippers and “animists,” the contemporary visitor “finds converts to Christianity and Islam. Instead of indigenous handicrafts, he finds Coleman lanterns, Panasonic radios, and hand tools made in China.”⁸ Indeed, so-called African culture—or Masaai or Zulu culture, for that matter—is today more likely to be found in theme parks than in the streets, towns, and cities across Africa.

Given these and other momentous changes, one would expect to find “culture” very carefully and sensitively defined in the literature on cultural competence. One would expect it to be defined, at the very least, with a view to the permeable, rapidly changing, and interconnected nature of culture. This is rarely the case. In fact, the older view of culture as unique, unchanging, and organic still prevails. The American Medical Association (AMA) provides an instructive example in its Cultural Competence Compendium.

Our use of “cultural competence” and “culturally competent health care” reflects an inclusive definition of the word “culture”—any group of people who share experiences, language, and values that permit them to communicate knowledge *not shared by those outside the culture*. (our italics)⁹

The idea that there exists an “inside” and “outside” when it comes to culture hearkens back to the classic anthropological definition of culture as an organic and separate whole. This is an untenable definition in today’s world. Countries, regions, and people are growing too interconnected and are influencing one another to a degree that our definitions of “culture” and “cultural competence” need to account for. One way of doing this is to consider the effects of socioeconomic conditions on people, and to make a case for focusing on socioeconomic disparities or differences in our efforts to improve the quality and effectiveness of healthcare, rather than just cultural difference. Below, we explore this possibility through a case study that questions whether “cultural competence” is a truly meaningful concept in light of the socioeconomic gaps and differences shaping people’s everyday lives and struggles.

Our Research Aims

The main goal of our research in Masidaal, South Africa, was to better understand and develop a strategy for reducing women’s risk of developing cervical cancer. We chose South Africa for our cervical health promotion research out of concern for the fact that black South African women have a very high risk of developing cervical cancer as a result of limited cancer screening resources, lack of knowledge about the disease, and other factors. Our long-term goal was to develop a community-based intervention aimed at enhancing women’s knowledge of cervical cancer and access to screening services. We planned to work closely with the community and with local clinics and healthcare providers to identify ways of boosting local awareness of and capacity for preventing the disease.

Although we had a clear idea that this is what we ultimately wanted to do, we intentionally did not formulate a specific research question or set of hypotheses before entering and dialoguing with the community. In other words, we aimed to first develop a relationship with the community, present it with opportunities to reflect and comment on our broad plan to study and help prevent cervical cancer, and allow the specifics of the research to take shape from there.

Establishing a Relationship with the Research Community

Although there exist many different ways of engaging a research community, ranging from brief consultation to active and sustained collaboration,¹⁰ we opted for a “community-based participatory research” (CBPR) approach. CBPR has gained considerable traction among community-health researchers in the United States and in South Africa, among other countries.¹¹ Proponents of CBPR view research participants as subjects rather than objects of study, with the implication that they have a right to participate and share in the design, conduct, and outcomes of research. At its most idealistic, CBPR starts with the other’s agenda¹² and places subjects in the driving seat of the research process.¹³

Our CBPR approach started with our attempt to engage a broad range of community leaders and other stakeholders on the topic of our study. We also met with dozens of community members in order to make ourselves known to the community. We visited the community’s different neighborhoods, schools, informal social halls, local businesses, the local clinic and library, churches, and other places. We gave presentations introducing our research to and inviting commentary from local women’s organizations and women’s healthcare professionals. We established a diverse community advisory board (CAB) consisting of community laypeople, healthcare workers and activists, and local government officials. The board was charged with reviewing and approving the research (in addition to review and approval by the institutional review board at our home institution in the United States and local government in South Africa) and for overseeing all future stages of the research.

This process of engaging the community had a number of positive outcomes. It introduced us to the community and its people. It provided an opportunity for community members to get to know us and share their thoughts on our research. It drew our attention to the fact that the community had major unmet healthcare needs and that, in principle, just about any kind of applied research was welcome. Our upfront efforts to dialogue with the community also provided the community with the chance to communicate to us its fear of being exploited. People alluded to this concern when they jokingly asked whether we would be “running back to America” with our research findings once the study was complete. We explained that we would not consider the study complete until positive, sustainable change had taken place. We also conveyed that we intended to share the results of our research with the community so that it could help interpret and act on them. We therefore attempted to respect the community’s concerns about possible exploitation and to reassure it that our intention was to develop a long-lasting partnership toward health.

In sum, our implementation of CBPR sought to provide the community with a chance to get to know us, to critique and reshape our research, and to increase awareness of our mutual roles, responsibilities, and constraints. It also provided an early opening for us to address a number of misperceptions that, left unaddressed, threatened to undermine our attempts to engage the community as an active and equal partner in the effort to improve cervical health. Finally, our collaboration with the community allowed us to conduct a series of well-attended and successful focus groups designed to find out more about the community and its concerns and problems. We conducted these focus groups with a cross section of community members ($n = 181$), including with high-school girls and boys ($n = 112$), female parents ($n = 17$), educators ($n = 34$), school support staff ($n = 11$), and several other community stakeholders ($n = 7$). Local community members were invited and hired to help design, gain consent for, and lead the focus group discussions. Written consent was obtained from all participants. Below, we report on some of the findings from these focus groups in an effort to support our claim that socioeconomic rather than cultural differences shape local reality and therefore need to guide our efforts to improve the quality and effectiveness of healthcare.

The Community of Masidaal

Masidaal is an urban community near Cape Town consisting of 37,132 people, according to the latest (2001) South African census estimates (actual numbers may be significantly higher).¹⁴ Masidaal’s residents are mostly “Coloureds” of mixed race (59%) and indigenous Blacks (41%). Unlike some of its neighboring communities, Masidaal is not a “shanty town.” However, it is poor: More than half of the able-bodied, adult labor force is unemployed. Among the employed, most wage earners earn \$260 or less a month. By contrast, Durbanville, a predominantly White community less than 10 miles from Masidaal, has an unemployment rate of 2.8%. Among the employed in that predominantly White community, most wage earners earn \$1,600 or more a month.¹⁵

Masidaal was created in the early 1980s, when people were forcibly removed from other areas and relocated there in response to the apartheid vision of racial segregation and control. Others arrived later, driven from rural areas by land dispossession and poverty. On the face of it, Masidaal is typical of any inner-city community in the United States. A quick walk down the main street of the community reveals more that is apparently foreign and imported than it is African. There are the ubiquitous Coca Cola signs, Toyota trucks, jeans, T-shirts, and Nikes. There are the distinctly American cultural representations, for example, the two rappers someone has painted on the side of a hairdresser’s, complete with skullcaps and impressive amounts of gold and diamonds. Beyond these contemporary images lie signs of other, older periods of profound religious and cultural cross fertilization: Methodist and

Moslem centers, humble Cape Dutch architecture, high school students dressed in uniforms and reading assigned text books such as a modern British classic, *Lord of the Flies*.

Young people in our focus groups talked about the kinds of music they enjoyed. They mentioned South African *kwaito*, R&B, pop, hip hop, and rap. They talked to us in Afrikaans, Xhosa, and English filled with Anglicisms (e.g., “balcony,” “cool-drink”) and a great many Americanisms (e.g., “like,” “gonna,” “kids,” “getting high,” “hot,” and “cool”). Participants also talked of the many things that people in Masidaal need and want but cannot have owing to class differentiation and poverty. One teenager said, “there is jealousy amongst the young people. The one wears a Levi, another a pair of Nikes. If you don’t wear proper clothes, you cannot walk with me.” Girls report that they enjoy “window shopping” in the shopping malls in some of the other, wealthier, areas outside Masidaal. Youth gangs, whose members often stand out because they wear imported clothing and gold in their teeth include, “the Americans,” “Dixie Boys,” and “80 Cent” (there is an American rapper called “50 Cent”). Gangs such as the “Luxury Kids” clearly express the value young people place on material goods, yet, their idea of luxury is modest and expressed through items that more fortunate young people may take for granted: jeans, T-shirts, sneakers, a radio for listening to music.

Shopping malls outside Masidaal are filled with expensive brand name items and White people shopping for them. In stark contrast, parents in Masidaal struggle to adequately cloth and feed their children. Access to basic healthcare is made difficult by the lack of local healthcare services. Service delivery problems force people to either forgo healthcare or to travel further afield, an expensive prospect in a community where half of the adult labor force is unemployed. Parents in Masidaal worry about drugs, crime, gang violence, and putting enough food on the table for their children.¹⁶ Aware of the many adults in the community who are unemployed or who earn very little, high school students question the value of their educations and staying in school. Some fear they will never make it out of high school. Asked when he hoped to graduate from high school, one boy in Grade 8 responded: “In four years from now. If I am still alive.” Crack cocaine, ecstasy, and methamphetamine use, alcoholism, rape and sexual abuse, and HIV-AIDS are major concerns to parents and many children alike.

The need and desire for money and material goods take on dangerous proportions given these dimensions of poverty. One boy pointed out, “Even you can steal clothes, you feel that my friend wears this and that, oh no! he wears All Star and whatever, and I don’t have those things. Maybe you can think, okay, I should also go and steal, maybe in the White areas, so that I can get what my friend has.” More and more young people have turned to gangs and violent crime to access money, food, clothing, and a sense of self-respect. In our focus groups, gangs were revered by boys as young as 11 and 12 who talked of their flashy dress style and displays of bravado and wealth. Girls, too, were said to be attracted to the cash, jewelry, clothes, and other scarce commodities that gang members could provide. They “run after their money and gold,” one boy explained. Girls also become “taxi queens,” whereby they offer small sexual favors to taxi drivers in return for free transportation and cash.¹⁷

Adults in our focus groups talked of the link between people’s health-related attitudes and behaviors and the dynamics of poverty in their community. They said that young people took risks with their health and personal well-being because they lacked appropriate role models and hope for the future and because the environment they lived in was ill suited to promoting healthy behaviors. One mother said, “The health of our children, the times they live in are really bad, because our children like drugs. For example, a child will leave at 5 and she or he will come back at 5 in the morning. They are at these jukeboxes [informal social/music halls].... They drink alcohol and it is easy for them to get raped there. So now

they will get AIDS that way. So I'm saying the time of our children is very bad." Others pointed out that young people took tremendous risks attempting to help out their families. They cited the case of a high school student who died violently trying to support her family through sex work.

It was also clear from our focus groups that adults, particularly mothers, were often so concerned with the everyday needs and risks facing their children that they put these ahead of their own health and well-being. For example, a mother might spend the money she desperately needed to go visit the doctor or clinic on food or clothes for her children. The alternative, as one mother emphasized, was to increase the risk of a son joining a gang or a daughter selling sexual favors because they don't get such basic things as decent clothes and "*bread and such*." Mothers also pointed to the possibility that employment and income differences within the community led to problems. One mother said: "You can give a child love as much you can, but if you can't give him/her food like it is cooked next door, and the dress like the other child is wearing, in this day and age most children can't stand for that, you see. So, crime groups come because of unemployment."

Discussion

Although interpretations differ, cultural competency in health promotion research is generally held to mean that health research and interventions should be "uniquely tailored to each community or individual by integrating or being responsive to the spectrum of factors that influence attitudes, behavior, and experience."¹⁸ These factors, or "cultural indicators," include differences of language, race/ethnicity, religion, nationality, socioeconomic class, education, and others. To effectively engage and mobilize community members, CBHP efforts need to be reflective of and responsive to these and other differences. What is less clear, however, is how cultural commonalities and socioeconomic differences among people and nations ought to figure into the framework of culturally appropriate, community-based health promotion. Below, we discuss our findings with a view to suggesting the usefulness of distinguishing between cultural commonality and socioeconomic difference in CBHP initiatives.

Cultural Commonality

Hyun¹⁹ has commented on the idea that different cultures may be considered similar on the grounds of their shared sense of right and wrong, among other values. Our perspective is responsive to a different set of cultural commonalities, namely, those brought on locally by globalization. In both the cultural competency and CBHP literature, very little attention has been given to these forces and their capacity to shape local attitudes, beliefs, and behaviors. Yet, people's lives have been profoundly shaped by global processes, including colonialism and postcolonial exploitation, widespread immigration/emigration, foreign investment, advertising, outsourcing, and other processes.²⁰

Some of these processes have profoundly affected South Africa since the ending of apartheid in the early 1990s. A period of intense repatriation, travel, and contact with the outside world followed. The dismantling of segregationist laws and temporary relaxation of strict immigration policies fueled migration and movement both within and from without the country. Music, film, literature, goods, and products previously banned or unavailable in South Africa as a result of economic sanctions filled stores and advertising space. American, British, Japanese, and other multinational companies started openly trading and advertising in the country. Thus South Africa has rejoined the global community, and the effects of this show in virtually all domains of South African life. The country's popular culture is in many ways a global popular culture, which has permeated everyday life and language and linked communities such as Masidaal to the wider world.

One key implication of recognizing these linkages is that they can help dispel old and lingering stereotypes of “black South Africa” as primitive, undeveloped, and fundamentally different from the rest of the country and the world. Colonial and apartheid institutions in South Africa long promoted this stereotypical dichotomy.²¹ It is also evident in Western travel discourse, for example, in the commercial byline from Lufthansa, published in National Geographic in the late 1970s, alongside a picture of mud huts and open savanna: “Come to Africa before the 20th century beats you to it.”²² This kind of Western nostalgia for “darkest” Africa can and ought to be combated by accounts sensitive to the similarities among South Africans of all races, and, indeed, among South Africans and people in the rest of the world. Cultural competency approaches that duly recognize the influence of globalization and commonality on local cultures can help dismantle these kinds of stereotypes and prejudices.

Socioeconomic Difference

The commonalities that urban cultures increasingly share occur in the context of ever widening socioeconomic differences and disparities. Globalization is an unequal process, and it has widened many of the gaps in wealth and health that have long existed between the developed and developing world. Ethicists Benatar, Daar, and Singer point out, for example, that in 1900 the ratio between the richest and poorest 20% of the world’s countries was 9:1; by 1997, that ratio had widened to 70:1.²³ These and other global gaps in wealth reinforce those existing at national and local levels. In South Africa, foreign investment and export/import traffic still mostly benefit the White minority in control of a large proportion of the country’s economic assets. Despite some decentralization of economic power and wealth, White South Africans still enjoy a level of income, employment, and access to healthcare far greater than the country’s non-White majority. As a result, South Africa’s class structure is characteristic of many developing world countries, consisting still largely of a two-tiered, upper and lower system. In communities such as Masidaal, people are economically separated not only from the wealthier “outside world,” but also from one another as a result of differentiations brought on by limited employment, petty entrepreneurialism, gang activity, and factors that provide some people with greater—if still limited—access to coveted goods and necessities. Some of our focus group participants alluded to this differentiation when they talked of jealousy among youth, and unemployed mothers’ not being able to provide for their children in the way that employed mothers can. A community such as Masidaal exists, therefore, in a complex matrix of socioeconomic differences and disparities. Global as well as local conditions and forces shape these differences and disparities. Recognizing this interplay has major implications for how researchers define and provide culturally competent CBHP.

Key Implications for Culturally Competent CBHP

International CBHP researchers who work in the developing world need to be aware of and sensitive to the global as well as local contexts of their work. Theirs is a profession that is as much a product of unequal global relations than any other international professional activity. Moreover, international CBHP researchers are often visitors to the developing world, where they typically spend a limited amount of time before returning home.

Given these and other factors, developed world researchers need to demonstrate a particular sensitivity to conducting research in the developing world. They may need to invite and face questions about their accountability, goals, and intentions. We encouraged such questions and criticism through meeting with a diverse range of community stakeholders, forming a community advisory committee, and always being honest and upfront about the fact that we were from the United States—although we are both originally from South Africa and could easily be mistaken as South African based. We also invited community members to

participate in our research, for example, by helping to script our focus group questions, run the focus groups, and assist in analyzing the data.

Participatory research strategies help build rapport and trust, and demonstrate commitment.²⁴ They also help to offset the view of communities as passive agents in the CBHP process and that “outside” agents such as ourselves will simply provide the community with much-needed information, services, and resources.

Thus, culturally competent CBHP is respectful of the disparities and local perceptions of power and difference between the developed and developing world. It also aims to facilitate ways in which communities and researchers can work together in meeting mutually agreed upon goals, rather than accentuating insider/outsider boundaries and differences.

The commonalities shared by urban, particularly youthful, cultures also need to be taken into account in the development of culturally competent CBHP efforts. Many African youth are urbanites who embrace decidedly modern values, fashions, and communication styles such as talking openly about sex, money, and taking drugs. In this respect, they are similar to urbanized youth the world over who no longer subscribe to the cultural restrictions and taboos of the past.

This modern phenomenon presents an opportunity. It may make present and future generations of youth receptive to potentially sensitive health promotion topics such as sex and sexuality. It may allow for innovative health promotion strategies focused on encouraging youth to find safe, healthy ways of fulfilling their desires for upward mobility, wealth, health, and happiness.

In sum, our research demonstrates some aspects of cultural commonality and socioeconomic difference in an urbanized community in South Africa. Our data illustrate how youth and parents must deal with profound socioeconomic inequalities while being increasingly subjected to messages and processes promoting material consumption. This trend is not limited to urban communities. It has been documented in rural areas as well, testifying to the penetrating power of global commodification and commercialization.²⁵ Simultaneously, one has to be careful not to equate widespread change, overt displays of materialism, and material consumption as an endorsement of intrinsic Western values and beliefs such as individualism and competitiveness. Older, culturally unique values and beliefs can coexist with more recent changes.

Conclusion

Community health promotion initiatives, particularly in developing countries, are likely to be more effective if they are responsive to the permeability and transcendence of cultural boundaries in today’s interconnected world. To be effective they also need to reflect critically on class differences, because these greatly affect people’s lived, everyday experiences everywhere. Rather than limit cultural competency to notions of cultural diversity and difference, it ought to be conceived as an orientation for focusing on the complex and dynamic ways in which people try to survive and pursue a better life. Cultural competency should also be employed as a lens for viewing and understanding what is happening across the globe today, as powerful homogenizing forces act out on local cultures. How these forces intersect with and help shape the socioeconomic and cultural fabric of communities should be a central focus of our efforts to be culturally competent and to improve health in all sectors of society.

Acknowledgments

We thank the Comprehensive Cancer Center at Case Western Reserve University and University Hospitals of Cleveland, Ohio, for supporting the research on which this paper is based. We are also grateful to the wonderful people of Masidaal, our project coordinator, Debbie van Stade, and our large team of research assistants for making the research possible.

Notes

1. Mosavel M, Simon C, van Stade D, Buchbinder M. Community based participatory research (CBPR) in South Africa: Engaging multiple constituents to shape the research question. *Social Science & Medicine*. 2005; 61:2577–2587. [PubMed: 15955605]
2. Baker, QE. Community-based public health: The community perspective. In: Bruce, TA.; McKane, SU., editors. *Community-Based Public Health: A Partnership Model*. Washington, D.C.: American Public Health Association; 2000. p. 37-43.
3. Tylor, EB. *Primitive Culture: Researches into the Development of Mythology, Philosophy, Religion, Art and Custom*. New York: H. Holt and Company; 1874. p. 1
4. McLuhan, M. *Understanding Media*. New York: Mentor; 1964.
5. Liebes, T. *The Export of Meaning: Cross-Cultural Readings of 'Dallas'*. New York: Oxford University Press; 1990.
6. Schiller, H. *Culture, Inc.: The Corporate Takeover of Public Expression*. New York: Oxford University Press; 1989. p. 149
7. Clifford, J.; Marcus, G., editors. *Writing Culture: The Poetics and Politics of Ethnography*. Berkeley, Calif.: University of California Press; 1986.
8. Taylor, C. *Milk, Honey, and Money: Changing Concepts in Rwandan Healing*. Washington, D.C.: Smithsonian Institution Press; 1992.
9. American Medical Association. [Retrieved on May 12, 2005] *Cultural Competence Compendium*. 2002. Available from: <http://www.ama-assn.org/ama/upload/mm/40/04a.pdf>.
10. Minkler, M.; Wallerstein, N. Introduction to community-based participatory research. In: Minkler, M.; Wallerstein, N., editors. *Community-Based Participatory Research for Health*. San Francisco: Jossey-Bass; 2003. p. 3-26.
11. Campbell, C. "Letting them die": Why HIV/AIDS prevention programmes fail. In: de Waal, A.; Ellis, S., editors. *African Issues*. Bloomington, IN: Indiana University Press; 2003. Campbell C, MacPhail C. Peer education, gender and the development of critical consciousness: Participatory HIV prevention by South African youth. *Social Science & Medicine*. 2002; 55:331–345. [PubMed: 12144146] Minkler M. Ethical challenges for the "outside" researcher in community-based participatory research. *Health Education & Behavior*. 2004; 31(6):684–697. [PubMed: 15539542] Motteux N, Binns T, Nel E, Rowntree K. Empowerment for development: Taking participatory appraisal further in rural South Africa. *Development in Practice*. 1999; 9(3):261–273. Williams B, MacPhail C, Campbell C, Moema S, Mzaiduma Y, Rasego B. The Carletonville-Mothusimpilo Project: Limiting transmission of HIV through community-based interventions. *South African Journal of Science*. 2000; 96:351–359.
12. Pestronk, RM. Community-based practice in public health. In: Bruce, TA.; McKane, SU., editors. *Community-Based Public Health: A Partnership Model*. Washington, D.C.: American Public Health Association; 2000. p. 71-81.
13. See note 10, Minkler, Wallerstein 2003.
14. [Retrieved on January 10, 2005] *Statistics for City of Cape Town–Ward 20*. 2001. Available from: www.statssa.gov.za.
15. See note 14, *Statistics for City of Cape Town* 2001.
16. See note 1, Mosavel et al. 2005.
17. See note 1, Mosavel et al. 2005.
18. Rankow E. Applying principles of cultural competency to research on lesbian health. *Journal of the Gay and Lesbian Medical Association*. 1998; 2(3):135–138. at 135.

19. Hyun I. Clinical cultural competence and the threat of ethical relativism. *Cambridge Quarterly of Healthcare Ethics*. :154–163. this issue.
20. Appadurai, A. *Modernity at Large: Cultural Dimensions of Globalization*. Minneapolis: University of Minnesota Press; 1996.
21. Spiegel, A.; Boonzaier, E. Promoting tradition: images of the South African past. In: Boonzaier, E.; Sharp, J., editors. *South African Keywords: The Uses and Abuses of Political Concepts*. Cape Town and Johannesburg: David Philip; 1989.
22. Prokop, M. [Retrieved on April 26, 2005] Africans in advertisements: an analysis. (undated). Available from: <http://it.stlawu.edu/~spapson/archive/x0mprok/index.html>.
23. Benatar S, Daar A, Singer P. Global health ethics: The rationale for mutual caring. *International Affairs*. 2003; 79(1):107–138.
24. See note 10, Minkler, Wallerstein 2003; Israel BA, Schulz AJ, Parker EA, Becker AB. Community-Campus Partnerships for Health. Community-based participatory research: Policy recommendations for promoting a partnership approach in health research. *Education for Health*. 2001; 14(2):182–197. [PubMed: 14742017]
25. Mason, K. [Retrieved on April 26, 2005] Commodification and the Masaai in Kenya. 2002. Available from: <http://www.trentu.ca/anthropology/anth409h/commodification.html>.