

Exploring Myths Associated with HIV/AIDS with Examples from A Few Countries of the World

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ABSTRACT There are various myths and misconceptions surrounding HIV/AIDS within South African communities that lead to the stigmatization and discrimination of people living with HIV/AIDS. The aim of this paper is to explore and spell out the underpinnings on underpinnings on myths surrounding HIV/AIDS in South Africa. This paper has used a review of literature methodology. Findings indicate that South Africa embraces immense mythical beliefs about HIV/AIDS. Also myths flourish due to: misinformation, misinterpretation, misperceptions of information associated with HIV/AIDS; are reinforced by cultures and patriarchy; and are also associated with the traditional healers. As a way of dispelling the myths, the paper recommends clients to look or seek scientific evidence in the therapies at their disposal, adapt the use of condoms, demystify the use of the ARV treatment modalities; and enhance community education; and government to regulate the work of traditional healers.

INTRODUCTION

AIDS is often characterised as a disease of intolerance and ignorance, compounded by social and economic issues such as gender inequity, poverty, and a lack of political will, among others (Krenn and Limaye 2004). This is because people associate HIV/AIDS with terrifying myths which lead to stigma and discrimination towards people living with HIV. These myths are a barrier to testing and prevention of HIV/AIDS. Myths present misleading and destructive information. It is therefore critical that they are dispelled amongst the communities. Myths have been documented to negatively stifle the response to HIV/AIDS responses in different continents, regions and countries. For example in America, especially in the nascent stages of HIV/AIDS discovery, the African Americans mythically conceptualized it as a white, gay disease (Neff 2006). This made the African American political leaders to be hesitant to embrace HIV/AIDS as an African- American disease for fear of accepting homosexuality. This means that community leaders feared accepting the HIV/AIDS epidemic within their communities, which made HIV/AIDS prevalence to rise fast. It is such perspectives that have put the campaign against HIV/AIDS in jeopardy in many countries of the world. This is because myths determine the di-

rection at which prevention and response follows, or is pursued.

In African countries, myths have also been huge stumbling blocks in the fight against HIV/AIDS. A myth which has lingered for far too long in the Southern African countries is the belief that people living with HIV/AIDS can rid of the disease if they sleep with virgins (Jackson 2002). This myth has been propagated by some traditional healers. This has left the young girls vulnerable and has also increased incest, rape and other forms of sexual abuse to girls (Jackson 2002; Kang'ethe 2009a). This has put the rights of young women in jeopardy and thereby undermining their constitutional rights against being abused. This has also undermined the countries efforts towards fulfilling Millennium Development Goal number three that envisages increasing women empowerment and equality with men (UNDP 2004, 2008). Another dimension of myths surrounds albinism of women and the girls. This in southern African countries has made them easy targets of rape and defilement following people's belief in the myth that sleeping with an albino woman or a virgin girl can also cure HIV/AIDS (Thuku 2011). The same myths and cases of women and girls with albinism being targets of rape by men living with HIV/AIDS have also been reported in Zimbabwe, Swaziland, and South Africa. This has de-

veloped the state of sexual violence and thereby undermining women and girls rights. This has left the victims contracting HIV infection which complicate their health and psychological condition.

Myths and stigma have been documented as the possible cause of increased HIV/AIDS prevalence in Botswana where the epidemic of HIV/AIDS is often accompanied by stigma and discrimination that create the circumstances for spreading (Letamo 2003). In his research study on stigma, the results showed that people were unwilling to care for their family members with HIV/AIDS. This left them with no option other than being taken care of by the government project called Community Home-based Care projects whose aim is to relieve public hospitals of HIV/AIDS patients. He also indicated that young people and those who believed that they can get HIV infection by sharing a meal with an HIV/AIDS person had discriminatory attitudes towards people living with HIV/AIDS.

Problem Statement

Misinformation, misinterpretation, misperceptions and myths associated with HIV/AIDS continue to spell a blow to the success of the battle against HIV/AIDS in many countries of the world, South Africa notwithstanding. These phenomena have derailed people from the paths of truth and thereby compromising their response to prevention, care and support. With the country of South Africa being the refuge for the highest number of people living with HIV/AIDS, researches, debates and discourses to dispel myths, misconceptions and misinterpretations associated with HIV/AIDS messages are topical and crucial. This is to ensure that people adequately respond to HIV/AIDS and adopt prevention methodologies that free them from infection, or re-infection, or if infected enjoy positive living.

METHODOLOGY

This paper uses a review of literature methodology. It has used current journals, books, United Nations publications etc. The literature so collected forms debates and discourses that aim to correct myths, misconceptions and untruths associated with HIV/AIDS. This is to ensure that correct information is given to people

so that they can increase their capacity to respond to HIV/AIDS.

THE DYNAMICS ASSOCIATED WITH MYTHS AND PREVALENCE OF HIV/AIDS

HIV/AIDS Landscape and Effect of Myths Surrounding the Disease

South Africa is in the midst of a catastrophic AIDS epidemic (Ramphela 2008). The country is not at ease with between 11% and 20% of South African adults who are HIV positive, 42 000 children who are orphaned by AIDS and 1500 new infections each day (Kalichman and Simbayi 2003). Kalichman and Simbayi indicate that the South African government has established more than 450 Voluntary Counselling and Testing centres (VCT) with more than 800 counsellors around the country. The VCT can reduce high risk sexual behaviours and direct HIV infected people to antiretroviral (ART) therapy. Unfortunately, only a small number of people visit these VCT and therefore a huge number of its people do not know their HIV statuses. Although according to Kang'ethe (2013a), the campaign on information dissemination appears to be weak especially in the rural areas where the role of NGOs is critically lacking, it is believed that the state of stigma and discrimination associated with HIV/AIDS deter people from gathering courage to know their status. Observed as well as documented information also suggest that people are preoccupied with myths especially from the traditional practitioners peddling lies about HIV/AIDS aetiology, transmission; and how it can be subdued (Kang'ethe 2009a). This has put South African's campaign process in jeopardy (Treatment Action Campaign 2007; Barnett and Whiteside 2006).

History of Myths in A Few Countries

Myths are stories that in absence of a scientific explanation try to explain some of the mysteries of life. These stories can be a recipe of half truths, mistruths, misinformation, or stereotypes about a phenomenon (Kang'ethe and Rhakudu 2010). In many countries, incorrect beliefs about casual contact continues to harbour apprehensions pertaining to HIV/AIDS transmissions (Jackson 2002; Kang'ethe 2009a). For example many Americans continue to believe that they

can get AIDS by donating blood. This is because some people are not aware that the blood is screened before someone donates it (Herek, Capitanio and Widaman 2002). The authors above also further argue that some people in United States avoid shopping with people living with HIV/AIDS, and avoid their children being in contact with HIV positive children at school. These perceptions indicate that PLWHA are subjected to greater stigma. Secondly, there is a false belief surrounding HIV/AIDS called the virgin cleansing myth in South Africa. The virgin cleansing myth was first reported in the 16th century and gained prominence in the 19th century in Victorian England as a cure for syphilis and gonorrhoea (Earl-Taylor 2002). Earl-Taylor suggests that the virgin cure myths explain the staggering rise in child or infant rapes in South Africa. In Zimbabwe, the virgin cleansing myth is perpetuated by traditional healers who advise the HIV positive men to cure the disease by having sex with virgin young girls. It is argued that the rape of young children or girls is associated with the virgin cleansing myth in Zimbabwe (Jackson 2002). Therefore, the high rate of infants and young girls' rape in South African countries could be associated with this mythical perspective and practise (Bowley and Pitcher 2002). This requires effective strategies to demystify these myths because the future of young children is now fading.

Sexuality Myths Reinforced by Cultures

Observably, the dynamics of sexual transmission in many settings suggests that information on sexuality is surrounded and driven by truths, mistruths and misinformation reinforced by cultures (Jackson 2002). These practices are either stereotypes or mythical. For example, boys who do not engage in sex are usually laughed at by their peers, are condescended, and sometimes abused or bullied around. One of these researchers bears evidence because when he was twenty, the grandmother was chasing him out of the house to go look for girlfriends just like his peers. The grandmother was driven by the mythical belief that a man should not be innocent, naive, and should culturally engage with women as a test that he was indeed a man. This perspective driven by myths and stereotypes reinforced by cultures make many young people prone to HIV/AIDS. There is also the cultural and mythical belief that men should prove to women that they are strong. That has also driv-

en the practice of sexual violence and abuse. It is also poses human rights denial to women and therefore undermines the achievement of Millennium Development Goal number three of endeavouring to see women getting empowered and achieving equality with men (UNDP 2004, 2008). Significantly, the issue of myths and the cultural reinforcement of them runs counter the achievement of Millennium Development Goal number six that aims to fight HIV/AIDS and other diseases (Kang'ethe 2012a).

Patriarchy Forms A Platform of Sex Related Myths

Cultural myths on sex are also reinforced by patriarchy. In patriarchal context, it is generally men who initiate sex and decide whether or not to use a condom (Kang'ethe 2009b). This shows that many women in South Africa are coerced into sexual activity against their wishes (Vetten and Haffejee 2005). All these aspects of sexual violence escalate the risk of contracting and spreading HIV. Additionally, many cultures mythically perceive AIDS as a woman's disease. Women may be blamed by their partners, families or community for not raising their HIV positive sons and daughters properly (Kang'ethe 2013b,c).

Due to the mythical belief and cultural norms that men are not satiated by one man, many patriarchal norms of masculinity encourage men to have multiple and concurrent partners. This has been researched and documented to increase both men's and women's vulnerability to HIV/AIDS (Kang'ethe 2009b, 2013b, c; Harrison, Sullivan, Hoffman, Dolezal, and Morrell 2006). These norms also shape men's attitudes towards the use or misuse of contraceptives such as condoms. Also driven by the cultural belief and sometimes myths that marrying many women, or sexually relating with many women is a sign of cultural brevity and a sign of great manhood, and could contribute to wealth, many men have dissuaded themselves from using contraceptives generally such as condoms. This has greatly increased their vulnerability to HIV/AIDS (Barnett and Whiteside 2006).

The Mbeki Mythical Belief That HIV Does Not Cause AIDS

South Africa's strategy for combating AIDS has been shaped by a long-standing antipathy on the part of President Thabo Mbeki and his

Health Minister towards antiretroviral therapy (Nattrass 2005). In the early years of his Presidency (1999-2000), this was framed by Mbeki's questioning of the science of AIDS and his support for AIDS denialists who believe that HIV is harmless and that AIDS symptoms are caused by malnutrition and even by antiretroviral therapy themselves. Mbeki's faulty myths about HIV and AIDS relationship also led his Health Minister, the late Manto Tshabalala-Msimang to refuse the introduction of antiretrovirals for mother to child transmission prevention (MTCP) until she was forced to do by a Constitutional Court in 2001 (Treatment Action Campaign 2007; Ndinga-Muvumba and Pharoah 2008). The late Health Minister by that time promoted beetroot, garlic and lemon juice as immune boosters for PLWHA. She encouraged people to use them instead of antiretroviral drugs (Mbali 2004). Later on, the world proved Mbeki's claim to be a pseudoscience (Kang'ethe 2013a; Ndinga-Muvumba and Pharoah 2008)

Myths Associated With Traditional Healers in South Africa and Botswana

In South Africa, many people believe in the strength of traditional healers. There are several types of traditional healers such as *igqirha* (they speak to the ancestor and are diviners) or *ixhwele* (known as herbalists). For many years, people have obtained medical advice, remedies and cures from these healers (Hirst 2005). Some of these traditional healers have been documented peddling lies to people living with HIV/AIDS about how they can get cure. Some have told people living with HIV/AIDS to look for the virgins and sleep with them as a cure; or look for women and girls with albinism to sleep with them. These advices have led to rapes and other sexual related abuses to young girls and women. (Kang'ethe 2009a). The connection between HIV/AIDS causation and witchcraft has especially been evident in responses to HIV/AIDS in Africa. The phenomenon of witchcraft has been explained by anthropologists as an attempt to make sense to an unexplained illness (Knox 2008). Therefore, the blame to witchcraft serves a defence mechanism to those who do not want to accept their HIV positive statuses.

Myths indicating that traditional healers can cure HIV/AIDS have also affected the health of

people living with HIV/AIDS in Botswana. This could also explain the fact that the environment of the traditional healers is less stigmatized than the environment of the clinics and hospitals offering HIV/AIDS services. This state of stigma associated with biomedical facilities in Botswana was found to make caregivers and their clients seek services of the traditional healers (Kang'ethe 2010). People seek help from traditional healers because they know that nobody would see them unlike the use of health care facilities where they are seen by everyone. However, observation and scientific evidence indicates that the services interfere with the effectiveness of antiretroviral therapy because people tend to mix traditional herbs with ARV's. Other researches by Kang'ethe indicates that traditional healers in Tsabong District of Botswana have died in the hands of the healers, or resort to accessing the services of the biomedical practitioners when they are very weak (Kang'ethe 2012a).

STRATEGIES TO DISPEL MYTHS SURROUNDING HIV/AIDS IN A FEW COUNTRIES OF THE DEVELOPING PART OF THE WORLD

Clients to Look or Seek Scientific Evidence in the Therapies

Information need to be spread to all the service recipients to look for services that displays scientific evidence. This should make people avoid and possibly seek a second opinion on medication and services that may not show any substantial change in a client's health. This would discount many traditional practitioners whose trade is to cheat clients of their money by claiming that they can heal HIV/AIDS (Jackson 2002). According to an analysis by UNAIDS (2008) and the World Health Organisation (2006), expanded access to proven prevention strategies could avert half of the 62 million new HIV infections projected to occur between 2005 and 2015. Governments, therefore, need to caution people against unwarranted and unscientific modes of treatment to tackle HIV/AIDS. The government should also reinforce the licensing of the healers to ensure that they are held responsible and accountable to their treatment modalities (Kang'ethe 2012a)

Condom Use

Any mythical belief against the use of condoms needs to be fought fiercely with the education referring to countries which have used the condoms massively and managed to lower their HIV/AIDS prevalence rates. Condom, if used correctly and consistently has been proven in observational studies to be very effective in blocking the transmission during sexual intercourse (Padian, Buve, Balkus, Serwadda and Cates 2011). According to Speybroeck (2012), condoms are the most widely available prevention tools. Unfortunately, they are currently not used to their full potential as a low cost prevention technology. People should be advised and cautioned against the mythical information in Botswana that condoms cause diarrhoea. Perhaps the education about the success of condom use should quote countries such as Thailand and Uganda where condom use have achieved notable success in HIV prevention (Kang'ethe 2013a). In his study, he further commends the massive use of condoms in countries such as Cambodia in its endeavour to fight against HIV/AIDS. Through this medium, these researchers advise South Africans to follow the above model countries of consistently and correctly using condoms as HIV/AIDS prevention tools.

Adopting Male Circumcision

Myths against male circumcision have been peddled in many countries such as Zimbabwe, with some people worrying that the foreskins could be used for witchcraft purposes to hurt the initiate. It is to this end that the government of Zimbabwe has engaged people in massive community mobilization to misconstrue the myth (Kang'ethe and Gutsa 2013). In December 2006, scientist announced the results of two randomised controlled trials of male circumcision for HIV prevention (UNAIDS 2008; WHO 2006). These studies which were conducted in Kenya and Uganda confirmed the findings of an earlier trial in South Africa that getting circumcised reduces a man's chances of becoming infected with HIV by about 60 percent. An expert panel, convened by the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS in March 2007, concluded that the efficacy of male circumcision in reducing female to male HIV transmission has been proven beyond reasonable doubts. Therefore, these re-

searchers believe that governments of especially countries with higher HIV/AIDS prevalence rates and low male circumcision rates should take the male circumcision education and campaign to its people; and persuade them to undergo male circumcision (Kang'ethe and Gutsa 2013).

Demystifying the Use Of ARVs Treatment Modalities

The use of ARVs is increasingly being accepted as one of the best treatment therapy for people living with HIV/AIDS in the world (Padian et al. 2011). It is to this end that countries especially the seriously ravaged are heavily investing in the provision of the ARVs to their HIV positive people. Although there has been myths and stigma associated with the use, the myths are also in very low scale today. Perhaps the stigma and the myths surrounding their use emanated from their side effects such as making the user's tummy to bulge out, making women to look beautiful etc. However, the ARVs are registering a huge success in that many people who were bedridden have been able to wake up and do their tasks and chores with ease (Kang'ethe 2012b).

Community Education

In countries such as Zimbabwe, programmes for the prevention of HIV/AIDS have been implemented to address the multidimensional impacts of HIV/AIDS. These interventions have been spearheaded by various stakeholders including public and private sectors, non-governmental organisations, and formal and informal institutions (Chevo and Bhatasara 2012). In South Africa, there is a mythical common belief that sexual education should be the domain of the private sector and should not be a part of public education. This, in these researchers' perspective is wrong. The fight against HIV/AIDS should attract as many stakeholders as possible, both formal and informal stakeholders. The role of traditional healers and their possible collaboration with the modern biomedical practitioners should be welcome.

Borrowing a Leaf from Model Countries

Countries hardest hit by the epidemic needs to borrow a leaf from countries whose HIV/AIDS campaign has been successful. This put the case

of Uganda and Thailand to the focus. Uganda is one of the first countries in Sub-Saharan Africa to experience the HIV epidemic and to take action to control the epidemic (Kang'ethe 2013a). This is the result of high level political commitment to HIV prevention and care, involving a wide range of partners and all sectors of the society (Buryama, Bunnell, Ransam, Ekwaru, Kalule, Tamuhairwe, and Mermin 2004). The above researchers also argue that Uganda was the first country in the Sub-Saharan Africa to introduce the VCT services in 1990. VCT service has been the cornerstone in HIV prevention and care activities in Uganda.

Thailand has also shown that a well-funded, politically supported and shrewdly-implemented response can change the course of the HIV/AIDS epidemic. This means that Thailand has managed to adequately address the Millennium Development Goal number 6, that envisages to halt and begin to reverse the spread of HIV/AIDS by 2015 (Kang'ethe 2012b). Thailand's success in responding to the HIV/AIDS epidemic would not have been possible without the emergence of firm and focused political commitment, the active roles adopted by top political leaders, the high public spending, the active non-governmental organizations (NGO's) and communities.

Government Regulating the Work of Traditional Practitioners

Perhaps why there has been a treatment lapse between the biomedical practitioners and the traditional practitioners is that the latter in many countries are neither regulated nor licensed for their services (Kang'ethe 2012a). In August 2004, South Africa legalized the practice of traditional healers, largely in response to the HIV/AIDS pandemic (Flint 2008). However, the Basic Conditions of Employment Act (BCEA) does not consider sick notes issued by healers to be valid. This creates a dilemma for employees, whose right to consult a practitioner of their choice is protected by the constitution (Mbatha, Street, Ngcobo, Gqaleni 2012). Therefore, the government should allow the traditional health practitioner's registration and enforce employers to honour sick notes issued by traditional healers. This is because South Africa is a diverse country; people have the right to make their own choices and their belief systems needs to be respected.

CONCLUSION

Incontrovertibly, myths and misinformation surrounding HIV/AIDS contribute to the high prevalence of new HIV infections in several countries of the developing part of the world. Therefore, HIV/AIDS awareness campaigns should play a significant role to dispel myths and misinformation surrounding HIV/AIDS. The community leaders should show their concern and participate in these campaigns. HIV/AIDS should be addressed in various possible public forums. This is to ensure that people are not cheated by any practitioner as to how to treat HIV/AIDS.

REFERENCES

- Barnett T, Whiteside A 2006. *AIDS in the 21st Century. Disease and Globalization*. Palgrave. Macmillan.
- Bowley DM, Pitcher GJ 2002. Motivation behind infant rape in South Africa. *Lancet*, 23: 359(9307): 711.
- Buryama F, Brunnell R E, Ransam RL, Ekwaru JP, Kalule J, Tumuhairwe EB, Mermin JH 2004. HIV voluntary Counselling and testing data for monitoring the Uganda epidemic, 1992-2000. *Journal of Acquired Immune Deficiency Syndromes*, 37(1): 1180-1186.
- Chevo T, Bhatasara S 2012. *HIV/AIDS Programmes in Zimbabwe: Implications for the Health System*. University of Zimbabwe: Harare. Vol. 2012 (2012). Article ID 609128 11 pages
- Earl-Taylor M 2002. HIV/AIDS, the Stats, the Virgin Cure and Infant Rape. *Science in Africa: Africa's First Online Magazine*. April 2002 (Retrieved on 13 December 2011).
- Flint KE 2008. *Healing Traditions: African Medicine, Cultural Exchange and Competition in South Africa, 1820-1948*. Ohio: Ohio University Press.
- Harrison A., O'Sullivan LF, Hoffman S, Dolezal C, Morrell R. 2006. Gender role and relationship norms among young adults in South Africa: Measuring the context of masculinity and HIV risk. *Journal of Urban Health*, 83(4): 709-722.
- Herek GM, Capitanio J, Widaman KF 2002. HIV related stigma and knowlegde in the United States : Prevalence and trends, 1991-1999. *American Journal of Public Health*, 92(3): 371-377.
- Hirst M 2005. Dreams and Medicines: The Perspective of Xhosa Diviners and Novices in the Eastern Cape, in South Africa. *Indo-pacific Journal of Phenomenology*, 5(2): 1-22.
- Kalichman SC, Simbayi LC 2003. HIV testing attitude, AIDS stigma, and voluntary HIV counselling and testing in a Black Township in Cape Town. *South Africa. Sex Transm Infect*, 79: 442-447.
- Jackson H 2002. *AIDS AFRICA. Continent in Crises. Safaids*. Harare, Zimbabwe: Avondale.
- Knox P 2008. *AIDS, Ancestors and Salvation: Local Beliefs in Christian Ministry to the Sick*. Kenya, Nairobi: Paulines Publications.

- Kang'ethe SM 2009a. Traditional healers as caregivers to HIV/AIDS patients. *Sahara Journal*, 6(2): 83-91.
- Kang'ethe S M 2009b "Inadequate Male involvement in Health Issues: The cause of gender skewed HIV and AIDs situations in Botswana". In: T Maundeni, BZ Osei-Hwedie, E Mukaamambo, PG Ntseane (Eds.): *Male Involvement in Sexual and Reproductive Health. Prevention of Violence and HIV/AIDS in Botswana*. Cape Town: Made Plain Communications.
- Kang'ethe SM 2010. The perdify of Stigma Experienced by the Palliative CHBC of Kanye in Botswana. *Indian Jan Pallit Care*, 16(1): 30-35.
- Kang'ethe SM 2012a. Attitudes of PLWA and other selected communities in Tsabong towards operationalizing bio medical and traditional therapies in tandem to face the AIDs epidemic. *Social Work/Maatskaplike*, 46(1): 55-69
- Kang'ethe SM 2012b. HIV/AIDS in Botswana: Taking stock of the performance of MDG 6. *Fort Hare Papers*, 19(2): 150-164
- Kang'ethe SM 2013a. An examination of HIV campaign in South Africa towards eliminating stigmatization. *Journal of Human Ecology*, In Press.
- Kang'ethe SM 2013b. Exploring feminization of HIV/AIDS and Millennium Development Goals (MDGs) with examples from Botswana and South Africa. *Journal of Human Ecology*, In Press.
- Kang'ethe SM 2013c. The panacea and perfidy of culture as a platform of behavior change with examples from Botswana and South Africa. *Journal of Social Sciences*, In Press.
- Kang'ethe SM, Rhakudu M 2010. *Religious Education Book for Form 2*. Gaborone: Heinemann Publishers.
- Kang'ethe SM, Gutsa Takudzwa 2013. Exploring the Stumbling blocks on the way to a successful Male Circumcision Campaign in Zimbabwe. *Journal of Human Ecology*. In Press.
- Krenn S, Limaye R 2004. *The Role of Social and Behavior Change. Communication in Combating HIV/AIDS*. In Marlink, RG, Teitelman, ST (Eds). *Br Med J*, 328: 848-849
- Letamo G 2003. Prevalence of, and factors associated with, HIV/AIDS-related stigma and discriminatory attitudes in Botswana. *J Health Popul Nutr*, 21(4): 347-357.
- Mbali M 2004. AIDS Discourses and South African State : Government Denialism and Post apartheid AIDS policy-making transformation: *Critical Perspectives on Southern Africa*, 54(1): 104-122.
- Mbatha N, Street RA, Ngcoobo M, Gqaleni N 2012. Sick certificates issued by South African traditional health practitioners: current legislation, challenges and the way forward. *S Afr Med J*, 102(3 Pt 1): 129-131.
- Ndinga-Muvumba A and Pharoah R 2008. *HIV/AIDS and Society in South Africa*. Durban. University of Kwazulu Natal Press
- Nattrass N 2005. *AIDS Policy in Post-Apartheid South Africa*. Draft July 2005
- Neff K 2006. The HIV/AIDS pandemic in African American MSM : Targets for intervention. *Journal of Health Disparities Research and Practice*, 1(1): 109-126.
- Padian NS, Buve A, Balkus J, Serwadda D, Cates W 2011. *Biomedical Interventions to Prevent HIV Infection: Evidence, Challenges, and Way Forward*. Chicago: Chicago University Press.
- Ramphele M 2008. *Laying Ghosts to Rest. Dilemmas of the Transformation in South Africa*. Cape Town: Tafelberg Report. Participatory Education, Evaluation and Research.
- Speybroeck N 2012. Predictors of condom use and refusal among the population of Free State Province, South Africa. *BCM Public Health*, 12: 381.
- Thuku M 2011. *Myths, Discrimination, and the Call for Special Rights for Persons With Albinism in Sub-Saharan Africa*. Amnesty International (Dutch Section), Special Programme on Africa (SPA)
- TAC (Treatment Action Campaign) 2007. Government Leadership on HIV/AIDS Irrevocably Defeats Denialism! Implement a New Credible Plan with Clear Targets! From <<http://www.tac.org.za/AIDSDenialismIsDead.html>> (Retrieved on 22nd February 2007).
- UNAIDS 2008. *Report on the Global AIDS Epidemic, 2008*. CITY/COUNTRY: Global HIV Prevention Working Group.
- UNDP 2004. *Botswana Millennium Development Goals. Achievements, Future Challenges and Choices*. United Nations: Republic of Botswana.
- UNDP 2008. *Situation Analysis on Gender Based Violence in Botswana*. Draft Report. Gaborone: Participatory Education, Evaluation and Research.
- Vetten L, Haffejee S 2005. *An Analysis of Gang Rapes Reported At the Inner City Johannesburg Police Stations*. Johannesburg: Centre for the Study of Violence and Reconciliation.
- WHO 2006. *Preventing HIV/AIDS in Young People: A Systematic Review of the Evidence from Developing Countries*. Geneva: WHO Technical Report Series. No 938, 2006.