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An Examination of HIV and AIDS Campaign in South Africa towards Eliminating Stigmatisation

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ABSTRACT The fight against the HIV and AIDS pandemic in South Africa has proved difficult because of the state of stigmatisation that the pandemic has ushered in. The objective of this paper is to discuss the undesirable effects of stigmatisation and possible measures to address the phenomenon in South Africa. The paper has used extensive review of literature to generate debates and discourses on stigmatisation. Findings indicate that stigmatisation is still pervasive and prevalent due to: communities being subjected to different and conflicting truths on HIV and AIDS from both traditional and the bio-medical practitioners; poor policy and campaign conceptualization at nascent stages of the campaign making the disease looks mysterious and fearful; and inadequate community education on stigma and stigmatisation. The paper recommends: increased political goodwill; massive community mobilization and sensitization campaigns especially on stigma and stigmatisation; benchmarking the campaign strategies with other model countries that have tackled stigma; and taking advantage of South Africa's idol personalities in the campaign who have overcome stigmatisation

INTRODUCTION

From a lay man's understanding as well as from this researcher's thinking, stigma is the act of disapproval of or discontent with a person/s on the grounds of characteristics that distinguish them from other members. It poses psychological and social challenge deterring one's freedom to freely mix with people. This, therefore, compromises one's dignity, self-worth, confidence and integrity (UNAIDS 2002; Uys and Cameron 2003). Retrospectively, the process of stigmatisation or the act of subjecting stigma to groups of people is as old as history (Goffman, cited by Oyserman and Swim 2001). Goffman (cited by Oyserman and Swim 2001) outlines three types of stigma. Stigma derived from physical deformities, or displaying some infirmity or a disease; stigma associated with perceived "blemishes of individual character" including phenomenon such as mental disorder; homosexuality, and radical political behavior; and stigma associated with race, nation, and religion.

However, some diseases have always formed an opportunity for stigmatisation (Parker and Aggleton 2003) especially if a disease is dreadful, fatal, and associated with situations that are not easily comprehendible by the society. In the history of mankind, diseases such as tuberculosis and cancer have had their histories of stigmatisation (Parker and Aggleton 2003). In the 1920s, 30s, and 40s, for instance, cancer was a widely feared disorder. It was then perceived as a death sentence and a disease which few sufferers or families would speak about publicly or privately (Goffman, cited by Oyserman and Swim 2001). This stigmatisation emanated partly from the fact that these diseases' aetiology, epidemiology and social circumstances were not adequately comprehended. Although the situation has changed today as education on the diseases expanded, tuberculosis, because of its relationship and linkage with HIV and AIDS still remains a stigmatized disease (Macq et al. 2005).

People have also been stigmatized on the basis of their sexual orientation (Barret-Grant et al. 2001). For example, for a long time, homosexuals in most parts of the world have been ostracized as communities perceive their inclination as devoid of normal human characteristics. Only a few countries especially of the developed world tolerate homosexualism, although the degree of their acceptance is growing as countries embrace the tenets of global human rights and a realization that human rights are inalienable to all the citizens of a country (Barret-Grant et al. 2001). Stigmatisation especially, due to homosexualism has been exacerbated by its perceived vulnerability to HIV and AIDS (Barret-Grant et al. 2001). Since stigmatisation vary from country

to country, it is good to look at its theoretical underpinnings in different contexts. An examination of the South African context is likely to unearth possible and plausible underpinnings with the hope of coming up with possible recommendations to address stigmatisation.

HIV and AIDS remains one of the greatest killers of humankind in the 21st century, with Africa South of Sahara carrying about 80 percent of the global cases of people living with HIV and AIDS (Kang'ethe 2010a). Current global statistics indicate that South Africa has the highest number of people living with HIV/AIDS (UNAIDS 2008). Sources from UNAIDS (2008) indicate that by 2007, South Africa had 5.7 million individuals living with the virus. This has had the effect of increased death toll as well as lowering life expectancy for the South Africans (Steinberg 2008; Ramphele 2008). This calls for strong goodwill and concerted efforts from different stakeholders, starting with the government, non-government organizations, private sector, religious organizations, and the ordinary individuals to address the epidemic (South African National AIDS Council 2007). Reducing or eradicating stigma, then, remains one of the pivotal steps towards achieving a strengthened campaign front (Treatment Action Campaign (TAC) 2007; Ramphele 2008; UNAIDS/WHO 2005). It is this author's contention that the South African government should borrow practices from countries such as Botswana that have significantly reduced the state of stigma. This is because stigma in South Africa continues to derail the HIV and AIDS aspects of prevention, care and support (TAC 2007; Bannet-Grant et al. 2001). Further, successful mitigation of the state of stigma calls for a fair exploration of possible and plausible gaps in the HIV and AIDS campaign in South Africa. An examination of such gaps forms an important educational discourse that can inform HIV/AIDS policy operationalization towards confronting stigma and stigmatisation head-on.

The disastrous effects of stigma are the fact that many people fear being tested for the disease because of the fear of the consequences. This has a clinical dimension in that some people even face the challenge of dying without seeking treatment and medication for fear of knowing their status. This could greatly explain why a greater population in South Africa has not dared to know its sero-posotivity (Barret-Grant et al. 2001). The state of stigma has ushered in a spate of unexplained fear. For those who are prescribed to be positive, some have avoided medication due to denial, while some have taken the route of seeking other medical routes such as consulting traditional healers, who may be poorly equipped in diagnosing diseases such as AIDS (Kang'ethe 2009, 2012). Some people who have owned to be seropositive have faced ostracism from their relatives as well as community members. Some have not been cared for by both their relatives and the community members (Parker and Aggleton 2003; Mbuya 2000; Kang'ethe 2009, 2012). Cases of a few individuals committing suicide have not been uncommon especially in the nascent stages of the disease history in South Africa (Barret-Grant et al. 2001). However, it should be appreciated that the situation is changing as the campaign takes momentum. It is therefore pertinent that the gaps in the campaign that derails total annihilation of stigma and therefore stigmatisation be brought to the fore for possible attention.

The following subtopics, from this researcher's view and backed by diverse literature discuss gaps driving stigmatisation in South Africa.

Problem Statement

Many countries including South Africa recognize stigma as one of the stumbling blocks militating against success in the battle against HIV/AIDS. Since stigma is a social challenge and a social construct, different countries have different social terrain, which makes it crucial for researchers to look at the social underpinnings responsible for increased stigma. Despite South Africa's concerted efforts to address the HIV and AIDS epidemic, the battle is proving to be difficult. This is because of the experience of ostracisation, incarceration, and inhumane treatment that some people living with HIV and AIDS have faced in the near past (Barret-Grant et al. 2001). The paper diagnoses social underpinnings to lay bare the possible factors behind stigma, and suggest possible ways of addressing it. Since HIV and AIDS continues to paint a gloomy picture to South Africa's shining economy, and its exemplary democracy, it is imperative for this image to be corrected through discussions and counter discourses against stigma.

Study Rationale

The paper attempts to examine different social terrain surrounding the state of stigmatisation in South Africa through interrogating and reviewing diverse literature to create debates, discourses and thinking that validate stigmatisation and proposing ways and strategies to address the phenomenon.

METHODOLOGY

This paper is based on an extensive review of literature on aspects of stigmatisation of HIV and AIDS. It has consulted journals, different books and publication especially from United Nations; and experiences of this researcher as a HIV and AIDS practitioner. Although literature is becoming increasingly generated in the domain of HIV/AIDS, decimating stigma still remains an arduous task. It is therefore still crucial to synthesize, package and repackage information on stigma and stigmatisation in South Africa in an endeavour to expose its underpinnings. Review of relevant and diverse literature is hoped to bring to the fore some interventions that may have been used elsewhere, although social contexts and political terrains may be different. Such synthesized and tailor made literature could become an important intervention with educational value. Although the review of literature may not be given equal weight as compared to empirically researched data, it could offer a benchmark against which the desired change to address it could be based on; or offer tips as to how interventions to address the challenge could be operationalized.

OBSERVATIONS AND DISCUSSION

HIV/AIDS Campaign Gaps Driving Stigmatisation in South Africa

The discussion of the possible gaps responsible for stigma and stigmatisation in South Africa may not be exhaustive. Their presentation is an attempt to assess their validity to stigmatisation with the hope that their content will be unearthed and laid bare to heighten opportunities to be worked on by the government, policy makers, NGOs and other HIV and AIDS friendly groups.

Contrasting Information between Bio medics and Traditional Therapists

Stigma is a by-product of social-cultural factors such as beliefs prevalent in any society (UNAIDS 2002). Although South Africa has boldly faced the reality and importance of traditional healing practitioners and considered them as important stakeholders in the health services of the country, a strong and plausible collaborative working spirit is yet to succeed (Kang'ethe 2009; Mbuya 2000). This is because societies especially those living with HIV and AIDS continue to be subjected to two realities, one from the bio medics indicating that HIV/AIDS has no cure, and the second one from the traditional healers informing communities that they can subdue HIV and AIDS. This has had the effect of throwing communities in confusion and in a state of dilemma. This means that one chooses to stick to one reality at the expense of the truth and benefit of the second truth. This state of conflicting truths has made the disease to be mysterious to many people and therefore, a dreadful one. This has seen people viewing those who are seropositive as very desperate individuals whose fate is already determined. This has attracted a state of stress and distress surrounding the disease. This is the state of stigma created by the scenario of the two truths. The interplay of the two truths will fully be achieved once the traditional healing practitioners and the bio-medics are able to share the same forum, accept one another, and work together as a team. The existence of the two healing procedures has had disastrous effects of hiding the truth about HIV and AIDS, its aetiology, as well as its epidemiology, largely obscuring and weakening prevention efforts (Kang'ethe 2009). Jackson (2002), documents a sad state of affairs in which some traditional healing practitioners in South Africa misconstrues the phenomenon of HIV and AIDS by advising those that are living with the virus to sleep with virgins as a way of ridding the disease from the body. This has complicated the search for reality and has locked the doors to fully comprehend the clinical aspects of the disease, its aetiology, epidemiology, as well as predisposing the general populace to HIV and AIDS ramifications. This has put efforts and attempts to reduce stigma into disarray; and hence the difficult position the county has been ushered

into to confront the dreadful epidemic (Ramphele 2008; South Africa National AIDS Council 2007). These two aspects of reality presented by both the bio medics and the traditional healers have made efforts to educate people about the disease and ways of containing it an ardous task; a difficult one to be understood; and one with diverse mysteries. This state of affairs has to some extent increased the disease's state of stigmatisation.

The HIV and AIDS Campaign Started on a Wrong Footing

In many social settings, stigma is a by-product of socio-cultural-political issues prevalent in any community. It is exacerbated by the fear of death and perception that HIV is automatically a death sentence (Barret-Grant et al. 2001; TAC 2007). Unfortunately, South Africa was politically treated to conflicting messages about the disease when it was very necessary to hear the correct message. The political establishment in the early 90's gave the message that HIV does not cause AIDS and that poverty was the possible challenge to the HIV/AIDS phenomenon (Barret-Grant et al. 2001), which led to a divided policy attention, on one front to have the stronger goal of fighting the poverty, which I believe has always been on the government priority agenda, and the other front of putting in place strong interventions to ward off the deadly HIV and AIDS epidemic (Cameron and Geffen 2005). Former President Mbeki and his former Minister of Health, Tshabalala Msimang cannot escape the blame that they had led the denial team. Mbeki's argument amid other denialists presented the argument that HIV exists but that it is a harmless passenger virus and is not the cause of AIDS (Cameron and Geffen 2005). However, there has been a global conclusive consensus by the scientific community that HIV indeed causes AIDS (TAC 2007). This succinctly rejects AIDS-denialist claims as pseudoscience based on conspiracy theories and faulty reasoning (Kalichman 2009). The impact of denialism in South Africa has had disastrous effects of exacerbating stigma and also sacrificing the health of very many South Africans who got the virus but there were no stronger interventions and political goodwill to have them helped (TAC 2007). Perhaps that is why there was a lot of blame and accusations against the then Minister of Health, Tshabalala Msimang upon her death in December 2009 (Mail and Guardian 2009). Tshabalala Msimang supported unscientific remedies for HIV/AIDS including beetroot, African potato and garlic, and was known to be hostile to antiretroviral drugs. This environment and conflicting messages from the governing authorities put most people into confusion about the reality of the disease, ushering in a fertile niche for stigma to remain at large in the country (Mail and Guardian 2009; Rampele 2008).

However, while effects of the history may continue to negatively influence the environment of the disease and stigmatisation, the government through South African AIDS Council (SANC) in collaboration with NGOs such as Treatment Action Campaign have launched a strong campaign muscle that could see the state of stigma declining significantly. This researcher commends the current government's increased goodwill to tackle HIV and AIDS issues. The role of Treatment Action Campaign especially on stigmatisation could in the near future put stigmatisation to a minimal. TAC has especially been advocating for the rights of people living with HIV and AIDS especially the homosexuals (TAC 2007). The group has been a target of stigmatisation from members of the communities. On the campaign against stigmatisation, NGOs and other bodies in the campaign have richly been supported by the South African government. TAC has also attracted immense foreign funding with the blessing of the government (Ndinga-Muvumba and Mottiar 2007).

The History of Violence against People Living with HIV and AIDS

In the history of HIV and AIDS, living with it has not been an easy thing to most of the communities of the world. The way some people living with HIV/AIDS are treated determines the pace at which stigma can be tackled (TAC 2007; UNAIDS 2002). Perhaps the ugly historical incidents that characterised the denial and the response of communities against those purported to have contracted the disease could be a phenomenon that continue to spill over to the thinking of the present day community members in South Africa. Though stigma has continued in many parts of the globe, it has not attracted public sentence of death as was the case in South Africa, when in 1998, a woman called Gugu Dlamini

was murdered by people in her community for publicly disclosing that she was living with HIV and AIDS (Barret-Grant et al. 2001). In another similar stigma related scenario, a man in Soweto in the year 2000 murdered his wife and father-in-law, and then committed suicide after his wife and himself were diagnosed to be sero-positive (Barrett-Grant et al. 2001). This is an agonizing and a dreadful historical perspective that may make the place of stigma in South African societies linger a little longer (Barrett-Grant et al. 2001). However, the scenario above must have sensitized the government and other stakeholders in the HIV and AIDS campaign in South Africa to work hard against stigma and stigmatisation. This saw the government increase its goodwill and support for the NGOs that undertake to campaign against stigma and stigmatisation. Also many NGOs such as Treatment Action Campaign have been intensifying their campaigns against stigma and stigmatisation. Infact, today the government has incorporated its chairperson to sit in the SANAC council. It is at this gesture that this researcher calls for the increased government effort to strengthen anti-stigma and anti-discriminatory laws (Kang'ethe 2010a).

Inadequate Education on Both ARVs and Social Grants

South Africa is now on the frontline in the provision of ARVs and the requisite physical and psychosocial support especially the nutritional support grant to facilitate adequate working of the ARVs (Department of Health 2003). This was achieved after strong lobbying and advocacy especially from members of the Treatment Action Campaign (TAC 2007; Department of Health 2003). Due to the country's goal of ensuring that all the people living with the virus are adequately taken care of, a massive ARV roll out was undertaken by the government, although through a court order in 2002 (Mail and Guardian 2009). This was also to try to benchmark the concern with the United Nations/World Health demand that countries access a certain allotted quota of its population with ARVS by the year 2005. This was a global campaign, dubbed the WHO "3x5" initiative, whose goal was for the world to achieve accessing to at least 3 million people living with HIV and AIDS (UNAIDS/WHO 2005). However, how good the intentions were, this blackmailed the countries to embark on ARV access without adequate time for the other significant requisite HIV and AIDS education to the beneficiaries. South Africa was no exception (UNAIDS/WHO 2005; UNAIDS 2008). Therefore, even if South Africa has been able to access ARVs to many of those who are in need, adequate education to overcome social challenges such as stigma have not had a good and sufficient opportunity to be bankrolled to the larger population. This to an extent validates the presence of stigma in South Africa. HIV and AIDS, being a stressful disease as well as one that is highly stigmatized calls for patience and increased adequate education (Kang'ethe 2010a). Subjective anecdotal information from some quarters in South Africa suggests that some people wishes to depress their immunity to be at CD_4 count levels that permit accessing the nutritional grants. If this could be validated, it would serve as a pointer to inadequate information pertaining to the disease. It also carries a serious moral dimension that needs urgent attention. It is also apparent that such people, even if they may be HIV-positive, may not be committed to the desired behavioural change that is necessary to beat down the epidemic to manageable proportions. It is this researcher's belief that when massive education campaign will be carried out, stigma is bound to come down significantly.

Possible Suggestions to Confront Stigmatisation

The discussion below, from the researcher's point of view suggests possible factors that could be employed to mitigate stigmatisation in South Africa. Though the measures may have been tried elsewhere, or may be in place in South Africa, the researcher considers them worthy being emphasized to possibly strengthen the policy guiding them or strengthen their implementation to confront stigmatisation process.

Increased Political Goodwill

No country can solve its HIV and AIDS challenge or successfully face any epidemic without adequate political goodwill (TAC 2007; Ramphele 2008). While it is evident that the current government has ample goodwill to arrest the growing epidemic and therefore revert the ever burgeoning cases of HIV/AIDS, this has not been a smooth sailing process. During the June 2001 United Nations General Assembly Special

Session (UNGASS) meeting in New York, South Africa was one of the important signatories promising to offer viable leadership in the campaign so that the country can approach the year 2015 with confidence that the Millennium Development Goal number six that aims to see the spread of HIV and AIDS halted will be achieved (UNAIDS 2001; UNAIDS 2008). However, South Africa did not start the campaign on the right footing, but started on a shaky ground (Barrett-Grant et al. 2001). The current government does not have to shy off to explain the faults that the erstwhile government did. Owning the mistake would have a positive effect of bolstering confidence from all the other stakeholders prompting the belief that the campaign would henceforth be smooth sailing. Critics of the Mbeki regime have strong grounds in that the emphasis on ARV was not upheld, with the former Minister of Health, Tshabalala Msimang, indicating that she did not have confidence with the ARVs. She instead recommended the use of unscientific treatment methodologies through the consumption of vegetables such as garlic, beetroots etc. (Mail and Guardian 2009). It is critical that all the players, either non-governmental organizations, private sectors, and the general populace would want to see a determined government go hands-on to expedite the campaign process (Kang'ethe 2006, 2010a, 2012)). Perhaps at this juncture, this researcher would wish that all the players in the campaign adopt the 1995 WHO call for "shared rights, shared responsibilities" where each party or the stakeholders from the individual to the government need to forge a formidable collaborative effort to face the epidemic head-on. Further, all the parties should be informed by the social work based systems and functionalist theories that espouse working in an interdisciplinary team to face a challenge head-on (Segal Gerdes and Steiner 2007). However, leadership and direction from the government is pivotal to give all the other players space and a palatable niche to bolster the response.

Massive Campaign Mobilization and Sensitization

Although the HIV and AIDS campaign fronts like those presented by Treatment Action Campaign are commendable (TAC 2007), their activities are concentrated in urban settings as opposed to the rural areas where the majority of the people reside. It is also in rural areas where more information on HIV/AIDS, its aetiology, epidemiology, and possible prevention strategies, as well as information pertaining to living positively with it, is most pertinent. Although not undermining the traditional healing stakeholders such as Sangomas, spiritualists, herbalists and others, it is evidently clear that these personalities may have a critical healing role to play in the rural areas than in the urban settings (UNAIDS 2000a; Kang'ethe 2009, 2012). Since some of these traditional practitioners have been found to mislead the public on the meaning of HIV and AIDS, and on ways to contain the disease, and therefore putting the lives of the communities in jeopardy, it is important that more players such as NGO's occupy an important niche in the rural areas' campaign to give people the right information. Unfortunabely there are still scanty NGOs in the rural areas to facilitate a formidable response to the epidemic (Kang'ethe 2010b).

Massive community education should go with publications of Information, Education and Communication (IEC) materials, possibly printed in all the major languages of South Africa so that no single person is left out in accessing information. Of pivotal and milestone importance in the HIV/AIDS campaign is making a breakthrough in the HIV and AIDS testing campaign. If possible, a door-to-door campaign, and home visits to explain the importance of testing and allay any fears associated with testing are critical. This would have far reaching effects in clarifying the mysteries and myths surrounding the disease, and therefore reduce stigma. The success of wooing and convincing the public to test is critical and serves as the entry point to a successful campaign. This is because, it is only after knowing one's status that the government machinery or any other campaign- friendly body can offer help and possibly individualized tailor-made education, counselling and any other necessary support system. If a larger population could know its status, then knowledge will snowball easily and stigma can be a thing of the past (TAC 2007; Rampele 2008).

Benchmarking the HIV and AIDS Campaign

Models are made to act as benchmarks from which other players can gauge their performance (Penelope et al. 2002). Because of the fact that

South Africa has the highest number of HIV/AIDS cases in the globe, it is good for its campaign architects to look into other countries which had very high prevalence and were able to bring them down. In 2005, the United Nations commended Kenya for lowering its prevalence rates from over 20 percent to about 5 percent (Kenya National AIDS Control Council 2009). This was a big leap and was associated with a major behaviour change despite the Kenyans' financial limitation to give its people free antiretroviral drugs by then (Kenya National AIDS Control Council 2009). Uganda has been a model of behavioural change that most developing countries facing the epidemic can emulate. The country in the early 90's had a prevalence rate of more than 30 percent, but by the turn of the century had a lower prevalence rate of around 6 percent (UNAIDS/WHO 2005). Since most countries wanted to benchmark their campaign with Uganda in the 90's, there was a lot of revelation of how the government had managed its campaign machinery. First of all, people were mobilized and sensitized to the adequate use of prevention tools, pivotally condoms. Strategies such as abstention especially among the adolescents were encouraged through the government offering incentives such as scholarships for girls who reached a certain age while still virgin; while secondary abstention was also encouraged among the adults. This researcher believes that the strategy of abstaining and maintaining virginity could be tried or resuscitated here in South Africa since traditionally, virginity testing has been a part and parcel of some societies in South Africa (http://www.plusnews. org 2011). Uganda campaign was concentrated in all the homesteads. The villages were divided into what was called *"Bamakumi systems"*. Under this system, ten household formed a unit to access all the prevention materials such as condoms, counselling and acquisition of information, education and Communication (IEC) materials. Even soldiers were told to take the same number of condoms equal to the number of bullets they were carrying. All the other bodies such as NGOs, especially the internationally known TASO (The AIDS Service Organization) were pivotal through home visits and counselling, and encouraging the caregivers of those living with HIV and AIDS (UNAIDS 2000b). The role of faith based organizations in this respect is critical (Byamugisha et al. 2002).

Emulation of Campaign Idols as Models of Positive Living

South Africans have already learnt the true working of the ARVs through personalities such as Edwin Cameron of South African Court of Appeal, who long went public with HIV status and has been instrumental in demonstrating to those living with HIV/AIDS that there is still life even when one is positive (Barrett-Grant et al. 2001; Cameron and Nathan 2005; TAC 2007). The phenomenon of accepting or opting to come out to tell the world that one is living with the virus is a very bold step and indicates a very high level of understanding and patriotism. It is a complete cycle of overcoming denial. For Edwin Cameron and his sphere of influence as one of the important members of legal fraternity in the South Africa court of appeal, his coming out is an important phenomenon with a stronger effect of nullifying the effects of stigma in South Africa (UNAIDS 2002). Perhaps the stature of personalities such as Cameron may be conspicuously missing in the rural areas where the epidemic could be gathering momentum at a higher pace. This is also exacerbated by the fact that many HIV and AIDS activists operate from the urban areas where they work with urban based organizations and community based organizations (CBOs). These organizations could be benefiting from such personalities in that it is believed that those living with the virus can be trusted more in disseminating information to those they are in the same situation. Unfortunately the HIV and AIDS campaign idols may also be lured to live and conduct their campaigns in urban areas and commit themselves little in the rural areas where people need information more than in the urban areas. This is because most urbanites have higher degree of literacy levels and can read and seek information with ease. Illiteracy, ignorance and a lack of information could be factors that may exacerbate infection rates, and could be a recipe of a strengthened stigma especially in rural areas (UNAIDS 2002).

In fact, some researchers have contended that HIV and AIDS is a poverty friendly disease (Mbirimtengerenji 2007; Kang'ethe 2004). It is therefore likely that HIV/AIDS thrives and flourishes well in rural areas than in urban areas. Con-

trastingly and ironically, rural areas could have their cultural checks as well as cultural social capital that could be virtues of either strengthening or weakening the campaign. However, this is debatable and may vary from contexts to contexts. In some rural areas of African countries, cultural hegemony, cohesiveness, norms that used to hold people together, determining do's and don'ts may be a thing of the past. The effects of westernization, modernization, civilization and globalization have immensely worn away the cultural bonds, discipline and norms that societies used to discourage the younger persons from sexual overtures (Mbuya 2000; Kang'ethe 2006).

Operationalizing the Traditional Healing Services and Modern Bio Medics in Tandem

Despite the South African Health Ministry opening doors to the traditional health practitioners for a mutual collaboration, because of the latter's niche in the society in that they are respected, trusted and culturally appropriate (Mbuya 2000; Kang'ethe 2012; UNAIDS 2000a), services of the traditional health practitioners are shrouded with mysteries, secrecy and sometimes bound with fallacious and misleading information packages that threaten the campaign success (UNAIDS 2000a; Kang'ethe 2009). Research in the region on the interplay between the traditional healing practitioners and the modern bio medics indicates that traditional health practitioners thrive in situations where the modern medical services are weak (UNAIDS 2000a; Kang'ethe 2012), or where people are not adequately accessed with ample social and clinical information to make an informed consent (Neuman 2007). Empirical evidence, especially in South Africa also reveals that healers peddle lies in order to market their services, especially by indicating that their services are spiritually grounded (Jackson 2002). It is critical that the communities in South Africa are given ample education on the pros and cons of the two therapeutic systems, the modern biomedical one and the traditional one, and leave one to make informed choice about their treatments. The government should ask the healers to release the correct information, or face the wrath of the law. The government machinery needs to centralize the information that the clients get from either of the two healing systems so that information is not lost in between. The packaging and repackaging of truthful information, this researcher believes, could have a great impact in reducing the stigma associated with the choice of each treatment procedure.

Theoretical Framework

The state of stigma in the society can be explained by many conceptual frameworks, each contributing a significant part of the explanations. The following conceptual framework, from this researcher's perspective, can contribute significantly to addressing the proliferation of stigmatisation.

Social Support Theory

Social support theory underpins social interaction between people in which an individual has a source of psychological, emotional and physical assistance (Segal et al. 2007). It espouses a state of belonging to a group or network of individual that is trustful and caring and doing things together. The theory espouses a state of interdependence among people in which support is availed to the needy individuals. There is also the notion of team work, team spirit, sharing of information and companionship. People are connected to one another through a social network (Segal et al. 2007). The network can be provided at workplace, family, friends etc.

Social support theory is an appropriate conceptual frame. It thrives on rich social capital built by community support systems, making interactions that are accompanied by love, mutual trust, interdependence, and a feeling of togetherness (Kang'ethe 2011). Applicably, information acquisition by members where a particular society enjoys strong social support ensures that new ideas can easily travel to all the members in the society or a community. At the same time, any correction of the misinformation can be handled easily through the already well built and reliable social support systems. Perhaps the misinformation from some stakeholders would easily have been corrected in many African countries, South African notwithstanding, if communities were still adequately entrenched in social support group systems (Kang'ethe 2011).

The social support theory also carries responsibility of the much needed psychosocial

support to those infected and affected (Uys and Cameron 2003). It has a goal of increasing social support and decrease sources of stress and negative forces in the client systems (Kang'ethe 2011). This support in most communities is not easily forthcoming as those already infected shy from disclosure as well as discussing their problems; find coping with the vice a difficult phenomenon; while some close family members, friends and the general populace sometimes run away and refuse to be identified with those who are either seropositive, or those caring for them due to stigma (Kang'ethe 2010a). This conceptual framework, therefore, offers a leeway and buffer stock to challenge this stigma related behaviours (UNAIDS 2002). However, the forces of modernization, euro centrism, civilization, and globalization have weakened most African communities' traditional social ties that made communities very cohesive, with mutual trust running across all the fibres of societies (Mogogi 2001). The concept of individualism, a characteristic of most western countries has taken the place of the African communalism, and to some extent socialism (Mogogi 2001). Though this conceptual frame helps to shed light on the societies practising stigma and stigmatisation, the challenge needs to be tackled through the application of other conceptual frameworks.

CONCLUSION

South Africa has no choice but to work round the clock to ensure that stigma is controlled and contained urgently. Stigma poses a great challenge to South Africa's efforts and pursuit to beat down the HIV/AIDS epidemic that has painted a gloomy picture of the country despite its big and enviable economy. Strong and sustainable community driven, and people centred campaigns will lead to people's change of the mind-set to easily accept HIV/AIDS as real and accept to live positively with it; succinctly understand its aetiology, epidemiology and its ramifications, and how to stem down the fear associated with the stigma. People need to be sensitized and mobilized to accept testing as a leeway to accepting the HIV/AIDS epidemic and its negative spin-offs. Any misconstrued facet of information that may have been a pivotal part of the history of the epidemic needs to be corrected; and the public assured of the government's paradigm shift in looking at the disease in due time.

Truthful and reliable information needs to be disseminated, with the government taking charge to control different sources of information from different players such as the traditional healing practitioners. Borrowing a leaf from other countries which have put the state of stigma to rest is central. Regrettably, the concerted efforts of the government, NGOs, private sector and the general public on tackling stigma head-on is taking a snail's pace.

RECOMMENDATIONS

Importantly, political goodwill is central to funding and managing anti-stigma interventions and campaigns. Campaigns are usually expensive and calls for governments, NGOs and private HIV/AIDS friendly bodies to invest immensely in them. For example, the government may have to mobilize and lobby law makers to institute, or strengthen anti-stigma laws and policies. People living with HIV/AIDS need to be protected against stigmatisation. Importantly also, communities and societies need to be encouraged to use or invent indigenous methodologies of love, trust and selflessness in treating the vulnerable members of the society. Since education is key in achieving information dissemination, it is critical that governments, NGOs and private bodies friendly to HIV/AIDS strengthen their resolve to mainstream ant-stigma education. This is especially central in all the public institutions. Public institutions should be encouraged to have agenda on HIV/AIDS and stigma in their daily businesses.

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