PROJECT COMPLETION REPORT		
SECTION 1: BASIC INFORMATION (Maximum 2 pages)		
1.1	**UK Organisation Name**	World Association for Christian Communication (WACC)
1.2	**UK Organisation Address**	71 Lambeth Walk, London SE11 6DX **Telephone:** 020 7735 2877 **Fax**: 020 7735 2877 **Website**: http://www.waccglobal.org
1.3	**Project partner(s) (with countries where they are based if more than one country)**	Christian Council of Ghana (CCG); **Main Contact:** Ms Joyce Larko Steiner, Senior Programme Manager. **Address:** F146/2 Lokko Road, PO Box GP 919, Accra, Ghana; **Telephone:** +233 21 776678/773429; **FAX:** +233 21 776725. **Website**: http://www.christiancouncilofghana.org/wacc.html
1.4	**Project Title**	Reducing HIV& AIDS Related Stigma and Discrimination among Vulnerable Groups: A Local Rights-Based Communication Strategy
1.5	**CSCF Number**	446
1.6	**Country/ies**	Ghana
1.7	**Local area(s) within Countries(s)**	**Ga West, Dangme West and Manya Krobo**
1.8	**Project Start & End Dates**	**Start:** 07/ 2008 **End:** 06 / 2011
1.9	**Date report produced**	28/09/2011
1.10	**Name and position of person(s) who compiled this report**	**Name:** Joyce Larko Steiner **Position:** Senior Programme Manager, CCG
		Name: Sarah Macharia **Position:** Programme Manager, WACC
		Name: **Position:**

SECTION 2: NARRATIVE REPORT	
2.1	**Acronyms**
	ARTs – Anti-Retroviral Therapy; CCG - Christian Council of Ghana; CSOs – Civil Society Organisations; FBOs – Faith Based Organisations; GAC-Ghana AIDS Commission; PLWHA / PLHIV - People Living With HIV and AIDS; OICI – Opportunities Industrialization Centers International; OLKI - Other Key Local Influencers, namely traditional leaders & opinion formers, women & youth leaders, teachers, health workers & media practitioners ; PWD – Persons With Disabilities; RL-Religious Leaders; WACC-World Association for Christian Communication; S&D-HIV-related Stigma & Discrimination; MDGs-Millennium Development Goals; OVI-Objectively Verifiable Indicators; WACC – World Association for Christian Communication;VCT-Voluntary counselling and testing.
2.2	**PROJECT DESCRIPTION** *Maximum 5 lines.*
	The project addressed HIV-related stigma and discrimination in 3 districts in Ghana by transforming local leaders into advocates for the rights and dignity of PLHIV. Religious, community, traditional, women and youth leaders, along with teachers, health workers and media practitioners, gained capacity and support to undertake rights-based advocacy and communication.
2.3	**PROGRESS OVER THE LAST YEAR** *Maximum 10 lines.*
	The project reached its peak with key stakeholders involved in campaigns designed collectively at the local level. Community dramas, radio programmes, local festivals and sports/ games were among the strategies used. Participation was high and the level of ownership exhibited gave hope for the continuation of stigma reduction efforts after the project ends. Networks are functioning well; the collaboration between health workers, teachers, traditional authority and other key stakeholders including PLHIV has become a good legacy. The advocacy materials translated into local languages helped community members understand the message and relate it to behaviour change. Spiritual camp leaders who hitherto obstructed PLHIV's access to ARTs joined the campaign and assisted several of them to seek medical treatment.
2.4	**SUMMARY OF OVERALL ACHIEVEMENTS** *Maximum 15 lines.*
	With the new capacity the key stakeholders effectively advocate for the rights of PLHIV, in particular, the right to non-discrimination. There is now extensive knowledge in the target districts on the actions and inactions that contribute to S&D. The changes were anticipated and come directly from the project. Communities' willingness to engage in open dialogue on HIV has created a climate conducive to addressing HIV and improving the quality of life of PLHIV. Rights awareness: PLHIV are aware of their rights to non-discrimination. They participate in increasing community knowledge and were instrumental in leading the rights' advocacy campaign and education. Empowerment: RLs uphold the rights of PLHIV through the pulpits and other spaces in which they have authority. The PLHIV networks formed have been empowered to become proactive. Nyemisuomi Foundation in Dangme West for instance negotiated with the District Assembly to secure use of an abandoned clinic for meetings. Uptake of VCTs has improved in the districts in turn demonstrating will to live positively. Advocacy: Specific rights secured include the right to housing, as landlords were lobbied to halt eviction of HIV+ tenants. Right to non-discrimination as PLHIV lobbied Manya and Amasaman hospital authorities to abandon the practice of segregating HIV+ outpatients. Poverty reduction: Reduction in HIV stigma (related to MDG 6) has led PLHIV to participate actively in their communities. Some are now self-employed in income generation work. The PLVIH support groups access monthly food supplements available OICI groups.

2.5	**HISTORY OF SIGNIFICANT CHANGES AND LOGFRAME REVISIONS**
	Revisions were made to logframe indicators to render them more specific and measureable. In some cases the national-level statistics were not available, in others the data was too personal to collect and in others better indicators were possible. Specifically, 1. At the Goal level: the indicators 'Upward annual trend in attendance of men and women in VCT in Ghana' and 'Upward annual trend of PLHIV undergoing ART in Ghana' were removed because the country data was not available. What is available however the HIV prevalence rates. The indicator 'Number of fact sheets on S&D disseminated' was removed, being part of the knowledge base in an existing indicator. 2. At the Purpose level: The means of verification were reduced to three to correlate with the indicators. 3. At the Outputs level: Indicators for Outputs 3 and 5 were reduced, with the deletion of indicators whose data could be collected only through media audience research that was outside the scope of the project. A qualitative indicator on media programming and print press content was retained. 4. Indicators for which the data was too personal and therefore difficult to collect included 'Upward trend of families who no longer feel ashamed of openly declared relatives by month 20 and after', and, 'downward trend in family refusal to share objects with HIV+ family members by month 20 and after'.
2.6	**TARGET GROUP**
	a. Number and description of direct beneficiaries: The following persons were trained in the HIV stigma awareness and advocacy skills workshops in the three districts: • 186 religious leaders, • 438 women leaders, • 428 youth, • 120 traditional leaders, • 246 Opinion leaders, • 128 teachers and health workers, • 30 persons with disabilities, and • 150 PLHIV. Out of these, 264 were trained as campaign leaders. The attendance lists of the workshops are part of the project records.
	b. Number and description of indirect beneficiaries: More than 24,000 people have indirectly benefitted from the project. The number of indirect beneficiaries is calculated through a record of names from one-on-one and focus group meetings, and through reliable estimates of participation in campaign activities. Not included in this count are the CCG member churches, FBO networks, CSOs working on HIV and AIDS in Ghana and WACC networks reached through distribution of the project materials, newsletters and project information.
	c. Did this change from what was envisaged in your proposal and if so why? More stakeholders than envisaged were reached because of the decision to deliver the training through non-residential workshops where this was possible as well as the remarkable buy-in into the project by the communities.

2.7	PARTNERSHIP, MANAGEMENT AND CAPACITYBUILDING

a) WACC and CCG collaboratively monitored and managed the project over the 3 years. CCG as the local project partner was responsible for implementing activities, liaising directly with the local stakeholders and communities and keeping WACC abreast of developments in the implementation process. WACC monitored project progress through email and teleconference consultations with the local partner and through annual monitoring and planning field visits. CCG and WACC shared the responsibility of financial accountability: CCG oversaw management and reporting on the local budget while WACC oversaw the overall financial management and reporting to DFID. The partnership and project management arrangements between WACC and CCG remained stable throughout the length of the project.

b) CCG gained institutional capacity for anti-HIV and AIDS-stigma interventions particularly in work with grassroot communities. CCG gained recognition within the constituency of organisations working in the same thematic area, visible through the requests for training on faith-based responses to HIV stigma. Other organisations learnt about the project through the Ghana AIDS Commission and requested for training on incorporation of an anti-stigma focus into their work. One such organisation is the Society for Women Against AIDS in Ghana. A second example is the request by the HIV&AIDS Prevention Education project (funded by the Japan International Cooperation Agency) in the Eastern and Ashanti regions of Ghana. CCG's capacity to mobilize grassroot communities for anti-stigma collaborative action has been built through this project. The project strategy and resources enabled direct work with grassroot communities in underserved areas of the Greater Accra Region. This would not have been possible without the project. CCG's profile in this thematic area was raised in Ghana through participation in meetings convened by the Ghana AIDS Commision, through information and advocacy resources widely distributed to the network of CSOs working on HIV/AIDS and to CCG member churches. WACC's capacity for faith-based responses to HIV and AIDS stigma has increased. New resources from the project are the training manual 'Facilitator's guide for training on HIV and AIDS Stigma and Discrimination Reduction'; the booklet 'HIV Fact Sheets', advocacy campaign posters 'Stop Stigma, Stigma Kills'. The resources are available to WACC's broader constituency worldwide of faith-based organisations engaged in anti-stigma work. WACC's capacity to partner on HIV projects has increased with new insights on effective long-term project partnerships, advisory, monitoring and management skills. It is probable that the capacity for effective long-term project partnerships would have been strengthened eventually, but was nevertheless accelerated through the project.The networks of allies were expanded. Newly established in the UK were links with the African Health Policy Network, the Terrence Higgins Trust, and the UK Consortium on AIDS and International Development.

c) The project did not work directly with children however, it indirectly involved children in the anti-stigma advocacy campaign through their teachers who had been trained in the advocacy capacity-building workshops. The project collaborated with the District Education Directorate (a government agency) in encouraging the teachers to involve school children as part of the HIV ALERTschool programme which is a national model for addressing HIV infection among children. While CCG's regular work does not involve children directly, it observes measures and structures in place to protect children. In the context of this project, activities were undertaken with the participation of the government agency responsible as well as school administrations.

2.8 EFFECTIVENESS OF THE PROJECT APPROACH

The project approach has been to build and enhance the capacity of selected stakeholders and use a rights-based strategy to challenge HIV-related stigma.

a) We would extend the number of years for the project to five because sustaining attitudinal transformation – in this case from stigma and discrimination to acceptance and support –benefits from a longer term engagement with communities.

b) We would place more emphasis on building project reporting capacity of the local partner in order to capture the richness of the experience more exhaustively than has been documented.

c) A major success is the community engagement in the project that was in part made possible by the capacity built and responsibilty given to the district coordinators to lead implementation. Enormous trust was built between the cordinators, the local leaders, key influencers and communities. The communities took ownership of the project and were at the heart of the anti-stigma advocacy campaigns. The idea of voluntarism for a greater social good took root which was new in an environment in which most NGO-led actions are accompanied with monetary payments. At the same time resources were a key challenge given the lack of a budget for full-time staff in the districts. The stipends built into the budget were sufficient for the district co-ordinators' out-of-pocket expenses. A second challenge was the local partner's difficulties in results-based management leading to an insufficient focus on documenting results, measuring and reflecting on impact.

2.9 VALUE FOR MONEY (VfM)

The project generated tremendous value for money given the documented successes and reach of the project for an average of about £80,000 per year. Calculated per person trained, a total of about £140 over three years per 1726 persons trained and transformed in stigma reduction advocacy led to demonstrated change in community and health practices in districts with a high HIV prevalence rate. This value increases in consideration that the persons trained have significant community authority and leadership which maximize the reach of the messages and attitudinal and behaviour change. Further, much more was achieved as a result of the remarkable community ownership inculcated that superceded the actual monetary resources invested. Local capacity was strengthened to enable the sustainability of the project outcomes. Training and advocacy materials have been created which are already being used beyond the three districts, extending the impact of the project.

2.10 RISK ASSESSMENT

Risk Identified	***Did the risk materialise?***	***If the risk materialised, how did the project deal with it and reduce the impact on the project?***	***If the risk did not materialise, was this as a result of measures put into place by the project? If yes, please explain how.***
Political – Election 2008 and delays to work	Yes	Election tensions delayed work in the first year. Unaccomplished tasks were carried over into Year 2.	

Risk Identified	*Did the risk materialise?*	*If the risk materialised, how did the project deal with it and reduce the impact on the project?*	*If the risk did not materialise, was this as a result of measures put into place by the project? If yes, please explain how.*
Exchange rate losses caused by fluctuation of the Ghana cedi against the GBP	Yes	Project funds were kept in a foreign currency account during the period. Specific amounts needed to offset activity costs were changed into local currency as and when required.	
A potential risk of losing trained staff during the period	No		The emphasis on personal commitment coupled with satisfaction in seeing project impact were effective in retaining staff.
A potential risk of religious leaders deciding not to become involved	No		The participatory approach as well as respect for local culture and custom ensured a high rate of involvement.
A risk of women becoming victimized if they publicly disclosed their HIV status	No		This reality was present before the project. The project tackled stigma and discrimination at the outset and achieved demonstrated impact in reducing discrimination.

2.11 LESSONS LEARNED

The following lessons were identified in the course of the project and applied over the life of the project, changing aspects of the approach, strategy and monitoring and evaluation to improve the overall impact of the project:

1. Effective advocacy: The use of drama and other community resources increases the chances of effective participation and ownership of the process, leading to increased opportunities for communities to tailor advocacy events to meet local interests and needs. Further, a successful advocacy campaign adopts creative, even controversial ways initially to evoke debate. For example female project volunteers dressed in mini-skirts when posting up campaign posters to provoke debate with passers-by on myths that fuel HIV stigma. It is subsequently important to sustain debate by creating and using the multiple community spaces for continued discussions. (*new lesson*)

	2. Self-stigma: Interactions with the PLHIV reveal a need to design strategies to deal with self -imposed stigma and discrimination. That community members were unaware of PLHIV among them was indicative of widespread non-disclosure of HIV status in communities that were statistically documented as high prevalence. Addressing self-stigma directly and building self confidence has been useful in empowering PLHIV to be advocates and aiding the process of disclosure and living positively. Further, stigma reduction campaigns need to be accompanied by a 'know your status' campaign. Testing comes with counselling that teaches individuals about the impact of stigma. (*lesson previously reported*) 3. Inclusive dialogue: Genuine learning happens when all stakeholders are part of the dialogue. Health workers became more conscientious about practices initially considered 'caring' – such as enquiring during a public gathering whether a person was taken her medication – that were in fact stigmatising. The lesson here is that PLHIV have to be part of the dialogue even when the change being sought is from a different stakeholder group. Involving PLHIV in training other stakeholders is an opportunity to learn firsthand the less obvious manifestations of stigma and discrimination. (*lesson previously reported*)
2.12	**CROSS-CUTTING ISSUES**
	Women readily engaged with the project, visible through their greater participation in the PLVIH networks in comparison to men. Women are in effect disproportionately impacted by HIV and AIDS due to inequalities in power relations, stigma associated with attribution of infection to promiscuity and the burden of care for the sick and children orphaned by AIDS. This explains women's willingness to participate in the project and to contribute to raising awareness about stigma through their daily interactions in the marketplace and other social gatherings. More effort however was required to increase men's understanding of gender and women's right to negotiate for safer sex. The challenge of securing men's participation and cooperation was gradually surmounted with continuous education and the one-on-one interpersonal interactions. The youth played an active role in the awareness raising and advocacy campaigns through their associations and as project volunteers. They found innovative strategies such as football matches and improvised spontaneous skits (mini-drama) to attract audiences to project events. A conscious effort was made to include PLHIV from an association of people with disabilities into the project. The inclusion of PLHIV at all the levels served to raise awareness with other stakeholders about PLHIVs direct experiences and to provide an opportunity for them to build self confidence and advocacy skills. This created an enabling environment for disclosure and for increase of the uptake of VCT services.
2.13	**SUSTAINABILITY**
	A sustainability plan has been implemented which celebrated the achievements in each district and encouraged continued commitment to advocate for the rights and dignity of PLHIV. Community celebrations were organised for this purpose at the end of the project. Networks of trained participants continue to function and have developed short and long-term plans. Advocacy and training materials are available to support further efforts within and beyond the three districts. Stakeholders have clearly indicated their commitment to continue, and the training has provided a base of understanding about HIV&AIDS which is critical to overcoming stigma and discrimination. However special events and coordinated efforts that make significant impacts on attitudes or issues may not occur due to the absence of district coordinators previously financially supported through the project. In addition, without support for travel, networks will not be able to easily meet with related networks in other districts for mutual support and activities.

2.14	INFORMATION DISSEMINATION AND NETWORKING (INCLUDING IN THE UK)
	Project news as well as training and advocacy materials have been disseminated through local and national councils of churches and through CCG and WACC communication channels. A case study of the project was presented to the international HIV consultation of the Ecumenical Advocacy Alliance held in Thailand in March 2011 and an article on the project disseminated through their bulletin to over 3000 subscribers. The project and ensuing resources continue to be publicized through the development organisations' partnership Communication Initiative that disseminates information on communication initiatives around the world. (A full list of networks to which information has been circulated is available).

2.15	CONTRIBUTION TO CSCF OBJECTIVES
☒ Building capacity of Southern civil society to engage in local decision-making processes	CCG capacity to engage with grassroot communities, evident through their participation with local keyinfluencers in leading a response to HIV in the communities.
☒ Building capacity of Southern civil society to engage in national decision making processes	GAC and CSOs now recognize CCG as an authority on faith-based HIV interventions with a focus on stigma reduction. CCG has participated in several national-level consultations in this capacity.
☐ Global advocacy	
☐ Innovative service delivery	
☐ Service delivery in difficult environments	

2.16	CONTRIBUTION TO MILLENIUM DEVELOPMENT GOALS
☐ Eradicate extreme poverty and hunger	
☐ Achieve universal primary education	
☐ Promote gender equality and empower women	
☐ Reduce child mortality	
☐ Improve Maternal Health	
☒ Combat HIV/AIDS, malaria and other diseases	The number of persons who have benefited from the project and are also carrying out activities in their respective districts have contributed to government efforts to combat HIV& AIDS.
☐ Ensure environmental sustainability	
☐ Develop a global partnership for development	

2.17 **EVALUATION REPORT**

Overall the report largely provides a fair reflection of the project. Some of the observations made had been voiced during the implementation process. One conclusion (3 below) that raised questions on the willingness of the communities to continue advocating against stigma was challenged by stakeholders at a meeting to validate the evaluation findings. The Christian Council of Ghana and the Ghana project manager will be responsible for implementing the recommendations.

Conclusions	CSCF grant holder response
1. "The evaluation of the project has highlighted some major successes. These include the increasing family and community support for PLWHA, the increased awareness on the part of the PLWHA and the desire of the PLWHAs to support each other". "The project has contributed in increasing the rights awareness, especially among the PLWHA".	Interactions in the communities during and after the advocacy and awareness campaign show this conclusion to be true. The support groups also reiterate the significant extent to which PLHIV receive support from community members.
2. "Even though the poor and marginalised groups were engaged in the implementation, support for their empowerment was limited to knowledge acquisition and the preservation of their rights. This, the poor and marginalised (PLWHA's) were not too satisfied with".	Direct economic empowerment was not an objective of the project. Reducing or eliminating stigma provides an impetus for PLHIV to participate in their communities. Some members of the PLHIV support group in Dangme West received support from the District Assembly to establish themselves as traders in the local market. Their work generates income to support their families which prior to the project, they did not have. Members of registered support groups receive support from the OICI in the form of monthly food supplements. As well, CCG has commenced negotiations with the Ghana Livelihood Empowerment Against Poverty (LEAP) secretariat to enrol PLHIV for livelihood enhancement support. Awareness of rights is the first step to claiming the rights. The Manya Krobo PLHIV support group with the assistance of 7 female lawyers successfully defended their rights where these were being flouted. A widowed member of the group secured compensation from the family of her deceased husband after the latter expelled her from the family home. Two members successfully reclaimed their market stalls from which they had been evicted because of their HIV status. The rapport established between the group and the lawyers will enable continued legal support whenever the needs arise. .
"	

	Further, CCG has designed an advocacy project to lobby the Department of Women and Children to enforce laws on domestic violence that hinder women's inability to negotiate for safe sex. This inability that stems from unequal gender power relations increases the vulnerability of girls and women to HIV infection. The project is at its initial stage as CCG seeks funds for implementation.
3. "The field discussion revealed that attempts were made by CCG to build the commitment of its stakeholders to carry on the fight against stigmatization and discrimination even after project closure. … this is likely to occur on a very limited scale. This is because almost all the stakeholders interviewed in the three project districts were rather expecting some financial support as volunteers	Previous projects created a culture in which participation was dependent on financial rewards. The project sought to create a new culture of voluntarism, working with volunteers and OLKIs who would promote community ownership of the project for the long term. In a workshop to validate the evaluation report, some religious and traditional leaders expressed the view that the report captured this point in a manner that suggested they would abandon the work once the project ended. In reality, their point was the need for continuous support in order to work effectively.
Recommendations	**CSCF grant holder response**
1. "There is the need to extend the duration of future BCC projects, especially those that seeks to influence behaviour as behavioural changes usually take longer time to occur"	Undoubtedly impact in a project that seeks to transform attitudes and behaviour would be enhanced by longer term support. CCG has committed itself to continue to provide guidance and support to the communities over the next 2 years to help embed new behaviour as part of daily practice.
2. "It is important to continuously educate the people to help the dissemination process by discussing the exit strategies developed and soliciting commitment from all the relevant stakeholders".	CCG is following up on this recommendation. The exit strategy has been discussed with the District Management Community members and the traditional authorities. A general meeting with all stakeholders is scheduled for the first week in October, 2011.

Achievement Rating Scale (ARS)

Overall assessment: 1

Comment: The change is remarkable, from closed communities in which HIV was taboo, misundertood and PLHIV stigmatised, to open communities where dialogue happens publlicly without shame or blame. There is a genuine openness and willingness to champion the rights of PLHIV. There is an informed understanding of HIV and AIDS by local key influencers and by the general public in the Dangme West, Manya Krobo and Ga West.

	ARS	Logframe Indicators	Baseline Value for indicators	Progress against the indicators (refer to milestones if applicable)	Comments on changes over the whole project period
Overall assessment	1				(see above)
Purpose Reduce HIV/AIDS-related S&D by building the capacity of religious leaders (RLs), other key local influencers (OLKIs) (traditional leaders & opinion formers, women & youth leaders, teachers, health workers & media practitioners)& PLHIV to challenge HIV/AIDS-S&D in 3 districts in Ghana through coordinated rights-based & gender sensitive communication advocacy initiatives.	1	1.1 Reduced fear of casual HIV transmission 1.2: Reduction in shame/blame judgements against PLHIV. 2: Reduction in stigmatising & discriminatory attitudes of RLs, OLKIs, teachers & health workers. 3: Reduce to 5% PLHIV reporting feelings of abandonment, rejection and denial.	1.1: 3.5% of baseline survey respondents afraid of casual transmission 1.2: 47% of baseline survey respondents expressing shame/blame judgements against PLHIV 2: 48% of RL, OLKIs, teachers, health worker baseline survey respondents expressing stigmatizing and discriminatory attitudes 3: 39% of PLHIV baseline survey respondents expressing societal attitudes towards them that include denial, rejection and abandonment)	1% at project end, random sampling survey 2% expressing shame/blame judgements against PLHIV 5% respondents in random sampling survey express discriminatory attitudes 2% of self-identified PLHIV in random sampling survey express societal attitudes of denial, rejection, abandonment.	Community ownership of the project in all three districts has produced these dramatic changes. Community ownership was enabled by the project strategy that centered the decision-making process on the key stakeholders, namely, the traditional leaders, religious leaders, teachers, youth and women leaders .

	ARS	Logframe Indicators	Baseline Value for indicators	Progress against the indicators (refer to milestones if applicable)	Comments on changes over the whole project period
		4: Increase to 85% longer-term PLHIV disclosing HIV-status. 5: Increased understanding & acceptance of link between S&D & HIV/AIDS & speak against S&D. 6: More key influencers express accepting attitudes. 7: Improved quality & sensitivity of media reports.	4: 48% survey respondents PLHIV disclosing HIV status. 5: 46% of trainees understand and speak out against S&D. 6: 52% of OLKI survey respondents expressing accepting attitudes towards PLHIV 7: Media reports generally insensitive.	93% had disclosed their status 91% of persons trained continue to speak out against S&D 93% of OLKI express accepting attitudes 7. 85% in random survey say media has played a helpful role in sensitizing the public about HIV	
Output 1 Contextualised training materials to increase knowledge & understanding of causes, effects & manifestations of HIV/AIDS-S&D among RLs, OLKIs & PLHIV & to build their anti S&D communication skills &	1	1. Field-testing of capacity-building materials.	1: Not enough training materials in local languages	1: Existing materials were adapted in consultation with the key stakeholder groups rendering them relevant for training in the local context.	No unintended impact

	ARS	Logframe Indicators	Baseline Value for indicators	Progress against the indicators (refer to milestones if applicable)	Comments on changes over the whole project period
advocacy capacity.					
Output 2 RLs, OLKIs & PLHIV in 3 districts have training, commitment, strategies & resources to combat S&D, including self-stigma, in their respective constituencies.	2	2.1 530 people have new skills & enhanced capacity, strategies & resources. 2.2 At least 50% RL new investment in PLHIV.	2.1: No known persons trained in communities 2.2: No new investment	2.1: 536 persons trained. Over 85% rated knowledge acquired as 'very good' or 'excellent'. 2.2: PLHIV have secured new financial support from OICI through the GAC. Churches and traditional authorities soliciting support.	No unintended impact
Output3 People attending churches & mosques, women & youth groups, community members have greater understanding of HIV/AIDS & adopt accepting attitudes for PLHIV through rights-based gender sensitive communication advocacy campaigns	2	3.1 Reduction in negative attitudes to 5% 3.2 100% women group leaders make referrals to support groups 3.3 Youth groups & students new initiatives 3.4 Decrease to 5% PLHIV experiencing violence	3.1: 65% baseline survey respondents expressing negative attitudes towards PLHIV 3.2: 47% baseline survey respondents who have referred PLHIV to support groups. 3.3: Zero initiatives 3.4: 38% of PLHIV survey respondents experiencing physical, emotional, psychological violence	5% project end random survey respondents express negative attitudes towards PLHIV. 100% achieved by end of year 2 Inclusive youth sports events all districts 2% of PLHIV at project end random survey reported experiencing violence	The results may partly be attributed to inclusive strategy, participatory decision-making with OLKIs, leading to a remarkable community buy-in into the project.

	ARS	Logframe Indicators	Baseline Value for indicators	Progress against the indicators (refer to milestones if applicable)	Comments on changes over the whole project period
		3.5 Increase to 95% of PLHIV receiving equal treatment in health centres.	3.5: 26% of PLHIV survey respondents who feel they are treated equally in health care centres	90% of PLHIV felt they were treated equally in health care centres	
Output 4 Coordinated sustainable anti-S&D networks of RLs, OLKIs & PLHIV established in 3 districts to ensure effective implementation & sustainability of advocacy initiatives during & beyond project life.	1	4.1 Coordinated & functional anti-S&D networks 4.2: At least 10% RL & OLKI joining & working in networks 4.3: Stakeholders affirm intent to participate in advocacy activities	4.1: no network in Dangme West; dormant network in Manya Krobo weak network in Ga West 4.2: None in networks 4.3: 100% of primary stakeholders affirmed they would participate in the project's advocacy activities.	4.1: Network formed in Dangme West now registered as 'Nyemi Suomi Foundation'. The networks in Manya Krobo and Ga West have been revived and/or strengthened. 4.2: Trained RLs & OLKI meet regularly with the PLHIV. 4.3: At least 80% of stakeholders trained participated in the campaigns.	The networks' rapid expansion indicated presence of a real need. PLHIV support groups provided emotional support important for them to live positively, the groups enabled legal support to secure their rights and material support accessible solely to registered groups.
Output 5 Dissemination/ sharing of lessons learned, best practices & communication tools in Ghana, Sub-Saharan Africa & other regions.	2	5.1: 95% primary stakeholders sharing & implement lessons & best practices by month 22. 5.2: Project S&D tools and best practices	5.1: 46% speaking out against S&D 5.2: No information available.	91% speak out against S&D CSOs working on HIV/AIDS in Ghana have either received or are aware of the project's	Reactions to news about the project include invitations to present case studies, requests to share the training and advocacy

	ARS	Logframe Indicators	Baseline Value for indicators	Progress against the indicators (refer to milestones if applicable)	Comments on changes over the whole project period
		widely known in Ghana and throughout Africa by end of project 5.3 By project end international organisations aware of available tools & best practices.	5.3: No information available	training and advocacy resources distributed directly to them or through the GAC. The Communication Initiative circulated news about the resources in *Live the Promise Campaign* Bulletin. The project has been featured in The Ecumenical Advocacy Alliance newsletter, WACC's Media Action and other partner resources.	resources and requests to advise on faith-based interventions to HIV-related stigma.
Activities *Please comment on the relevance, efficiency and effectiveness of the activities overall*	The evaluation found that the project was relevant to halting the spread of HIV among the impoverished communities in the Greater Accra Region through the reduction of stigma and discrimination. The project activities designed to create partnerships at the local level for project implementation were instrumental in informing the content, instruments amd spaces of advocacy such as the community durbar (fora), traditional events (e.g. the ancestal Ngmayem rooting out hunger festival). The new call-in radio programmes (e.g. on Obunu FM) with PLHIV speakers helped create dialogue on HIV and stigma with the larger radio listener audiences. The PLHIV networks and support groups thrived and attracted wide participation across the districts. Community members attest to a new climate that is supportive to upholding the rights of people living with and affected by HIV and AIDS. The project is recognized for its innovation as evidenced in invitations to present case studies at the international HIV consultation of the Ecumenical Advocacy Alliance (Thailand, March 2011), at a global WACC roundtable meeting (Finland, April 2011) and has been featured in The Drum Beat of the Communication Initiative development resource.			

1. **Title of CSCF Project**	Reducing HIV/AIDS-Related Stigma and Discrimination Among Vulnerable Groups: A Local Rights-Based Communication Strategy
2. **CSCF Reference Number**	446
3. **Country/ies**	Ghana
4. **Name of UK and local CSOs**	World Association for Christian Communication (WACC) Christian Council of Ghana (CCG)
5. **Project duration (dates)**	**Start:** 07/2008 **End:** 06/2011
6. **What problem does your project address? (please put into context and provide figures)**	CCG with input and support from WACC worked with community members, opinion leaders, traditional leaders and key district stakeholders to reduce HIV/AIDS-related stigma and discrimination in the Manya Krobo District of the Eastern Region, Dangme West and Ga West Districts in the Greater Accra Region. The 2009 Ghana HIV Sentinel Survey found the national HIV prevalence increased from 1.7% in 2008 to 1.9 in 2009, back to the rate registered in 2007. All the regions with the exception of Eastern Region recorded an increase in prevalence over 2008. Greater Accra Region ranks third highest at 3.2 per cent, behind Ashanti Region (3.9%) and Eastern Region (4.2%). Stigma and discrimination hinder the control of the spread of HIV/AIDS. Stigma and discrimination are directed at the infected and affected. They are high against people living with HIV and AIDS (PLHIV) in most communities, undermining prevention, treatment and care, affecting the human rights of PLHIV as well as posing a barrier to achievement of Goal 6 of the MDGs.
7. **How does your project address this problem?**	The project followed a rights-based participatory communication approach. It sought to build the capacity of religious leaders and other local key influencers to take the lead in actions against HIV-related stigma & discrimination in 3 districts in Ghana. The project attempted to instill an empowering process of social change that valued the voices of marginalised groups of PLHIV, and that was biased towards local content and ownership.

8. **Summary of achievements *(250 words)***	There is an extensive knowledge base in the Manya Krobo, Dangme West and Ga West districts of the Greater Accra Region about what constitutes HIV-related stigma and discrimination and how to challenge it. PLHIV and the communities clearly understand the facts about HIV, stigma and engage freely and openly in informed dialogue about HIV in place of the myths, mystery and taboo that surrounded HIV in the past. There is new capacity in the grassroot communities in the three target districts to support and advocate for the rights of PLHIV. A survey at project end found a sharp increase in the number of community residents who regularly speak out and advocate against stigma and discrimination, from 46% three years ago to 91% currently. In each of the target districts there are strong PLHIV support networks that as collectives have succeeded in accessing resources. Religious and traditional leaders have engaged fully in the fight against stigma and in the struggle to uphold the rights of PLHIV. Key beneficiaries have new advocacy capacity, communication skills and increased knowledge about HIV and AIDS. The achievements are perhaps best illustrated by the change in the HIV status disclosure rate. The baseline survey determined that 48% of PLHIV had disclosed their status to family or friends. Fear of stigma and discrimination discourages disclosure, in turn undermining prevention, care and treatment. By project end, 93% of PLHIV had disclosed their status owing to new found confidence resulting from the dramatic reduction in the fear of stigma.

9. **What is the actual impact of your project– who has benefited/what has changed?(*100 words)***	The project has created awareness of the rights of PLHIV and supported them to claim their rights to non-stigmatisation and non-discrimination. It has improved the lives of PLHIV in Manya Krobo, Dangme West and Ga West districts of the Greater Accra region to live, work and participate in their communities without stigma, shame and discrimination. It has created a climate that supports efforts to curb the spread of HIV and the harm it causes. The project has created a new understanding of HIV and AIDS that has dispelled myths, misconceptions and disinformation about transmission, prevention and treatment.
10. **What are the long terms benefits of your project?*(100 words)***	Local leadership has been established to drive continued advocacy for the rights of PLHIV over the long term. The highly regarded traditional and religious leaders have the tools, capacity and will to lead the communities to stand up against HIV stigma and protect the rights of people living with and affected by HIV. The communities have been empowered with new knowledge on the facts about HIV and AIDS, stigma and how to challenge it. The attitudinal change will in the long term sustain efforts to curb the spread of HIV and enable positive living for the affected or infected.
11. **If your project is complete, what made your project successful? (*100 words)***	The relationships built, the partnership approach and the valorisation of local input in all stages of the project contributed to enabling the project's success. The consultative approach in designing the advocacy campaign materials, the strategy and identifying community spaces for the campaigns helped inculcate a sense of ownership of the project. Applying multiple teaching resources especially the 'Quantity, Quality and Route of Transmission' tool (QQR) and other innovative ways to explain modes of transmission and address the fears of HIV contributed to the project's success.

12. **What makes your project innovative?*(100 words)***	PLHIV participated in workshops and radio programmes as resource persons on stigma, creating dialogue based on first-hand experience where none had existed prior. Decision-making processes on the project strategy were centered on the traditional leaders, religious leaders and other community influencers. Key stakeholders were involved in designing the training and advocacy material and in identifying the community spaces for the project's education and advocacy components. Additional advocacy resources were developed as PLHIV identified new advocacy issues based on their experiences. Impact of the advocacy campaign was enhanced by the project volunteers' creative and sometimes controversial strategies to provoke spontaneous debate.
13. **What is the most important thing this project is achieving?**	Championing the rights of people living with HIV and AIDS, especially the right to non-discrimination and the right to live free of stigma. Creating a factual understanding of HIV and AIDS that in turn supports efforts to halt its spread and the harm caused to the infected and affected.

14. **Human interest story (where possible, please provide names and direct quotes)** ***(250 words)***	Supernatural beliefs about the origin of HIV/AIDS have led many in Ghana to seek cures from spiritual leaders, often leading to neglect in observing their Anti Retroviral Treatment (ART) regimens and to gross exploitation of people desperate to have their health restored. Spiritual leaders known as prophets and prophetesses operate 'prayer camps' in which persons seeking help move into sometimes temporarily but often permanently. Their unpaid labour and any worldly wealth is given freely to the leaders in exchange for prayer. Many in their last stage of AIDS are chained and beaten to exorcise them of 'demons'. The project reached out to 42 prayer camps in Manya Krobo to increase understanding of HIV and AIDS, the rights of PLHIV, stigma and discrimination. One success story is Nyame Sum Bo prayer camp whose leaders Prophet Isaac Mangotey and Prophetess Lydia Amui agreed to participate in the capacity building workshop for religious leaders. They thereafter became part of the advocacy campaign leaders, educating residents of their camp and encouraging them to visit the St Martins Clinic for treatment. Amui says "ignorance is bad and people have died avoidable death because treatment was available and we didn't know... I have just watched the transformation of 4 PLHIV who had been put on ART". These model prayer camp leaders have requested for support to reach other camps in which exploitative practices continue.
15. **Please supply photographs as jpeg attachments, stating who/what the photographs show**. The photos show the advocacy campaign in progress.	
16. **Further information**	Prayer camps common across Ghana are sustained by several factors, among them, beliefs in traditional cures to diseases that are incurable with western medicine. Prayer camp leaders are treated as demi-gods who, with intense prayer and herbs, can cure all conditions, including HIV/AIDS. This in spite of national efforts to convey the facts about the virus. By reaching out to prayer camps, the project is perhaps one of few that have consciously made an effort to reach out to the camps and work in partnership with the prophets and prophetesses who are surprisingly willing to be part of the solution.

Authors: *Joyce Larko (CCG) and Sarah Macharia (WACC)*
Date: *27 September 2011*