

**PROJECT TITLE: REDUCING HIV&AIDS-RELATED
STIGMATIZATION AND DISCRIMINATION AMONG
VULNERABLE GROUPS: A LOCAL RIGHTS-BASED
COMMUNICATION STRATEGY**

**AGENCY NAME: DEPARTMENT FOR INTERNATIONAL
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Executive Summary

The project 'Reducing HIV and AIDS-Related Stigmatization and Discrimination among Vulnerable Groups: A Local Rights-Based Communication Strategy' was designed to reduce HIV and AIDS related stigmatization and discrimination in three districts of the Greater Accra and Eastern Regions, namely Dangme West, Ga West and Lower Manya Krobo. The project strategy was to build the capacity of religious leaders (RLs), other key local influencers (OLKIs) and PLHIV to challenge HIV-related stigmatization and discrimination. The project was thus expected to result in the establishment of strong, co-ordinated networks committed to challenging stigma and discrimination beyond the funding phase.

Using a variety of methods such as the collection and review of relevant documents, focus group discussions and key informants/stakeholders interview, the following among others were found.

- i. There was diversity in the stakeholders selected which provided a good platform for the sharing of experience;
- ii. The project objectives related favourably to the Human Resource Development Agenda of the Ghana's development strategy, The Growth and Poverty Reduction Strategy (2006 – 2009) which was in place at the start of the project. The strategy recognised that the HIV/AIDS pandemic results in loss of productive assets, high treatment costs and the break in the transfer of valuable livelihood knowledge from one generation to the next;
- iii. The project has contributed in increasing the right awareness, especially among the PLHIVs. As a result, almost all the PLs interviewed recognised their role in society in spite of their conditions;
- iv. The project generally was gender sensitive resulting in varied impact on the various segments of society, especially among the women and children;
- v. The project framework developed created a partnership system, which worked well during the early stages of the project implementation but had some challenges with some of the actors, especially, the community volunteers;
- vi. The willingness of people to offer support to those in difficulty was one impact observed in all the study districts. The help extended to the vulnerable included taking them to the hospital, providing food and even seeking support from health personnel; and
- vii. Increase Voluntary Counseling and Testing is one of the impacts of the project in the study districts. In addition, the use of condoms has been on the increase. For example, in the Dangme West District, 4,320 condoms were distributed between February and March 2011 while 2440 condoms were distributed in the Ga West District.

One important lesson found was the need for subsequent project interventions to empower the PLHIV's economically since some of the PLHIVs have not been going for the ART regularly due to the lack of funds. In addition, PLHIVs who serve as Model of Hope are confronted with situation, which require spending money, especially on transportation as part of assistance to colleagues during outreach programmes.

ABBREVIATIONS AND ACCRONYMS

CCG	Christian Council of Ghana
GIPA principle	Greater Involvement of Persons Living with HIV and AIDS
CSOs	Civil Society Organisations
GAC	Ghana AIDS Commission
PLHIV	People Living With HIV and AIDS
OLKI	Other Key Local Influencers
PWD	Persons with Disabilities
RL	Religious Leaders
WACC	World Association for Christian Communication
S&D-HIV-related	Stigma & Discrimination
MDGs	Millennium Development Goals
UNHCR	United Nations High Commissioner for Refugees
QQR	Quality Quantity Route Tool

INTRODUCTION

Stigma and Discrimination (S&D) fuel the HIV and AIDS pandemic. They are often reinforced by religious beliefs, cultural practices, and gender inequality. They nurture poverty, disease, ignorance, and exclusion and breed silence and denial. In Ghana many in the faith community fail to speak out, which has made the AIDS situation worse. Stigma and Discrimination towards people living with HIV and AIDS (PLHIV) is pervasive because it is fuelled by social and cultural values and norms, beliefs and practices. Community members often perceive them in various morally resonant terms as outcasts, promiscuous, dangerous, etc.

This project was designed to reduce HIV and AIDS related stigmatization and discrimination in three districts of the Greater Accra and Eastern Regions, namely Dangme West, Ga West and Lower Manya Krobo. The project strategy was to build the capacity of religious leaders (RLs), other key local influencers (OLKIs) (traditional leaders and opinion formers, women and youth leaders, teachers, health workers and media practitioners) and PLHIV to challenge HIV-related stigmatization and discrimination. It sought to equip them to develop and implement a range of communication strategies and tools for this purpose: from theatre, music, dance, sport, competitions, community radio, and TV to sermons, reflections, storytelling, and testimonies. The acquired skills would enable the beneficiaries to defend the rights of people living with or affected by HIV and AIDS (PLHIV) in Ghana, actions that would in turn contribute to eliminating stigma and discrimination against them. Thereby the project would support efforts to mitigate the HIV and AIDS pandemic and the human suffering it causes. The project was expected to result in the establishment of strong, co-ordinated networks committed to challenging stigma and discrimination beyond the funded phase. These networks will serve as channels to disseminate lessons learnt and best practices.

The Christian Council of Ghana (CCG) implemented the project in collaboration with UK-based partner, the World Association for Christian Communication (WACC). The Department for International Development (DFID) under the Civil Society Challenge Fund (CSCF) funded it. This 3-year project began in June 2008 with funding ending in June 2011.

STUDY OBJECTIVES

As per the Terms of Reference, the study objectives are as follows:

- i. Identify the impact of the project and ways that this can be sustained;
- ii. Record and share lessons;
- iii. Identify best practices that would enable replication of the project elsewhere in Ghana;
- iv. Account to local stakeholders and funders for the project's achievements; and
- v. Ensure that funds are utilised effectively and efficiently to deliver results.

GENERAL APPROACH AND METHODOLOGY

General Approach

The Terms of Reference (ToR) and the major deliverables identified therein dictated the study's approach and methodology. Review of relevant secondary documents, collection of data, development of relevant protocols (interview guides), field surveys, consultations, focused group discussions, key informant interviews, as well as the assessment of the project deliverables, and impacts constitute the main methods for data collection adopted in this study. A detail work plan is presented in Figure 1 and the following subsection. The proposed methodology incorporated a comprehensive series of activities from contact establishment with CCG, survey instrument development, data collection and analysis, as well as reporting.

Consultations and Key Informant Interviews

The assignment commenced with a kick-off meeting among stakeholders on June 3, 2011 to discuss the overall study. Extensive consultations and interviews were held with several key stakeholders to determine what their perceptions are with respect to the implementation of the project, the problems confronting them, the role they played and how best they could have made the implementation process a little more efficient. Some of the stakeholders that were consulted include the staff of CCG, the project manager, Religious leaders (RLS), Traditional leaders, Opinion formers, Women, Youth leaders, Teachers, Health workers, and PLHIV. Appendix 1 presents the list and designation of respondents.

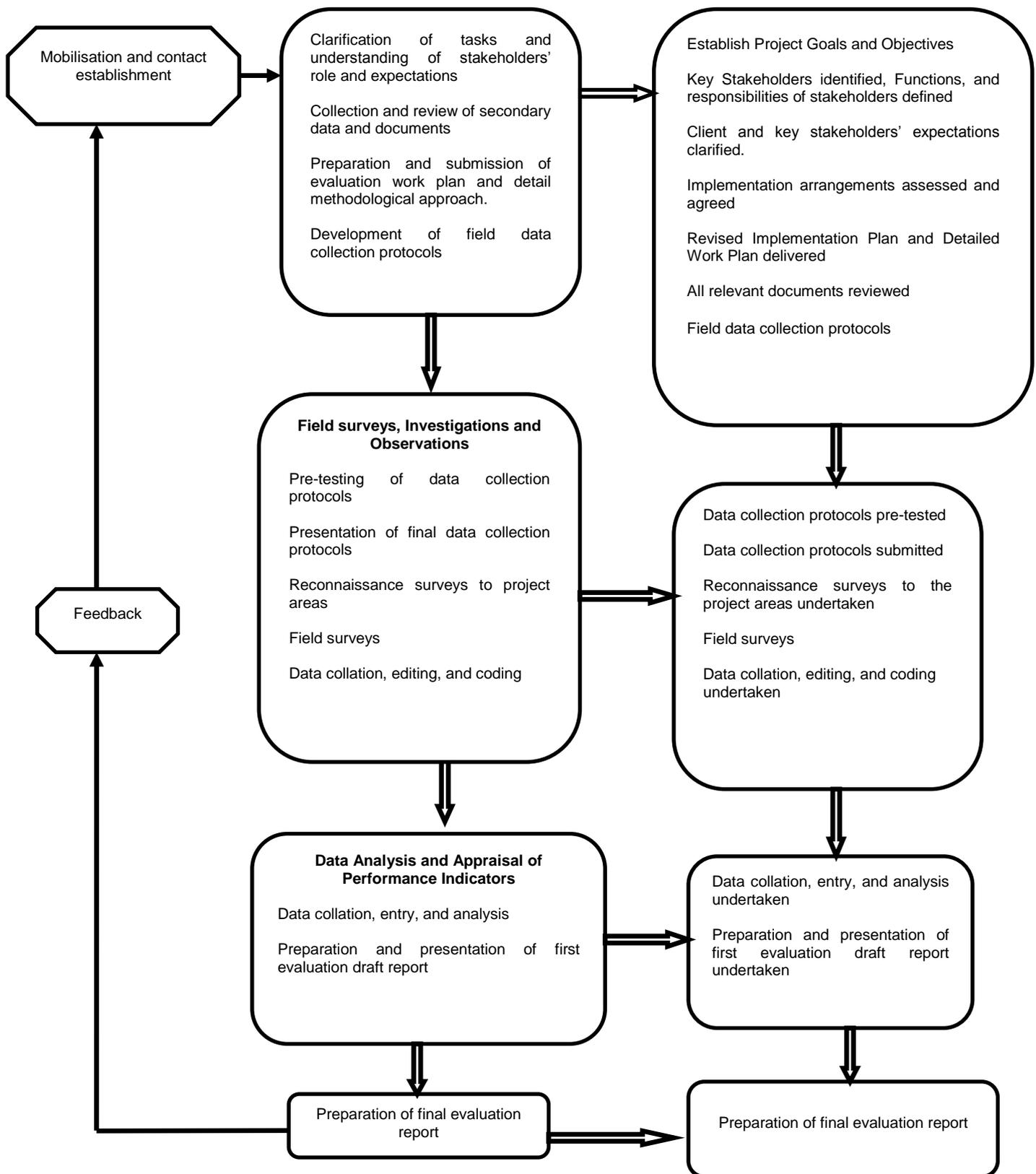
Collection and Review of Relevant Secondary Documents

With the assistance of the Christian Council of Ghana, relevant documents including reports and studies undertaken on the subject matter were collected. These reports included the following:

- i. Project Design;
- ii. Project Indicators;
- iii. Project Implementation Plan;
- iv. DFID Country Assistance Plan;
- v. List of Stakeholders;
- vi. Project Progress Reports; and
- vii. Project Log Frame, among others.

Earlier protocols designed for data collection in similar studies (if any) were reviewed and adopted for the field data collection. This was particularly relevant for the data collection from the various stakeholders such as religious leaders (RLs), other key local influencers (OLKIs such as the traditional leaders and opinion formers, women and youth leaders, teachers, health workers and media practitioners) and PLHIV to challenge HIV-related stigmatization and discrimination. In addition, other field protocols to aid the assessment of the project implementation and management was designed and used.

Figure 1: Proposed Approach and Methodology



Sample Design and Types of Surveys Conducted

In selecting the target group to be interviewed, the following issues were considered:

- i. Diversity in stakeholders in the project areas;
- ii. Differentiation in issues to be investigated;
- iii. Interrelations among issues of concern;
- iv. Consideration of orientation of key stakeholders; and
- v. Need for regular triangulation on emerging issues with the relevant stakeholders in the course of the survey.

This provided the variations in responses and ensured that that the sample considered provided the basis for the effective generalisation and met the study objectives.

Focus Group Discussions

This was done only to a very limited extent at a time with groups because of the danger it could have had in inciting people about the project. The size of the focus groups ranged from a minimum of five (5) people to a maximum of 10 people. This was to enable the Consultant manage the groups effectively as well as help tease out all the relevant information needed to address the study objectives. In all, 71 people were interviewed (see Appendix 1 for details). Pictures 1 to 5 present some of the images of the interviews conducted during the field data collection. The intention was to find out more from them about the effect and impact of the project on their lives and the community in general.

Picture 1: Group of Selected Stakeholders in Ga West



Source: Field Data Collection, 2011

Picture 2: Group of Supported Stakeholders in Ga West



Source: Field Data Collection, 2011

Picture 3: Group of Selected Stakeholders in Dangme West



Source: Field Data Collection, 2011

Picture 4: Group of Selected Stakeholders in Dangme West



Source: Field Data Collection, 2011

Picture 5: Group of Selected Stakeholders in Manya Krobo



Source: Field Data Collection, 2011

Case Studies

In addition to the Focus Group Discussions, individual cases were also documented to provide further details to the issues being discussed. The selection of the cases was done randomly and included teachers, health workers, school pupil/children, religious leaders, and PLHIVs.

Field Data Collection

The Consultant carried out interviews with samples of key respondents to address the main issues of the study using field protocol (see Appendix 2).

Data Processing and Analysis

To the extent possible, data gathered during the field surveys, from secondary sources were processed, and analyzed using simple descriptive inferences. In some cases, simple trends deciphered from the various discussions and available data were made from which appropriate conclusions were drawn. Based on these conclusions, recommendations were made.

Organization of Report

The report is organized under six main sections. Section 1 provides the background information to the study whiles Section 2 presents the objectives of the study. Section 3 discusses the approach and methodology used during the study. Specifically, it discusses the general approach, process used during the stakeholder consultations, the documents reviewed as part of the secondary data collection, sampling method used and the type of surveys conducted. Section 4 presents the discussions on the project overview, which highlight the activities undertaken during the project implementation. Section 5 presents the findings of the study discussed under the broad framework used in the evaluation whiles Section 6 presents the Lessons learnt and conclusion.

PROJECT OVERVIEW

The first two years of project implementation was concentrated on preparing contextualised training materials and commencing the first set of training workshops for stakeholders who were to assist in the implementation. The training materials were intended to increase HIV/AIDS-related knowledge and build anti-Stigmatisation and Discrimination advocacy capacity of Religious Leaders, Other Key Local Influencers, namely traditional leaders and opinion formers, women and youth leaders, teachers, health workers and media practitioners and People Living with HIV and AIDS (PLHIV). These training materials were prepared based on the data gathered during field research in Ghana and reports and publications from secondary sources. The secondary research produced an annotated bibliography, a compendium of training materials and of advocacy resources to combat stigma and discrimination. The field research in Ga West, Manya Krobo and Dangme West districts in Ghana gathered first-hand information from PLHIV, their families,

community members, and other key influencers on stigma and discrimination, and the extent to which socio-cultural and gender inequalities influence and reinforce HIV/AIDS stigma. The last year of the project implementation focussed on the district/community educational and sensitization campaigns using the resource (both material and human) developed and equipped during the first two years.

From the field interviews, it was realised that the following constituted the project activities and outputs:

1. The development of communication and advocacy training materials, which targeted RLs, OLKIs and leaders of PLHIV groups, on HIV/AIDS-related Stigmatization and Discrimination. This was done based on primary research in Ghana as well as secondary research in published sources;
2. The organisation of participatory training workshops held for different categories of primary stakeholders, including RLs, OLKIs and PLHIV groups in each district. The stakeholders were trained to have a better understanding of how stigma fuels the spread of HIV/AIDS and to understand the effects of Stigmatization and Discrimination on the rights of PLHIV. The training workshop was to help the stakeholders gain increased capacity to undertake advocacy actions to fight Stigmatization and Discrimination. This was done using a participatory approach involving RLs, OLKIs, and leaders of PLHIV groups. Communication strategies developed were adapted to the needs of the stakeholder districts and communities. After the training workshop, the stakeholders developed rights-based, gender-sensitive anti- Stigmatization and Discrimination materials such as posters, drama scripts, brochures, and information leaflets;
3. Specific advocacy campaigns were carried out in the respective constituencies of primary stakeholders. HIV/AIDS anti-stigma campaigns using the rights-based advocacy strategies developed took place in churches, women and youth groups, schools, health centres, and communities, and through media activities in the three districts; and
4. Coordinated anti-stigma networks of RLs, community and opinion leaders, women leaders, youth leaders, teachers, media practitioners, health workers and PLHIV groups were formed in each participating district. These networks did implement the different strategies and use the communication tools developed to tackle Stigmatization and Discrimination in their own context.

It was found during the field visits, that the documentation of the lessons, knowledge, best practices, and communication tools developed to be disseminated within Ghana, sub-Saharan Africa and other regions through WACC's global network was underway.

STUDY FINDINGS

Relevance of the Project

A critical look at the project activities and deliverables revealed that the project objectives relate favourably to the Human Resource Development Agenda of the Ghana's development strategy. The Growth and Poverty Reduction Strategy (2006 – 2009) which was in place at the start of the project recognised that the HIV/AIDS pandemic results in loss of productive assets, high treatment costs and the break in the transfer of valuable livelihood knowledge from one generation to the next. In view of this, the Government of Ghana sought to reduce the impact of HIV/AIDS related vulnerability, morbidity, and mortality; and enhance the coordination and management of the national HIV/AIDS response. This was expected to be done through several initiatives of which the promotion of strategies to reduce stigma and discrimination played an integral part. In view of the fact the project seeks to empower beneficiaries and the wider society to help the vulnerable in society by reducing stigmatization and discrimination, it can be argued that this project has contributed in the national development efforts.

In addition, the project has contributed in increasing the right awareness, especially among the PLHIVs. As a result, almost all the PLs interviewed recognised their role in society in spite of their conditions. It was noted that these PLs were willing to help in the national development efforts by serving as peer educators and models of hope to help fight against the spread of the disease.

It was also established that the project directly supports DFID's Ghana CAP and CSCF objectives to halt and reverse the spread of HIV/AIDS, which is the sixth Millennium Development Goal, and contribute towards the reduction of poverty in Ghana. This is very significant because the vicious circle of poverty and HIV/AIDS is an established fact and well documented. It must be observed that not only are the poor and marginalised disproportionately vulnerable to HIV, but their poverty inequalities at every level increases and deepens because of the HIV/AIDS. The epidemic undermines the country's efforts towards poverty reduction and economic growth, thereby reversing the country's progress towards the realisation of the MDGs.

The DFID's Ghana Country Assistance Plan (CAP), which was based on Ghana's Poverty Reduction Strategy (GPRS), recognised the risk that an increasing HIV infection prevalence rate could pose to the country's development process, hence, the support for this initiative. This initiative has thus significantly contributed to halting the spread of HIV among the impoverished communities in Ghana, through the reduction of stigmatization and discrimination.

Project Equity Assessment

Discussions with stakeholders revealed that the project generally was gender sensitive resulting in varied impact on the various segments of society. From the field interviews, it was established that the men in the study districts initially were the most difficult group to convince especially when they were informed that shaking the hands, hugging and eating with the PLHIVs could not exposed them to any risk. The

difficulty encountered was due to the new information that was been disseminated which was different from what they had known all along. Initial campaigns in the districts led the people (especially the males) into believing that eating, hugging, eating and even laughing with an infected person placed them at risk. As a result, they had doubts concerning the message being put forward by the volunteers and because of that had a lot of difficulty accepting them. It must be noted however that the continuous education and campaign by the project implementers has helped to disabuse their minds. This had also led to the gradual change of attitude by some men the study districts. It was found from the representatives of the women group in the Ga West and Dangme West that most men in these areas have started to become more responsible to their wives by stopping their extra marital activities leading to the reduction in the incidence of conflicts between husbands and wives.

The targeting of women groups in the educational campaign was also an important initiative since most women in the study districts were the most vulnerable because of the disease. Discussions with representatives of the women group indicated that some women lost their husbands through death while others found themselves thrown out of their homes after being found to have contracted the disease. They were incidence of rejection of children by husbands of such women leading to increased burden on them. This may partly be due to the fact most people; especially the men saw the contraction of the disease as a sign of unfaithfulness. This was even more difficult for the women when these men had refused to go for the testing to determine their status. The use of the women groups to educate women in general has helped in creating the needed awareness.

The youth in the project districts also played an active role in the educational campaign. This was done through the youth associations where the youth volunteers and other volunteers use their meeting periods to share with them the need to avoid stigmatization and discrimination, especially among the PLHIVs. Children, especially those in the Junior High Schools had the opportunity to learn the ways in which their actions and the actions of others stigmatize PLHIVs. For example in Mount Mary Demonstration Junior High School, this was done using the teaching, learning and playing cards, worship periods and the involvement of the Parent Teachers Associations.

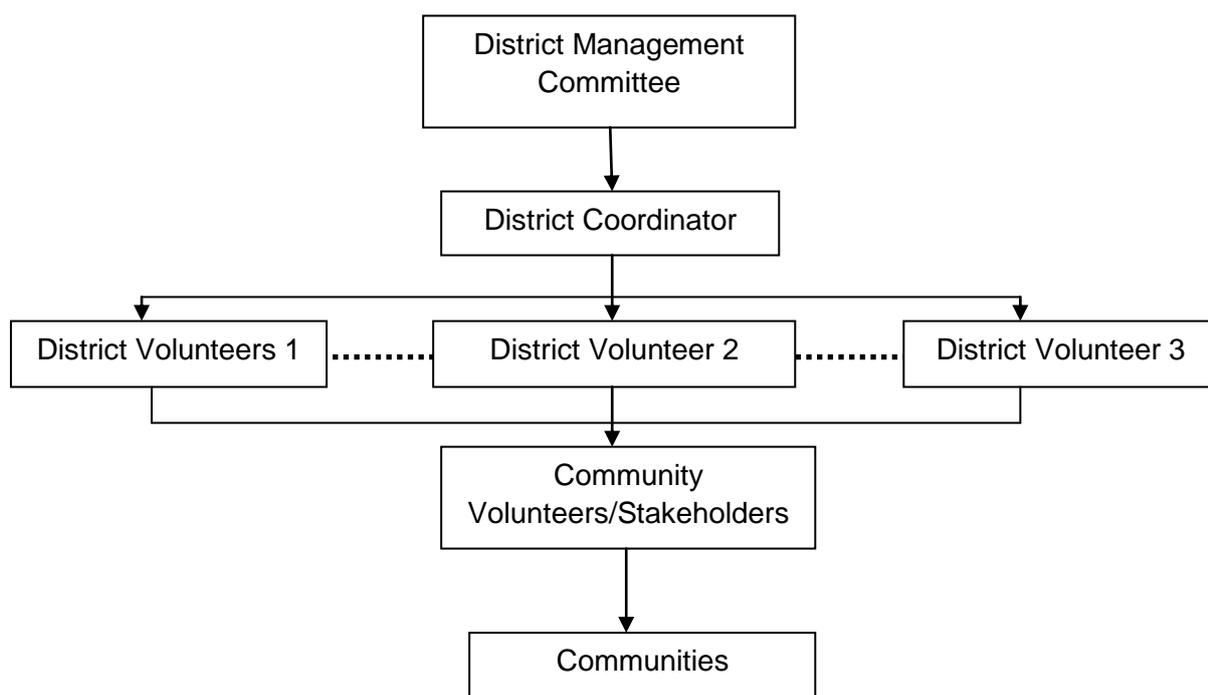
Even though the project largely was gender responsive, there were general concerns raised by stakeholders during the discussions. An example of such concerns was the seemingly neglect in most cases of the distribution of female condoms during the outreach programmes. The general concern among the women was that the condoms distributed were mostly the male condoms and that the female condoms were brought in only during demonstration sessions. This they felt left them out and gave their male counterparts some advantage over them. It must be noted, however, that this was not peculiar to the project but seems to be a general problem in Ghana because these female condoms are very expensive resulting in low patronage.

Efficiency of the Project

The implementation of the project at the three study districts was done within a framework, which sought to establish a partnership and management arrangement among the various stakeholders. Figure 2 presents the framework used in the study districts. From Figure 2, it can be seen that the District Management Committee is the highest decision making body in the districts with an oversight responsibilities on the activities carried out in the districts. This body meets every quarter to discuss the status of implementation and strategize for the next line of action. The committee is made up of leaders of the various groups and stakeholders in the districts. The District Coordinator is the focal person in the project district and serves as a liaison between the CCG and the other stakeholders in the district.

The District Coordinator is supported by three District Volunteers who are usually responsible for the dissemination of information in the sub-district areas. Working closely with the District Volunteers are the Community Volunteers. These volunteers are made of Youth Leaders, Traditional/Opinion Leaders, Religious Leaders, Health Workers, Women Leaders, Teachers, and PLHIV. the volunteers are responsible for the dissemination of information at the community level.

Figure 2 – Management Framework at the District Level



It is worth noting that this framework developed a partnership system, which worked well during the early stages of the project implementation but had some challenges with some of the actors, especially, the community volunteers. For example, it was established there were instances where programme patronage was affected due to clashes with other community activities such as funerals. This led to instances where programmes were postponed as established in the Ga West District.

Another observation was that some community stakeholders decided to become inactive because of the inability to receive any allowance for the work done in the various communities. This led to a few doing the work for the numerous campaign leaders trained as part of the project information dissemination strategy. It was further observed from the field interactions with the PLHIV that some health personnel (nurses) were stigmatizing them and discriminating against them. It was found in all the project districts (Ga West, Manya Krobo and Dangme West) that some health workers usually pass comments or caste insinuations and even shout which seems to offend the PLHIV. For example, a nurse in the Manya Krobo District is reported to have made the following statement to a PLHIV who visited the market with a friend:

'Have you been taking your medication? If you don't take it, please don't come and worry us at the Hospital'.

Even though this statement seems to encourage the PLHIV to take his medication, the facial expression, which accompanied it, sought to create the impression that, the person had a peculiar sickness. This statement among others goes a long way to make the PLHIV's vulnerable and target of discrimination. It must be stated that this phenomenon was observed to be a result of individual differences among the health workers, as this was not the norm. However in the forum created for the health workers and PLHIVs all these issues came up and things had changed.

It was established from the field discussions that the beneficiary stakeholders made up of the PLHIV, the Traditional/Opinion Leaders, Religious Leaders were involved in the entire project implementation phases starting from the sensitization and knowledge building workshops through to the actual field/community outreach programme.

The involvement of these stakeholders at the various stages of the implementation process was quite effective as was observed during the field interactions. For example, it became known that through the involvement of the traditional leaders/opinion leaders, the outreach/community volunteers received good reception at the various communities in the study district. Campaigners were given the opportunity to address the wider community membership during important occasion such as community durbars and festivals. In addition, the use of the PLHIV as model of hope also helped get access to several churches and church groups, which also made the implementation successful.

Effectiveness of the Project

The approaches adopted as part of the project implementation were varied and quite successful. Video shows were one of such approaches. This highlighted actions that contributed stigmatization and discrimination and the need to help avoid the phenomenon. The use of this method was realised from the field discussions to have made great impact as almost every respondent interviewed was very happy about. Respondents could easily tell what the video show was about, the message being conveyed and the scenes.

Floats were another approach adopted during the information dissemination. The floats involved driving through the various communities with the volunteers wearing their T-shirts, carrying banners, posters, fliers, and an accompanying music. During the floats, the public is educated on the basics of managing and preventing HIV infections. This forms part of the Reduce Stigma and Discrimination campaign. In addition, the volunteers still engage in the one-on-one and one-and-household/group bases of our campaign. This was done because it offered the opportunity to get down closer to people and to appeal their conscience while affording them opportunities to ask personal questions. Picture 6 presents some of the scenes taken during such floats. It was however observed from the field visits that the English and the Twi languages were used for the flyers, which made it difficult for some people, especially those who could only read the Dangme. This is in spite of the production of many of the flyers in Ga and Dangme. This probably may be due to the targeting during the distribution activities.

Picture 6 – Volunteers on Float



Source: First Quarter Progress Report, 2011

In addition to the video show and floats, is the use of sports to reach out to the youth in the various districts. Football competition, keep fit activities and other sporting disciplines were used to serve as platforms to get the attention and participation of the youth. Periods within these activities were assigned to the volunteers who used the occasion to educate the youth about the disease and the need to show love and compassion to the vulnerable. Picture 7 presents the youth in the Dangme District who used football as a means of disseminating the message.

Picture 7: Youth Football Competition used to serve as a Platform



Source: First Quarter Progress Report, 2011

Health walks, drama shows, communal labours, and durbars were part of the mass educational campaign used in the study districts. In addition to them, church visits were carried out to solicit the support of both the Christian and the Moslems in the efforts to reduce stigmatization and discrimination. VCT accompanied some of these activities in the study districts.

The use of all the above discussed approaches together helped in the widespread dissemination of the information. Volunteers were equipped through the various approaches to become more confident about the HIV/AIDs and this helped in the delivery of the message.

Impacts of the Project

The project's overall impact has been very encouraging based on the evidence from the field discussions. The first level of impact is the key stakeholders who were directly involved in the project implementation. Volunteers and other stakeholders who participated in the training workshop were equip with several skills, key among them being communication skills, increased knowledge about the mode of transmission of the diseases and appropriate communication tools. These skills empowered the volunteers to go out and make known the message received during the implementation.

Another impact observed during the field studies was the extensive knowledge base of the volunteer and the people interviewed on actions and inactions that contributed stigmatization and discrimination. This was even evident among the school children interviewed. Boxes 1 and 2 present what two school children in the Mount Mary's Junior High School (JHS) learned during the outreach/sensitization programme.

Box 1- Case 1

Stigmatization and discrimination occurs when people are left behind or prevented from expressing themselves because of the HIV/AIDS. This can let such people commit suicide or die early. I know that I can eat with them, shake their hands, and talk to them without contracting the disease. I know that they need our love and support and I am prepared to give them that.

Sackitey Clarence Kuuku, Mount Mary Demonstration JHS

Box 2 – Case 2

I know that in one house there was a sick relative by using a stick to push the bowl to him. He had a separate bowl, cup and spoon and we were told to always ask before we use any cup and bowl with the same colour. This, I have come to realise as stigmatization and discrimination. I now know that stigmatization and discrimination kills hence I joined my friends on a float to the hospital with a placard with the inscription “Stop Stigma”.

Agbadze Peace, Mount Mary Demonstration JHS

Another impact of the project is the willingness of people to offer support to those in difficulty. This was observed in all the study districts. The help extended to the vulnerable included taking them to the hospital, providing food and even seeking support from health personnel. Boxes three and four (3 and 4) present two cases of how people offered assistance to people who were experiencing some difficulties.

Box 3 – Case 3

I was at the beach one morning when I saw a young woman come over. She began removing her clothes and jumped into the sea. She wanted to be healed from a skin disease she was suffering from. I approached her and found out that the family had sacked her from the house because they suspected she was having HIV/AIDS. I went with her to a pharmacy shop, bought her a cream to treat the rashes, and followed it up by taking her home to discuss with the parents, the need to treat her with love. I went back a week later to pick her to the Tema General Hospital for her to undergo Voluntary Counselling and Testing. The result was negative. She is now happy and has joined us in the educational campaign.

Ebenezer Amanor Narh– New Ningo

Box 4 – Case 4

I was passing in front of a house when I saw a woman vomiting. She had lost a lot of weight. I went to her and asked if I could take her to the hospital, which she responded in the affirmative. When we got to the hospital, she was admitted. After a series of counselling, she opted for testing, which showed she had the virus. I encouraged her to take her medication, which she did. She is now doing very well.

Frederick Ayitteh, Nyamesuom Group, Old Ningo

From the project design report, the expected target group were the PLHIV, the youth, children, religious leaders, health personnel, and the wider community members in the project districts. This invariably informed the selection of stakeholders who were to help during the project implementation. Discussions during the field visits revealed that the projects did address the intended targets as outlined in the project design documents. Specifically, the direct beneficiaries of the project include the PLHIV, Children/Youth and those involved in the project implementation namely, the traditional/opinion leaders, religious leaders, women groups, health workers, teachers, etc. these groups benefited from the project through an increased awareness, capacity building, having the courage to undertake VCT, improved social and family interactions, and broader societal cohesion.

Increase VCT is one of the impacts of the project in the study districts. Field discussions revealed that, people are beginning to undertake VCT due to the awareness created by the volunteers. In addition, the use of condoms has been on the increase. For example, in the Dangme West District, 4,320 condoms were distributed between February and March 2011 while 2,440 condoms were distributed in the Ga West District.

The use of PLHIV as model of hope has also resulted in some positive impacts. Evidence from the field indicates that these PLHIVs through the campaigns have established contacts with people who subsequently link them with their family members or friends for education. The results of such linkages have been the saving of people affected by the disease from committing suicide, taking people to the hospitals for VCT and subsequently having access to the ART.

The challenge confronting the PLHIVs in undertaking their duties as model of hope is their inability to provide further support to the sick and the vulnerable due to the lack of funds. It was observed from the discussions with the PLHIVs that most of them are not working even though some visit the clinics to educate pregnant women undergoing antenatal care. An example is a case in the Manya Krobo district where a PLHIV owes a taxi driver GHS 30 for helping him convey a person who was diagnosed with the disease to the hospital. The situation sometimes is very critical that some of the people visited by the PLHIV go without food. This they argue is because they are usually called in when the person involved has spent all his/her resources seeking help from places either than the hospital.

The decrease in the case of self-denial is a major success of the project. According to the PLHIV, people who hitherto refused to accept that they had the disease are gradually changing resulting in them receiving better treatment. This has come about because the rate of stigmatization and discrimination has reduced substantially even though more can be done. The consensus among the PLHIVs is that the rate of stigmatization and discrimination has gone down with the improvement after the implementation pegged at between 60 - 65%.

Project Sustainability

A look at the project design indicates five ways to sustain the project benefit after the project closure. 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 was to ensure buy-in and ownership of the project and was done by the mobilisation of networks and other groups to change social system of attitudes and beliefs that generate stigma against PLHIV and the use of their own financial and human resources. Evidence from the field however indicated that 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 payments or enhanced remunerations even though they saw themselves as volunteers.

The passion, in which this concern was presented in all the project districts if not properly managed as part of the exit strategy, could derail the gains made in these districts if project funding ends. This is in spite of the fact that some allowances meant for transportation were paid to these volunteers during organized workshops or meetings by CCG. This may explain why some of the trained volunteers and campaign leaders have become inactive. The implication of this is that these volunteers may on their own renege on their responsibility to undertake sensitization activities such as church visits and house-to-house and one-on-one contacts. The drive to undertake sensitization activities at the individual level we believe was challenged by this expectation.

The training workshop, which is seen as the key to sustaining this initiative has developed the capacity of the religious leaders and other local key influencers, by equipping them with knowledge, strategies and tools that they will continue to use in their regular course of business, even after the project has ended. This has inculcated the desire to sustain the project into the stakeholders. It was observed from the field interaction that the need to sustain the project benefits is very intense among stakeholders. However, the motivation and resources needed to translate the intents into actions could be a concern if the funding ends. This finding calls for further engagement among the campaign leaders as part of the exit strategy and communication strategy. This will go a long way to help translate the desires and intents of the campaign leaders into actions, which will empower the stakeholders to continue to educate the wider community on the negatives of stigmatization and discrimination.

Exit strategies are crucial to project sustenance as it helps strategize to mitigate failures after the realisation of project objectives and the funding has ended. Even though attempts have been made to share the developed exit strategy with the District management Committees in the respective districts, the broader campaign leaders seem not to have any idea. Interactions from the field visits seem to suggest that there is no clearly understanding of the roles of the campaign leaders after project closure. This may probably be because of the limited information sharing and consensus building between the District Management Committees and the Community Campaign Leaders as to how the project should exit and managed at the end of the funding period. There is the need to expand the dissemination process to include the wider community campaign leaders since they are crucial in sustaining the gains made.

Project Approach worth Replicating

A critical assessment of the study approach revealed quite a high level of success. In the broader efforts of reducing discrimination and stigmatization, the following approaches are worth replicating in other districts of the Country:

- i. The outreach strategies adopted which included the video shows and floats through major streets in the districts and communities;
- ii. The encouragement and use of PLHIV's as model of hope stood out quite well during the entire project implementation. This is due to their role helping reduce self-denials among people and the increase in VCT;
- iii. The targeting of the diverse groups in the implementation activities in the three project districts is worth replicating. The use of the Youth Associations for example has led to high levels of desire which is crucial in sustaining the gains made; and
- iv. The use of the schools, mosques, and churches provide a platform to reach out to different segments of society (children, youth, women, men, Christians, Muslims). The effective collaboration between the District Education Service and the District Health Management was very useful in the implementation process.

LESSONS LEARNT

Several lessons can be learnt from the implementation of the project in the three districts. These lessons are discussed as follows:

- **Ability to change project indicators during project implementation makes for better impact.**

Four other indicators were dropped during the course of implementation because the information was either too personal or data not possible to collect within the scope of this project or there were no statistics available. They include the following:

- i. *Increased number of PLHIV retaining employment, housing and family life within target districts;*
- ii. *Percentage of RLs and OLKIs who don't judge or blame persons with HIV/AIDS for their illness;*
- iii. *Downward trend in family refusal to share objects with HIV+ family members by month 20 and after; and*
- iv. *Upward trend of families who no longer feel ashamed of openly declared relatives by month 20 and after.*

- **There was a need to blend behaviour change projects with economic empowerment especially when the vulnerability of a particular group is established.**

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 (PLHIV's) were not too satisfied with. This is because their involvement in the project as model of hope placed on them other responsibilities, which required finance. The financial support received as part of their outreach activities was inadequate and irregular.

- **An important lesson from the project implementation is the issue of voluntarism.**

The project was designed based on the support of the volunteers who were expected to offer themselves (time and other resources) to help reduce stigmatization and discrimination. However, some consideration be given to these volunteers so that they will work effectively.

- **Stigma comes from fear, insufficient or distorted information. It is of primary importance to know the facts about HIV – transmission, treatment and care.**

The use of the various tools especially the QQR and other innovative ways to explain modes of transmission and address the fears of HIV was one important lesson of the project.

Even though the project had a three (3) year duration, actual community/district outreach was done for one (1) year. This seems not to be enough as the call for an extension of project activities was very intense. Two issues come to play and they are:

- i. There is the need to extent the duration of future BCC Projects, especially those that seeks to influence behaviour as behavioural changes usually take longer time to occur; and
- ii. It is worth ensuring that managers of projects that seek to influence behaviour in the future try to reduce the period of preparation to make enough time for field implementation. Where the design will require more time, it may be useful integrating the field implementation with preparation to same time.

CONCLUSION

The evaluation of the project has highlighted some major success achieved. These include the increasing family and community support for PLHIV, the increased awareness on the part of the PLHIV and the desire of the PLHIVs to support each other. In spite of these gains, there are still some challenges, which need to be address. Some include the role of the volunteers in sustaining the gains after funding has ceased and the fact that behavioural change is a gradual process, which must be sustained. It is therefore 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.

Achievement Rating Scale

- 1 = fully achieved, very few or no shortcomings
- 2 = largely achieved, despite a few shortcomings
- 3 = only partially achieved, benefits and shortcomings finely balanced
- 4 = very limited achievement, extensive shortcomings
- 5 = not achieved

	Achievement Rating for whole project period	Logframe Indicators	Baseline for indicators	Progress against the indicators	Comments on changes over the whole project period, including unintended impacts
Overall Assessment	1				Project has largely achieved the intended purpose and there has been value for money.
<p>Goal:</p> <p>Reduce spread of HIV/AIDS & the suffering it causes in Ghana by contributing to reduction of S&D against PLHIV</p>			<p>National average HIV prevalence rate - 1.7%¹</p> <p>Manya Krobo - 8%. 21% of PLHIV undergoing ART²</p> <p>46% of people in target districts knowledgeable on S&D</p>	<p>92% of PLHIV undergo ART.</p> <p>About 97.2% of target population in the project districts confirmed knowledge about S&D.</p> <p>This has been completed as per the project implementation schedule and has resulted in high-level impacts. But since the issue is attitudinal, the process of reducing stigmatization is still on-going and discussed among stakeholders.</p>	<p>The project has achieved the desired impacts by reducing the incidence of HIV and AIDS related stigmatization and discrimination.</p>

¹ National HIV prevalence & AIDS estimate report 2008-2015, National AIDS Control Program (NACP) Ghana

² ibid.

	Achievement Rating for whole project period	Logframe Indicators	Baseline for indicators	Progress against the indicators	Comments on changes over the whole project period, including unintended impacts
<p>Purpose:</p> <p>Reduce HIV and AIDS related stigmatization and discrimination in three districts of the Greater Accra and Eastern Regions, namely Dangme West, Ga West and Lower Manya Krobo by building the capacity of religious leaders, other key local influencers such as traditional leaders and opinion formers, women and youth leaders, teachers, health workers and media practitioners and PLHIV to challenge HIV-related stigmatization and discrimination.</p>	1	<ul style="list-style-type: none"> i. Reduction in fear of casual HIV transmission & shame/blame judgements against PLHIV; ii. Reduction in stigmatising and discriminatory behaviour by RLs, OLKIs, teachers and health workers within the target districts; iii. Increased # of PLHIV reporting cases of acceptance & reintegration into society iv. Longer-term PLHIV disclosing their HIV-status. v. Increased # of RLs, OLKIs & PLHIV trained understanding and accepting the link between stigma, discrimination and HIV/AIDS and speaking against S&D; vi. Increased # of key influencers expressing accepting attitudes towards PLHIV vii. Improved quality & sensitivity of electronic and print media programmes & reports. 	<p>3.5% of baseline survey respondents afraid of casual transmission</p> <p>47% of baseline survey respondents expressing shame/blame judgements against PLHIV</p> <p>48% of RL, OLKIs, teachers, health worker baseline survey respondents expressing stigmatizing and discriminatory attitudes</p> <p>39% of PLHIV baseline survey respondents expressing societal attitudes towards them that include denial, rejection and abandonment)</p> <p>48% survey respondents PLHIV disclosing HIV status.</p> <p>46% of trainees understand and speak out against S&D.</p> <p>52% of OLKI survey respondents expressing accepting attitudes towards PLHIV</p> <p>Media reports generally insensitive.</p>	<p>1% of respondents afraid of casual transmission</p> <p>2% of respondents expressing shame/blame judgements against PLHIV</p> <p>5% of RL, OLKIs, teachers, health worker respondents expressing stigmatizing and discriminatory attitudes</p> <p>2% of PLHIV respondents expressing societal attitudes towards them that include denial, rejection and abandonment</p> <p>93% survey respondents PLHIV disclosing HIV status.</p> <p>91% of trainees understand and speak out against S&D.</p> <p>93% of OLKI respondents expressing accepting attitudes towards PLHIV</p> <p>Media reports generally sensitive.</p>	<p>The impact observed is intended. This is because project sought to reduce stigmatization and discrimination as well as build capacity to continue to educate stakeholders on the importance of Reduce HIV and AIDS related stigmatization and discrimination in three districts and Ghana as a whole.</p>

<p>Outputs</p> <p>i. 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 & advocacy capacity.</p>	1	<p>Successful field-testing of anti-S&D advocacy capacity-building materials with a sample of each group of RLs, OLKIs & PLHIV by beginning of month 8 and women & youth leaders, health workers & teachers, media practitioners</p>	<p>Not enough training materials in local languages</p>	<p>Enough and use of anti-S&D advocacy capacity-building materials in the educational campaign programmes of stakeholders during project implementation</p>	<p>Some materials were produced in the local languages but evidence from the field indicate they were not enough</p>
<p>ii. RLs, OLKIs & PLHIV in 3 districts have training, commitment, strategies & resources to combat S&D, including self-stigma, in their respective constituencies.</p>	2	<p>75 RLs, 90 community opinion leaders, 540 women leaders, 360 youth leaders, 195 teachers, 90 workers, 75 media practitioners & 180 PLHIV's representatives have new skills and enhanced capacity to develop anti-S&D strategies for use within their constituencies between month 9 and month 20</p> <p>At least 50% of RLs & OLKIs newly invest in openly disclosed PLHIV within 6 months of completed training.</p>	<p>No known persons trained in communities</p> <p>No new investment</p>	<p>536 persons trained with very good knowledge in S&D. All stakeholders interviewed are equipped with knowledge, strategies, and tools to combat S&D and openly talk about the issue.</p> <p>Churches & traditional authorities are now soliciting local financial support for PLHIV</p>	<p>Impacts were generally expected but the issue of motivation of some Community Campaign Leaders seems to be unintended.</p>
<p>iii. People attending churches & mosques, women & youth groups, students, families, community members & media audiences in 3 districts to have greater understanding of HIV/AIDS & adopt accepting attitudes for PLHIV through multi-sectoral rights-based gender sensitive communication advocacy campaigns</p>	2	<ul style="list-style-type: none"> Downward trend in people who report negative attitudes towards PLHIV in churches, mosques and community gatherings by month 18 and after Increasing # of women leaders willing to refer HIV+ women to support groups by month 20 and after Youth groups & students take new initiatives to make HIV+ young people feel welcome in their activities by month 20 and after Media audiences display accepting attitudes towards PLHIV by month 20 and after Churches, Mosques, schools & health centres adopt and implement policies 	<p>65% baseline survey respondents expressing negative attitudes towards PLHIV</p> <p>47% baseline survey respondents who have referred PLHIV to support groups.</p> <p>Zero initiatives</p> <p>38% of PLHIV survey respondents experiencing physical, emotional, psychological violence</p> <p>26% of PLHIV survey respondents who feel they are</p>	<p>5% of respondents expressing negative attitudes towards PLHIV.</p> <p>100% respondents have referred PLHIV to support groups.</p> <p>Youth groups & students take new initiatives such as floats, sporting events, etc. to make HIV+ young people feel welcome in their activities.</p> <p>2% of PLHIV survey respondents experiencing physical, emotional,</p>	<p>No unintended impacts</p>

		<p>to protect PLHIV's rights by month 20 and after</p> <ul style="list-style-type: none"> • Decrease in incidences of violence against & abandonment of HIV+ women and men by month 20 and after; • Reduced S&D and PLHIV treated equally in health care centres by month 20 and after. 	treated equally in health care centres	psychological violence. All PLHIV are treated equally in health care centres.	
iv. 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	<ul style="list-style-type: none"> • Strong, coordinated & functional anti-S&D networks are formed and use best practices and lessons learned by month 12 and after • At least 60% of primary stakeholders agree to carry on anti-S&D advocacy initiatives beyond project life by month 30 and after • At least 70% of all RLs & OLKIs trained in the 3 districts join and work in networks by the end of year 3 	<p>No network in Dangme West; dormant network in Manya Krobo and weak network in Ga West</p> <p>None in networks</p> <p>100% of primary stakeholders affirmed they would participate in the project's advocacy activities.</p>	<p>A strong, coordinated, and functional framework developed to ensure effective implementation even after project closure.</p> <p>At least 80% of primary stakeholders took part in anti-S&D advocacy initiatives and are willing to go beyond project life.</p> <p>At least 85% of all RLs & OLKIs trained in the 3 districts took part in the work. There is even a high desire to sustain the implementation but the lack of motivation and resources may not translate the intents into actions.</p>	Impacts were generally expected but the issue of motivation of some Community Campaign Leaders seems to be unintended.
v. Dissemination / sharing of lessons learned, best practices & communication tools in Ghana, Sub-Saharan Africa & other regions.	2	<ul style="list-style-type: none"> • Primary stakeholders share and implement lessons learned and best practices from month 12+ • By month 30 all EHAIA (Ecumenical HIV&AIDS Initiative in Africa) groups, 	<p>46% speaking out against S&D</p> <p>No information available</p>	<p>91% of respondents speak out & advocate within their communities against S&D</p> <p>Documentation of best</p>	No unintended impacts

		<p>Pan African Christian AIDS Network (PACANET), MAP International, Strategies for Hope Trust and others are aware of the tools and best practices</p> <ul style="list-style-type: none"> • By the end of the project international organisations including the Ecumenical Advocacy Alliance, PANOS, UNAIDS/WHO, International AIDS Society, World AIDS Campaign, Global Network of People Living with HIV/AIDS (GNP+) and others, WACC members and project partners are aware of the availability of the tools and best practices. • More districts adopting and using S&D tools and best practices in Ghana by end of project • Use of tools and best practices in at least other 10 sub-Saharan countries by end of the project • International CSOs, FBOs & development agencies in other regions where WACC is active refer to & use project lessons & best practices 	No information available	practices and lessons is ongoing. Coordinators weekly meeting and the quarterly meetings of District Implementation Committees are undertaken to share experiences and lessons.	
<p>Activities</p> <p>The development of communication and advocacy training materials, which targeted RLs, OLKIs and leaders of PLHIV groups, on HIV/AIDS-related Stigmatization and Discrimination.</p>	<p>This activity was highly relevant as it provided the stakeholders the needed training materials which was to help increase HIV/AIDS-related knowledge and build anti-Stigmatisation and Discrimination advocacy capacity of Religious Leaders, Other Key Local Influencers, such as traditional leaders and opinion formers, women and youth leaders, teachers, health workers and media practitioners and People Living with HIV and AIDS (PLHIV) in the entire project implementation phase. Since the prepared materials were based on the data gathered during field research in Ghana and reports and publications from secondary sources, they provided spot on information, which carried the intended messages really well.</p>				
<p>The organisation of participatory training workshops held for different categories of primary stakeholders, including RLs, OLKIs and PLHIV groups in each district.</p>	<p>Activity ii was also very relevant as it offered stakeholders the platform to be trained have a better understanding of how stigma fuels the spread of HIV/AIDS and to understand the effects of Stigmatization and Discrimination on the rights of PLHIV. It also helped stakeholders gain increased capacity to undertake advocacy actions to fight Stigmatization and Discrimination. And since this was done using a participatory approach which involved RLs, OLKIs, and leaders of PLHIV groups, it impacted positively on the skills and knowledge levels of stakeholders resulting in the development of communication strategies which were responsive to the needs of the stakeholder districts and communities.</p>				

<p>Specific advocacy campaigns carried out in the respective constituencies of primary stakeholders.</p>	<p>The specific advocacy campaign activities were highly relevant as it offered the opportunity to implement the knowledge gained from the training workshops as the materials developed for the sensitization. The implementation of the activities in the respective constituencies of primary stakeholders also helped project managers and other stakeholders to meet the needs of the community. The use of rights-based advocacy strategies in churches, women and youth groups meetings, schools, health centres, communities, and through media activities in the three districts was highly successful.</p>
<p>Formation of a coordinated anti-stigma networks of RLs, community and opinion leaders, women leaders, youth leaders, teachers, media practitioners, health workers and PLHIV groups</p>	<p>Activity iv is highly relevant as it created a partnership that can be sustained after the end of programme implementation. In view of this, it is worth noting that the framework developed for implementation created a partnership system, which worked well during the early stages of the project implementation but had some challenges with some of the actors.</p>

Appendix 1 - List of Interviewers

S/No.	Name	Designation
1	Solomon Tettey-Doe	Support Group
2	Cecilia Welle	Support Group, Baanuye Group
3	Naadu Lartey	Support Group
4	Rabatu Amerdey	Support Group
5	Buawobor Tettey	Atua Youth Association
6	Hon. Joyce Nartey	Korletsom Assembly Member
7	Joyce Amoah	Health Worker, Odumase Health Centre
8	Joyce Adjei	Health Worker, District Health Centre
9	Evans Tamatey	Volunteer
10	Samuel Teye	Member, Atua Youth Association
11	Mensah Henry Angbor	Youth Leader, Odumase Presby
12	Dominic Tekpetey	Teacher, Kpong Methodist JHS
13	Ayertey Seth	Teacher, Nuaso R/C JHS
14	Samuel Akumah Ayermor	Religious Leader, St Paul's Presby Church
15	Florence Aku Tetteh	Women Leader, Nuaso Presby Women Fellowship
16	Regina M Teye	Kodjonye Presby Church
17	Vivian Biotey	Women Leader, Nuaso Presby Women Fellowship
18	Joseph Tawiah Kwao	Health Worker, Atoa District Hospital
19	Theophilus Agbodjalu	Support Group
20	Mary Tetteh	Support Group
21	Rebecca Teye	Support Group
22	Emmanuel Tetteh	Support Group
23	Richard Ketadzo	Religious Leader, Afuaman Apostolic Church
24	Prophet Isaiah Larweh	Chairman, District Council of Churches
25	Shiela Tamatey	Teacher, Mount Mary Demonstration JHS
26	Sackitey Clarence Kuuku	Pupil, Mount Mary Demonstration JHS
27	Nelson Parku	Pupil, Mount Mary Demonstration JHS
28	Agbadza Peace	Pupil, Mount Mary Demonstration JHS
29	Martey Mabel	Pupil, Mount Mary Demonstration JHS
30	Nanor Samuel	Teacher, Ayermesu R/C
31	Vivian Boateng	Women Representative
32	Rose Osieku	Secretary, Pentecost Women Group
33	Kono Taynor	Opinion Leader, Obapa Community
34	Emmanuel Addo	Volunteer
35	Isaac Wayo	Volunteer
36	Shadrach Totimeh	Support Group
37	S. A Addo	Traditional Leader, New Ningo
38	Nicodemus Akornor	Traditional Leader, New Ningo
39	Ebenezer Amanor Narh	Opinion Leader, New Ningo
40	Rebecca Manor	Women's Group, Old Ningo Apostolic Church
41	Jane Cofie	Women's Group, New Ningo Apostolic Church
42	Elder Gabriel Nii Quarshie	Religious Leader, Divine Healers Church, Ayitebuer
43	Richmond Tetteh	Religious Leader, Divine Healers Church, Lotsubuer
44	Cynthia Afedo	Old Ningo Health Centre
45	Rebecca Ocuampa	Prampram Health Centre

46	Thomas Tetteh Dongo	Teacher, Good Shepherd Methodist Basic School
47	Emmanuel Ajapka	New Ningo Youth Association
48	Bernard Addo	New Ningo Youth Association
49	Jonathan Tawia	Old Ningo Youth Association
50	Diana Narh	Member, Support Group
51	Frederick Ayittah	Nyamesuom Group
52	Kokor Agyemang	Nyamesuom Group
53	Kojo Michael	Nyamesuom Group
54	John Allotey	Religious Leader
55	Millicent Lamptey	Methodist Women Fellowship, Nsakina
56	Mary Lamptey	Twelve Apostles, Asuom
57	Margaret Lamptey	Future Leaders, Nsakina
58	Yusif Lamptey	Religious Leader, Ayikai – Doblum Moslem
59	Noi Diana	
60	Theresa Lamptey	Future Leaders, Nsakina
61	Richard Ketadzo	Afuaman Apostolic Church
62	Joseph Ashiequaye	Ghana Mennonite Church, Obenyeyi
63	Noah Ashon Amanor	Ghana Mennonite Church, Obenyeyi
64	Berlinda Kwashie-Odoo	Teacher, Manhean Methodist Primary
65	Evelyn Aryee	
66	Kamal Ibrahim	Teacher, Manhean M/A Junior High
67	Rebecca Tetteh	Afuaman Presby Church
68	Ruben Quartey	Afuaman Apostolic Church
69	Henry Tetteh Amanor	Field Coordinator, Dangme West
70	Richmond Nii Afuah	Field Coordinator, Ga West
71	Getrude Tetteh	Field Coordinator, Manya Krobo

Appendix 2: Evaluation Protocol

“REDUCING HIV&AIDS-RELATED STIGMA AND DISCRIMINATION AMONG VULNERABLE GROUPS: A LOCAL RIGHTS-BASED COMMUNICATION STRATEGY (CSCF0446)

1. Relevance of the Project (**All Stakeholders**)
 - To what extent has the project contributed to rights awareness, in particular the rights of the infected and the affected and what impact has there been?
 - How well did the project relate to Ghana’s poverty reduction plans and DFID’s country assistance plan?
2. Equity Issues (**Project Managers, Women Groups/Representatives**)
 - Has the project actively promoted gender equality? If yes how?
 - What was the impact of the project on men, women and youth
3. Efficiency of the Project (**For Project Managers/Coordinators/Volunteers**)
 - How well did the partnership and management arrangements work and how did they develop over time?
 - How well did the financial systems work?
 - How were the beneficiaries involved?
 - How effective was this involvement?
 - What have been the benefits of or difficulties with this involvement?
 - Were the risks properly identified and well managed?
 - If yes, how?
4. Effectiveness of the Project (**Project Managers**)
 - How effective and appropriate was the project approach?
 - With hindsight, how would CCG and WACC have changed it?
5. Impacts of the Project (**All Stakeholders**)
 - What was the project’s overall impact?
 - How did this impact compare with what was expected?
 - Which Millennium Development Goals did the project contribute to and how?
 - Which of the core CSCF areas did the project contribute to and how?
 - Did the project address the intended target group?
 - If no, why?
 - What was the actual coverage?
 - Who were the direct and indirect/wider beneficiaries of the project?
 - What difference has been made to the lives of those involved in the project?
6. Project Sustainability (**All Stakeholders**)
 - What are the prospects for the benefits of the project being sustained after the funding stops? Did this match the intentions?
 - How has/could collaboration, networking and influencing of opinion support sustainability?
 - How was the exit strategy defined, and how was this managed at the end of the funding period?
7. Project Replicability (**Project Managers/Volunteers/Coordinators**)
 - What aspects of the project are replicable elsewhere?
 - Under what circumstances or contexts will the project be replicated?
8. Lessons Learnt (**Project Managers/Volunteers/Coordinators**)
 - Were there any significant changes in the project design or the project context?
 - If yes, what were the changes?
 - What were the reasons for these and can any useful lessons be learned from this for application elsewhere?

- How did the project engage with poor and marginalised groups and support their empowerment most effectively?
- For whom could these lessons have relevance?
- How do the lessons relate to any innovative aspects of the project that were highlighted in the project proposal?
- How has the design of the project been amended because of lessons learned during implementation?

9. Information, Dissemination, and Networking (***Project managers/Coordinators***)

- Have lessons been shared during the life of the project?
- If yes, with whom, and to what effect?