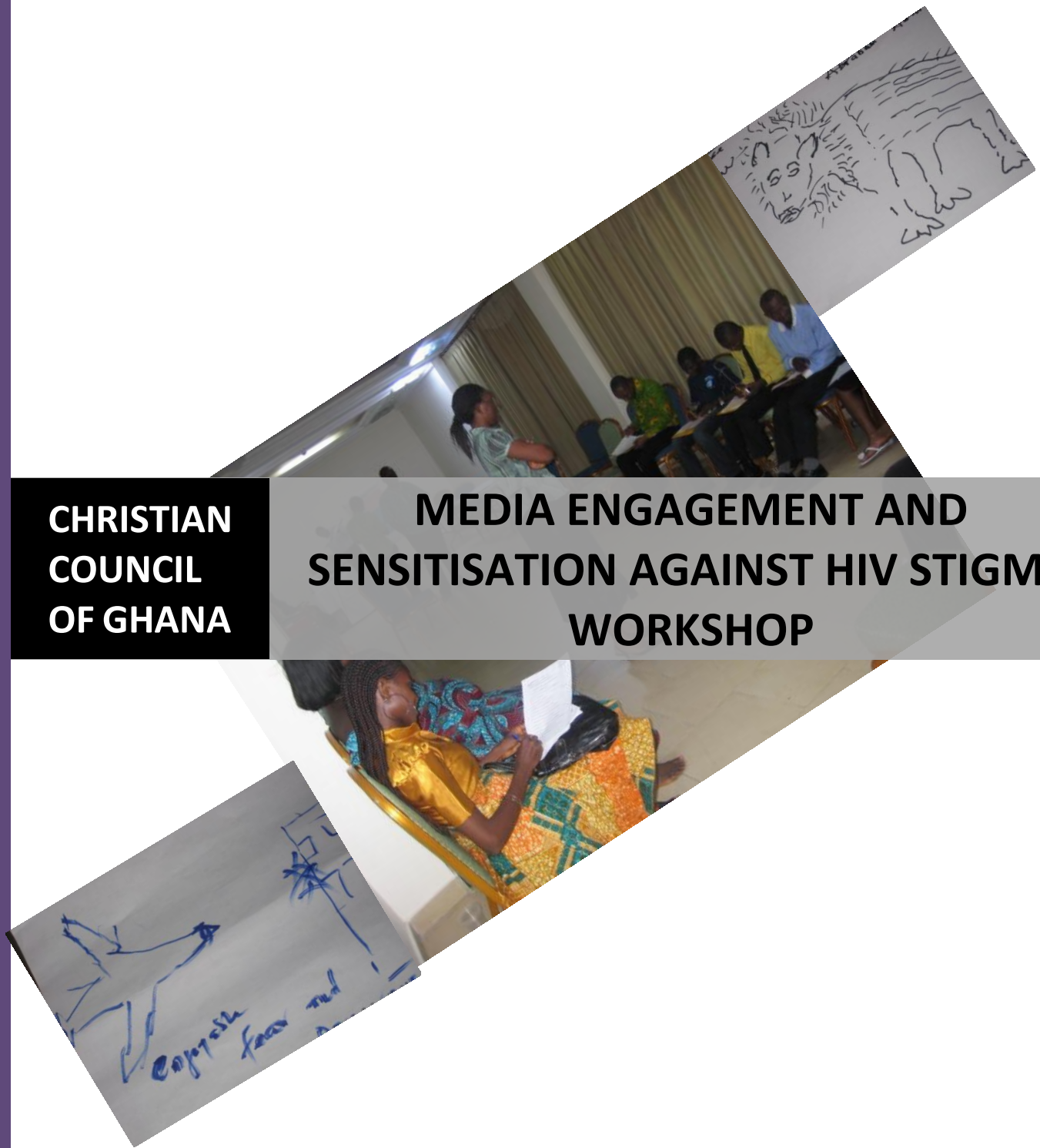
REPORT



CHRISTIAN COUNCIL OF GHANA

MEDIA ENGAGEMENT AND SENSITISATION AGAINST HIV STIGMA WORKSHOP

1.0 INTRODUCTION

1.1 Background CCG HIV Programme

Ghana has experienced a sturdy decline in HIV prevalence rate since 2004; from 3.2 percent in 2004 to 1.9 per cent in 2007 to 1.7 in 2008, indicating a stabilizing condition. However, there is a wide disparity in the rates in specific regions when compared to the national rate: from 1.1 per cent in the Northern Region to 4.2 per cent in the Eastern Region. With the exception of three Regions - Greater Accra, Ashanti and Eastern regions – who have recorded prevalence rates of three per cent and above all the rest have recorded a decrease. Agomanya in the Eastern Region alone recorded the highest with 8.9 per cent from 8.4 per cent in 2006.

The country's response to the HIV and AIDs epidemic is couched in a National Strategic Framework. The framework succinctly identifies discrimination and stigmatisation as a setback to the fight against HIV and AIDS. The Christian Council of Ghana (CCG) as part of its Research Based Advocacy activities is conducting a series of interventions to help improve understanding of HIV and AIDS and enhance communication and advocacy skills of religious leaders, faith-based organisations and other influencers. These (CCG) interventions are intended to build capacities of key animators in the project areas to enable them defend the rights of and facilitate the fight towards elimination of stigma and discrimination against those living with or affected by HIV and AIDS in the project areas, and thereby support efforts to mitigate the HIV and AIDS pandemic and the human suffering it causes. The project areas are Manya Krobo in the Eastern Region, Dangme West and Ga West in the Greater Accra Region.

1.2 Overview of Causes of HIV and Stigma in Project Areas

A baseline study on HIV and AIDS related stigma and discrimination in the three districts (by the CCG), identified **fear** as one of the major conduits to stigma and discrimination. Fear is rooted in the imagery and perceptions that have been conveyed by people and mainly the media. The report iterates that the media often compounds the problem by the "the vague and sometimes conflicting messages (it) conveys...". Majority of the respondents in the study receive their information on HIV and AIDs from the media. The report also highlights the inadequate information people have about HIV and AIDS and how this inadequacy has led to substantial misconceptions about the virus and its consequent misinterpretations on how it is contracted and managed. The study therefore recommended that in general, efforts should be made to mitigate the fears but in particular "the media should do more to reinforce these messages through positive portrayals of people living with HIV and AIDS".

Ghana has a wide range of media and, freedom of expression and media freedom are constitutionally guaranteed. The majority of people in the three project areas have access to radio and TV, although TV access reduces substantially in the most remote areas. Although print

media is within reach, its audience is small, mainly because of the high illiteracy rate in the areas. By far, radio is the most accessible medium in the area. Given its spread and influence, the radio is considerably an important tool in the fight against HIV and AIDS. However, it is hard to characterise HIV and AIDS coverage in the media as it has generally been patchy and mixed. Two general observed shortcomings are:

- The reasons behind stigma and denial have not been systematically examined. Yet stigma is one of the major barriers to dealing with HIV and AIDS. Stigma is a barrier to people going for treatment.

- The media has generally failed to engage adequately with, represent and seek out the views of PLHAs.

1.3 Media Engagement and Sensitisation Workshop on HIV Stigma

The CCG HIV programme seeks to develop and implement a range of communication strategies and processes: from theatre, music, dance, sport, competitions, community radio and TV to sermons, reflections, storytelling and testimonies. Its target beneficiaries are religious leaders, including representatives of the Islamic, Evangelical and Charismatic communities. The targets are trained as animators and challenged to engage in tackling stigma and discrimination. Through workshops they receive training in advocacy and communication, develop greater understanding of stigma and discrimination around HIV and AIDS, particularly with respect to cultural and gender based issues. They are also introduced to theological arguments underpinning the fight against stigma and discrimination and encouraged to develop networks of religious leaders committed to challenging stigma and discrimination. Similar programmes are also developed for the other key influencers. It is within this context and the other concerns raised above that the CCG organised a three day workshop for radio journalists, radio producers and presenters from selected radio stations with coverage in the three districts. The workshop and its output (an advocacy plan) is perceived as a possible means of addressing the issues of concerns raised above.

1.4 Objectives of the workshop

The overall objectives of the workshop include (but not limited to) the following:

- Establish the contribution of the media in HIV Stigmatization
- Set a new agenda for HIV and AIDS education and information dissemination by the media
- Develop a campaign strategy to challenge stigma and assist PLHAs to cope with effects of stigma

- Assist in reducing stigmatization of PLHAs in the three project areas – Ga West, Dangme West and Krobo Oduamse

1.5 Attendance and Participation

Analysis of the media habits and the sources of information for the stakeholders and specific targeted institutions suggest that a comprehensive communication strategy for stigma and discrimination will necessarily involve a few radio stations which have popular listenership in the project areas. Thus, five radio stations were invited – Obonu (Tema), Adom Fm (Tema), Omanye (Ga West) Peace Fm (Accra) Rites Fm (Somanya) and Ada Community Radio (Ada Foah).

Participants were skewed to involve the Station Mangers, Programme Editors, Producers, Reporters and Presenters. In all there were 25 participants comprising thirteen males and twelve females. It is worth noting that the CCG District Coordinators of the project areas, CCG Programme Assistants and representatives of Associations of Persons Living with HIV and AIDS were present. Two representatives of the World Association of Christian Churches visited on the final day of the workshop. See Appendix 1: List of Participants

Participation was very encouraging. Participants were more stable with little interruptions from outsiders.

2.0 Highlights of Interventions

2.1 Introduction to Stigma –Naming the problem

This intervention got participants to:

- identify stigma as a problem
- connect to stigma on a personal emotional level
- describe their own experience of stigma
- Express different types or forms of stigma , causes and effects

Participants were made to own the problem – to recognise that we are all involved in stigmatising people living with HIV and AIDS and that it is not someone else's problem. The intervention started with participant's own experience of and feelings about being stigmatised and stigmatising others. The aim is to get them to connect to the issue on a personal, emotional level rather than a theoretical level (through a definition). Participants were made to see how stigma affects everyone through their own experience of being isolated or excluded – and how it hurts. Participants were also made to understand what stigma means for people:

- What are the forms of stigma? What does it look like – in our attitudes, language and behaviour?
- What are the effects of stigma on individuals, families, communities, people's access to health services, etc?
- What are the root causes of stigma?

Summary of Participants' responses of 'What is Stigma'

- Discriminate
- Condemn
- Regardless
- Go(ing) away from PLWA
- Shun PLWHIV
- Rejection
- Isolating and disassociating due to illness or social status
- Looking down on oneself
- Finger pointing or public labeling
- Bedeviling or bewitching
- To feel better than another
- Associating with negative mind or thought.

2.2 Naming Stigma through Pictures

Participants were also taken through an exercise of naming stigma through pictures. Pictures of general stigma were displayed on the wall and participants, were asked to walk around and make critical observations what was happening in the pictures.

The pictures included:

Picture One: Eviction

A family is being ejected from the home- maybe one is HIV+, landlord doesn't want them in house.

He fears another tenant can get infected and he will be blamed.

Picture Two: Isolation in Bus

Passengers travelling on a bus have decided not sit by a particular passenger because he looks lean and sick. The isolated passenger feels dejected because he has realized that no one wants to sit by him.

Participants were asked to discuss and analyse:

- *What was happening in the picture in relation to stigma*
- *Why did they think it was happening and*
- *Whether this happens in their communities*

The following presents the highlights of participants' analysis

Many Ghanaians portray slim people as PLHAs. However, it is important that a slim person is a slim person, but some illness can drag you down drastically, which enable people to label you as an HIV+ person.

One must not use bad approach in pointing out peoples faults.

The participants expressed that people stigmatize because of Ignorance, Fear, type of language for expression, Culture (dressing), Social status (class of people differ) and Religion. They asserted that stigmatization has been in existence before the coming of HIV.

They identified forms of stigma as Gossip, Name calling, Condemnation, Self stigma, and Stigma by association

They described **discrimination** as a negative reaction triggered by stigma or 'treating a person or group of people differently from others'. For instance PLHA participant shared "I will not go to a place where I am not accepted".

2.3 Experience of Being Stigmatised

As a follow-up exercise to the first one, participants reflected on their own experience of being stigmatised and how it felt. Participants then shared their stories in a plenary.

The following is a summary of the experiences that were shared:

Highlights of Experiences of being stigmatised

A participant shared her story how she arrived home and found her sister in serious pain. She quickly sent her to the hospital. Upon several medical examinations she was diagnosed as having malaria. When treatment started she started developing rushes all over her body with different reactions. She sent her sister (patient) to the village to stay with family members. On a visit one day, she was so surprise to note that she was being accused of as the cause of her sister's ailment. The family members believed that she had performed some rituals with her ailing sister to enable her make some good money. She intimated that she has bearing this stigma for many years now.

Another participant revealed how his father rushed to the school to embarrass him after discovering that he (participant) had not wash his dish bowls. He said that his father brought the unwashed bowls revealing all the traces of left over food to the classroom to chastise him. Even more embarrassing was the fact that the food was a left over from the previous supper. Left over food in his community (called Kosa in the Dangme language) is usually identified with poverty. Compounding the situation even more was the fact that the maize dough used for preparing this particular food was the reject (dough) from the mill.

But now he is a big man now so "shame" is not part of him. In his language, it is expressed as "Inclamazu" meaning "no shame".

2.4 Overview of Media Programmes on HIV and AIDS

Participants discussed in plenary the kinds and trends of HIV programmes on the media and identified stereotypes of stigmatization. This discussion highlighted the media's contribution towards HIV and AIDS stigmatization. Specific strengths as well as weaknesses were brought to the fore.

Table 2 presents the highlights of the discussions:

What Can Be Improved	Areas of Progress
HIV and AIDS is referred to with names, which have somewhat negative connotations e.g. yare kodie wuo a eni yenyina be ko asamandi.	Adom Fm used to produce a Programme on Saturday morning on HIV. It should be continued
The terminology and appellatives used to described the virus incites death.	Host of programme hugs (physically) PLHAs after a radio show
language, structure and forms for which they present HIV and AIDS are often such derogatory.	Adom FM does not use visiting Pastor for its religious programmes. They are all in house and easy to control
Live presentations by pastors on HIV should be monitored because the bulk of misinformation on HIV and AIDS emanate fro these broadcasts.	All representative at the workshop will conduct general briefing for the entire programme staff and share workshop information staff
False claims by radio pastors that they have the prowess to cure HIV and AIDS	Delayed broadcasts was identified as one of the mechanisms that could be used in controlling language embedded with stigmatization
The media seems not to be covering the PLHAS who are relatively in high social statuses e.g. lawyers, doctors, diplomats, ministers etc As such, many people identify the poor and under class as the only HIV carriers	There should be more public education on HIV and AIDS. Radio Station and Media Houses should develop and promote a HIV programme to the level of any entertainment programme. e.g. Valentines day
There are substantial claims by some radio pastors on the local Fm Stations that they hold the gift of healing HIV persons. It was suggested these pastors should be banned.	Omanye FM conducts HIV outreach programme using drarna

An Experience Of Abuse Of PLHA By A Pastor

PLHAs participants cited the use of the airwaves by pastors who claimed they have cure for HIV, makes PHLAs even more vulnerable. In one of the many experiences shared by the PLHAs, they recounted how some colleagues (PLs) went to a prayer camp which claimed it had the panacea to HIV and AIDS. There, they were treated to different concoctions and made to abandon their ARVs. Consciously, one of them noticed that after three days of staying at the camp, he had drastically lost weight, and looked leaner than before so he quickly reverted to the ARVs, unknowingly to the camp managers and his colleagues. His health improved considerably, shortly thereafter. The pastor started claiming credit for the improvement and coerced him (PLHA) to testify on the pastor's radio show but he refused and deserted the camp.

The PLHAs advocated a ban of these charlatans from promoting any prowess in HIV cure.

2.5 Fears about HIV

This intervention helped participants to own or internalise the information and overcome their fears.

This presentation sought intends to:

1. Raise all fears, concerns and questions they have about HIV and AIDS.
2. Assess participants' knowledge level about HIV and AIDS. Find out what they know and don't know, including their beliefs and misconceptions.
3. Provide information geared directly towards their fears and misperceptions about getting HIV through casual contact. Provide information to challenge misperceptions and help participants fully understand HIV transmission and make informed decisions about different risk situations
4. Enable participants to relate their fears to their response to PLHAs
5. establish that key cause of stigma is fear of casual transmission
6. Emphasise common sense/everyday hygiene;
7. establish that key cause of stigma is fear of casual transmission
8. To help people explore all the fears openly and provide clear information about HIV is – and is not transmitted

Discussions on their fears were preceded by an exercise to sketch images, which expressed individual's current impressions of what the HIV and AIDS looks like. The outcome of the exercise is presented below:

2.6 SUMMARY OF HIV and AIDS IMPRESSIONS

A web of Winding Lines

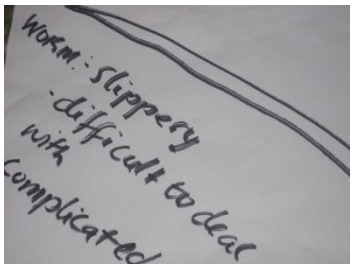
The picture is a web of winding lines whose source or end can not be identified. In essence HIV and AIDS is very confused concept to understand. There is so much information that can not be easily digested. Hence, this creates fear

The LION

HIV is elicits the fear of a wild lion. It is also as fearless as the lion.

Skeletal Body with Skin Diseases

PLHAs have lean skeletal bodies with all kinds of skin diseases



THE WORM

HIV is a slippery worm, difficult to deal with and complicated

An Aeroplane Flight

HIV and AIDS infection is analogous to having a good flight or enjoying life and then a sudden crash.

Skeleton and Hardships

HIV deteriorates and brings hardships on its victims

Skeletal Body

Lean and Skeletal bodies are associated with HIV and AIDS

The DOG

The figure on the right shows a skeletal image of someone suffering from HIV and the right, is an image of a dog, implying that if the right steps are taken the PLHA can live as healthy as a dog.

2.7 Assessing participants knowledge about HIV

Participants were made to discuss in pairs and then write down their points on cards on the different fears they have about HIV. These are some of the fears that the participants listed as to how one can catch HIV through non-sexual (casual) contact:

- Blood transfusion
- Body tattooing
- Kissing deep
- Contamination
- Open wounds
- Blood oath
- Licking
- Cut by sharp edges.

Participants were than asked to nominate the ones they believed did not seem to pose a threat to HIV transmission. This activity evolved into a lot of arguments as participants will try to justify why some non-sexual contact could aid in the transmission of HIV.

2.8 QQR – Quality, quantity, route of transmission

The Participants were informed that for HIV transmission to take place, the quality of the virus must be strong, a large quantity of the virus must be present and there must be a route of transmission into the bloodstream. All of these three things must be present for someone to get infected with HIV.

Quality

For transmission to take place, the quality of the virus must be strong.

- HIV cannot survive outside the human body. It starts to die the moment it is exposed to the air.
- HIV is not an airborne virus.
- There is no risk of transmission in sitting close to or sharing the same room with someone living with HIV.
- If the virus is exposed to heat, (e.g. if someone bleeds into a cooking pot) it will die.
- HIV does not live on the surface of the skin; it lives inside the body. There is no risk from shaking hands or hugging someone. The only place the virus can survive outside the body is in a vacuum (like a syringe) where it is not exposed to air.

Quantity

For transmission to take place there must be enough quantity of the virus to pose a risk.

- The only place that HIV is found in enough quantity is in semen, blood, vaginal fluids and breast milk.
- HIV is not found in sweat or tears.
- HIV can be traced in urine, faeces and saliva in laboratories but there is not enough quantity to pose any risk.
- Kissing, even deep kissing, poses no risk.

Route of transmission

For HIV transmission to take place, the virus must get inside your bloodstream.

- Our body is a closed system.
- HIV cannot pass through skin.
- Even if you have cuts and sores there is no risk for the following reasons:
  - If you have just cut yourself, the blood flows outwards, away from the bloodstream and it is impossible for anything to swim into your body against that flow; cuts do not suck things in.
  - If you touch someone else's cut, their blood will not swim into your bloodstream (and yours will not swim into theirs).

Participants were made to understand that common sense and everyday hygiene meant that many concerns that people worry about would not really happen in everyday life. For example, you would not share a toothbrush if it was covered in blood; you would wash if you cut yourself; you would wear gloves or cover your hands if you were cleaning up someone's diarrhoea.

The presentation emphasised that there must be enough quantity, the quality of the virus must be strong and there must be a route of transmission where the virus gets inside your bloodstream for there to be any risk.

Using QQR, the participants came to understand and agree why there was no risk of transmission by:

- Kissing. Hugging. Mosquitoes. Sharing cups and
- plates. Shaking hands. Giving blood. Sharing toilets.
- Using the same washing water. Going to school

The Quality Quantity Route (QQR) tool was a useful way of giving clear, unambiguous information about transmission.

2.9 Judging Characters

In this intervention participants were made to:

- identify effects of stigma on different players and institutions
- enable participants to discuss the judgments that underlie stigma: i.e. linkages between HIV Sex and morality
- establish the some groups of people get blamed for HIV because of these judgments
- To help people explore attitudes towards sex and morality, and to talk about sex openly and link sex back to pleasure instead of sin

The participants were made to understand some of assumptions often made about other people's behaviour based on their occupation, appearance, and/or perceived sexual behaviour. In making these assumptions participants were made to understand that we often generalise, e.g. saying that all people in a certain occupation are promiscuous. This, of course, is wrong. You may be a female singer, but this does not mean that you are promiscuous.

We stigmatise or condemn people without knowing their actual behaviour. As humans we often believe or assume the worst about other people, e.g. the female singer is assumed to be sexually active because of her occupation, but this assumption may be wrong.

Participants were made to understand that stigmatising others through shame and blame is not acceptable. We are all at risk of getting HIV, so we should stop judging other people. We are all sexual beings. We are all vulnerable. Stop blaming PLHA and help to normalise HIV and AIDS. Get people to regard PLHA as people with an illness, not people with bad behaviour. "Let he who is without sin cast the first stone."

Participants were also revealed to many different kinds of cells in our bodies. One is white blood cells, also known as CD4 cells, which are found in our blood. It was explained that White blood

cells protect our bodies by attacking germs that get into the body, keeping us from staying sick. Thus, once a person becomes infected with HIV, the virus begins to live and spread in white blood cells. HIV attacks and damages the white blood cells so that the blood cells cannot do their work of keeping the body healthy. Germs then take advantage of the weakened immune system and attack the body.

The intervention explained that the weakening of the immune system takes place over a period of time. People who are infected with HIV do not die right away. A person living with HIV often feels perfectly healthy and feels no sign of sickness. But over time the immune system weakens. The body has to work harder to fight off other germs and diseases. As the body gets weaker, it is attacked by different opportunistic infections, or AIDS-related diseases, including TB, pneumonia, bowel infection, cancer and meningitis. When the body is too weak to fight these diseases the person is said to have AIDS, a collection of diseases that attack a person after HIV has made the body weak. When the body becomes weak, the person can die.

Participants were also introduced to HIV Transmission during Childbirth. The intervention explained practices in childbirth that can reduce contact between the baby and the mother's fluids during childbirth. These include women going to the place of delivery early in their labour so that they do not delay breaking the; Health workers trying not to manually rupture the membranes unless birth is imminent and not use forceps or other instruments during delivery unless the baby's life is in danger. It was also explained that practices such as cutting the mother's vagina (episiotomies) should be avoided because they result in heavy bleeding for the mother. Again, then health workers were to routinely wipe out the mother's vagina with antiseptic lotions before delivering the baby. This should be done for all women in labour, whether they are HIV-positive or not.

The presentation further explained that breast milk provides babies with the best nutrition and protection from infection and that all mothers are advised to do exclusive breastfeeding (feeding the baby only breast milk) for the first four to six months. Feeding the baby anything besides breast milk (e.g., cow's milk or other foods) can damage the lining of the baby's gut. If the mother is HIV-positive, the virus can infect the baby through the damaged lining. Babies who receive mixed feeds (mixing formula and breast milk or feeding with breast milk and giving other fluids or solids) are more likely to become HIV-infected than those who receive exclusive breastfeeding or exclusive substitute feeds.

EXERCISE ON JUDGING CHARATERS

A number of character cards showing different types of people - businessman, farmer, tailor, schoolgirl, Housewife - were presented to the participants to explore who they thought was more or less stigmatised and why. This exercise was also used as a basis for creating stories about how different people are affected by HIV. Each participant selected a character and in pairs, discussed the lifestyle of their characters with their partners. They discussed:

1. What the character does for a living?
2. What they perceived as HIV risk status of that character and why

At a plenary, participants introduced their characters, and explained what they do and their perceived health risk- and then placed the picture under certain category – High Risk, Low Risk Other participants were invited to make changes to the characters as well. Through a process of consensus building the following results in Table 3 were arrived

able 3

High Risk	Low Risk	No Risk
		 Begs for money but will given in to any invitation for sex

High Risk	Low Risk	No Risk
		
	Lawyer, young and pretty, Only pretty lady in the community will therefore be attracted to too many men	Nyameye is a Gospel Singer. She barely gets in touch with people expect for handshakes
		
Dealer in Stolen Mobile Phone. Has a lot of girlfriends	This oldman has enjoyable youthful days but he still has a taste for young girls	
		
She is pregnant woman and had unprotected sex. It is therefore believed she HIV +. There is also the fear that she may be infected by the health workers during delivery	Once he gets drunk he goes straight to bed	

High Risk	Low Risk	No Risk

This soldier is often at peace keeping and other armed operations, hence he is not always with spouse

Very busy at work because of the high demand on clothes during the festive season but then when she is free is out there looking for guys

Business woman. Considering her numerous travels she may be promiscuous and has the propensity to be in the high risk group

A businessman who travells a lot and meets a lot people, especially women.

High Risk	Low Risk	No Risk

An International professionsal footballer who tarvels often to play tournaments in foreign countries

Meets a lot people in public places, hence she has a high propensity to be HIV +

Sex worker. Young, attractive and trendy woman and easily attractable

Summary of the Lessons participants shared on the exercise were:

- We often judge people by appearance and not by the facts we know we know of them
- We label people by their appearances
- We judge people through their perceptions and values
- Some professions place you at a higher risk to sex than others. E.g. soldier
- Some participants had to analyse their characters using the QQR tool
- An impression help of a character might not be the same judgement for someone else.

Things people say about some groups of people

The participants were also introduced to an exercise that links name calling to stigma. It helps participants to verbalise the stigma towards different types of people. In this exercise participants express their own stigmatising labels for other groups under the cover of attributing them to 'the people'. So while some of the words are those commonly used by the community, some are the words actually used by participants themselves. The whole point of this exercise was to help the participants to recognise how these words can hurt.

Participants are put into four groups. Everyone is given a group that they belonged to e.g. street child, MSM, sex worker, persons living with HIV, teenage girls, widows etc. Participants stay in the same groups to start the rotational brainstorm. At each flipchart they write down all the 'things people say about that group- name, expressions, beliefs. As a song starts, the groups switched flipcharts until all groups had written on all flipcharts. The results of the exercise are presented in Table 4 below.

What people Say about Teenage Girls	What people say about Sex Workers	What people say about Men Who have Sex with Men	What do people say about people living with HIV
Most teenagers are beautiful • ***They love going for the rich men*** • ***They are sexually active*** • ***Prone to peer pressure*** • ***They most experiment with sex*** • ***Intelligent*** • ***Believed to be wayward and immoral*** • ***They don't respect*** • ***Vulnerable*** • ***Marginalised in decision-making*** • ***Insatiable demand for sex*** • ***Husband snatchers*** • ***Mobo me Ka (Spend –cash- on me)*** • ***Curious and want to know more*** • ***Mewe (I'll chew) chicken ne (and) pizza***	• **They are immoral** • ***They are more prone to HIV*** • ***They are cheap and homeless*** • ***They are sexually Active*** • ***Spread HI Virus*** • ***Poor*** • ***They are shameless*** • ***Sinners*** • ***Unholy*** • ***Kpo kpon don (aka Ashawo)*** • ***Sisters*** • ***Gyantra*** • ***Tutuu*** • ***Ashawo*** • ***Red Light Girls*** • ***People think all Sex*** • ***Workers are HIV positive or wrong*** • ***Many Sex workers*** • ***Aggressive for money***	• **Kojo Besia** • ***Gay. Not fit to live in society*** • ***Homosexuals*** • ***Rock Buttocks*** • ***Trip (Leaking) Anus*** • ***Sodomy.*** • ***Can't walk well.*** • ***Walk like ladies*** • ***Can't sit for long*** • ***Trumu-Trumu*** • ***in Ghana sex is part of the society*** • ***They behave like women*** • ***They are fools*** • ***Sinners*** • ***Not interested in Girls*** • ***Immoral*** • ***Bone to bone instead of flesh to flesh*** • ***Taboo/Cursed*** • ***Impolite*** • ***Unclean/ Punishment from God*** • ***Indiscipline*** • ***Culture breakers*** • ***Unattractive***	• **Prostitutes** • ***We will dying soon*** • ***We are unhealthy*** • ***We spread the virus*** • ***We are cursed by God*** • ***We have a spiritual disease*** • ***We visited La Cote D'ivoire*** • ***We should be isolated and quarantines*** • ***We lead bad lives*** • ***If we are men then we are womanisers*** • ***We are not fit to live in society*** • ***We are cursed*** • ***We are immoral*** • ***We had unprotected sex*** • ***We have many partners*** • ***We will die early We will grow lean***

Table 4

SUMMARY OF LESSONS FROM THE '*Things people say about some groups of people*' EXCERCISE

- Generally the way we think is negative and refuse to see the good sides of anything These are all groups in our communities that we rather need to get closer to them and understand them
- People are socialised or conditioned to judge other people. They judge people based on assumptions about their behaviour.
- Sex is taboo – it is regarded as something shameful that we should not talk about. So people who have lots of sex are assumed to be shameful.
- PLHAs, sex workers, teenage women and MSM are all labelled as sexually immoral and called promiscuous, sinners, irresponsible, AIDS carriers. The judgements in this case are based on sexual morality.
- Categories of stigma – people affected by HIV stigma, e.g. women, sex workers, MSM, are often already stigmatised before they get HIV. They have the least power to resist or challenge stigma.
- These labels show that when people stigmatise people stop dealing with people as human beings – we forget their humanity (by using mocking or belittling words) and this gives us a feeling of power and superiority over them.
- These labels are based on assumptions for which we have insufficient information. They are generalisations that have no validity – we simply assume that 'other people' are dirty, lazy, promiscuous, bad luck, etc.
- We attribute characteristics to a group and everyone who belongs to that group, e.g. all PLHAs are promiscuous.
- Stigmatizing words are strong and insulting – they have tremendous power to hurt, humiliate and destroy people's self-esteem. "When we are shamed and blamed, it is like being stabbed with a knife – it hurts!"
- Why do we condemn some groups and accept others? We are not saying that sex workers are right or wrong. Whether or not you agree with someone, you don't have the right to belittle them. You must look at a person as a human being and empathise as if they are your son or daughter. Put yourself in the shoes of the other person. How would you feel to be called these names? Even if you don't like the person, try to understand them.
- We categorise people and stigmatise them based on nothing factual. We should see how we can change some of these things in order to work with them.

2.10 Using Advocacy to fight HIV Stigma

This intervention was designed to help participants develop practical skills to:

- explain stigma and discrimination simply and clearly
- facilitate discussion on stigma and what to do about it
- advocate for changes in attitudes
- motivate leaders and others to speak out against stigma
- challenge stigma and discrimination in a way that supports change.

As part of getting participants to tackle stigma, it was important to help them build strategies for supporting persons living with HIV and AIDS. PLHAs play an essential role in raising awareness about stigma. Fighting stigma inevitably links up to human rights and fighting to maintain rights is a key element of anti-stigma activities. Thus, participants were taken through an exercise that teases out assertiveness skills to support people to fight for their rights. Participants were taught that being assertive means saying what you think, feel and want in a clear and honest way that is good for yourself as well as for others. It is not being aggressive or showing anger.

Participants were put into two groups and one group was to prepare and hold a press conference to demonstrate how the right of a PLHA is violated and how using assertiveness skills can be used to try to maintain the rights, whilst the other group act as reporters, and journalists.

The issue for the Press Conference

A President of a certain country is a known PLHA. The President has testified publicly to this fact. For almost six months the President has been hospitalised in Saudi Arabia and is receiving treatment for some unknown ailment. Back home there have so many arguments and law suits for the President to step down for fresh elections to be held, because as PLHA he is unfit to rule the country. The very absence of the President for that period of time has created administrative vacuums stalling national policy implementation. The opposition parties are garnering up for major impeachment of the president and have sent a delegation to verify from the hospital in Riyadh, the state of the President. Meanwhile, many ordinary citizens hold the view that the President has brought disgrace to the country by and should resign.

As part of a series of strategies to allay the fears of the citizens that the President is bedridden and can not rule the country any longer, the embassy in Riyadh is holding an international press conference to allay fears of the world in general and citizenry in particular. The press conference was used to demonstrate how the right of the President as a PLHA had been violated and how using assertiveness skills can be used to try to maintain his rights.

Ultimately, the exercise was to demonstrate the extent to which participants can advocate for anti-stigma for PLHAs. They had to (1) Identify the problem; (2) Push the problem for people to understand (3) Design deliberate action for policy change; (4) Speak and act to achieve a certain objective, (5) Lobby people to understand their views; and (6) Speaking out to people on the issues.

Identifying the problem

The Press Conference identified 'Attitudes toward PLHAs' as the issue for the agitation for the removal of the President. This they realised stemmed from incorrect and incomplete knowledge of HIV and AIDS. So the press conference provided a platform for the Minister of Health to give a full brief of the what HIV and AIDS is and the made of transmission using the GGR tool. This was corroborated by representatives of PLHAs who were invited to the forum.

Push the problem for people to understand

The conference was designed to help the media and ultimately the people recognise that everyone has rights regardless of his/her HIV status, and these rights should not be denied just because they have HIV or AIDS. The Conference asserted that Rights go hand in hand with responsibilities, and these too need to be recognised in this debate. They emphasised that Stigma and discrimination lead to the erosion of rights, whether in a family situation, workplace or in the community.

Design deliberate action for policy change

The conference explored the use of assertiveness skills as a tool for protecting rights. The Government Team told the media what they think, feel and want clearly and forcefully. The President's Press Spoken person said, "I feel, think and would like to advocate and lobby for anti-discrimination legislation as soon as possible".

2.11 Developing an Advocacy Campaign Strategy

Advocacy was explained as a systematic and organised effort to change unhelpful laws, policies, practices or behaviour. It is about pleading for or supporting a cause. It is about social change – creating an environment where specific goals can be achieved.

Participants were introduced to the skills needed for advocacy work. These included:

- Plan a campaign that will succeed in changing people's behaviour.
- Tell people what the issue is and make them support you.
- Find others who agree with you and are prepared to back you up.
- Negotiate – deal with the different actors involved in making change.

The intervention also made participants aware the **Ten steps in an advocacy campaign**

1. Clearly state the problem or issue.
2. Develop a goal and a set of objectives.
3. Identify the target audience(s) to engage.
4. Identify groups who are affected by the campaign.
5. Formulate the advocacy message and identify the methods to get the message out to the target audience (e.g. meetings, drama).
6. Prepare a plan of action and schedule of activities.
7. Identify resource requirements (human, organisational, financial).
8. Get support from other key players, e.g. NGOs, government.
9. Identify monitoring and evaluation criteria and indicators.
10. Assess success or failure and determine next steps.

Choosing an issue

Participants were advised to select a specific aspect of stigma that they want to focus on, e.g. stigma towards orphans, or discriminatory practices towards families living with HIV and AIDS. They should further find out:

- Is the issue widely felt; i.e. by many people?
- Is it deeply felt – are people angry, frustrated, etc?
- Will it result in a real improvement in people's lives?
- Can you win on this issue?

Identify and brief key leaders

- Looking for key leaders who will support your campaign and influence others is key to the advocacy plan. Consider what their interest is in the issue. Don't assume that they are opposed. They may already be convinced of the need to address the stigma issue. Find out their ideas about the issue and get them on board.
- The intervention conveyed that in many cases the leaders will not be adequately informed about the issue and the campaign is to explain the issue and its importance clearly and persuasively. Use some of the 'naming the problem' exercises in to help them understand how stigma hurts not only those of us living with HIV, but the whole community. Use words and arguments from their perspective. Put yourself in their shoes, learn as much as possible about their situation, and tailor what you are saying to their own interests and concerns.
- The campaign should create some ownership of the need to change on the part of the leaders. Involve them in thinking through the issue themselves. Get them talking and help them see the issue from their own experience.

2.11 Action Plans Development

This intervention intended to:

- bring together all the things that had been have learnt about stigma, including what can be done practically to change attitudes and behaviour
- build up participants commitment to change things – to stop stigma
- focus on what participants can do to change, as individuals, groups and communities
- agree on goals and how to achieve them.

Participants were also introduced to the Ten [10] steps for moving to action as in Table 5

Table 5 - **Ten steps for moving to action**

STEP	EXAMPLES
Where are you now? Situation analysis	This helps you to look at what is happening at the moment around stigma. You can ask, "How have things been in the past?", "How are they now?" and "Where is the stigma in the community or workplace?"
Where do you want to be? Vision	How would things look if you could really make a difference? Create a vision of the future with reduced stigma.
How will you get there? Activities	What kind of activities can you do to help reduce stigma? Brainstorm all your ideas – practical and new actions to solve the problem.
Where will you start? Prioritise	What are the most feasible actions to start doing? What is the most important action?
What do you need? Resources	Identify any resources, skills or training that will help with your action – and any partners who can assist. Don't stop at this point – don't think you can't do anything because you have no funds.
What might get in the way? Obstacles	Identify any obstacles that might prevent your action from being successful. Try to make plans or strategies to overcome these obstacles.
How will you know that you are successful? Indicators	Decide how you will measure success. Identify indicators or signs that will show you that stigma is reducing (e.g. are more people talking openly about testing HIV positive?).
Action	Start the activities you have planned. Assign tasks to specific people.
Monitoring	Check how you are doing and whether anything is changing.
Re-plan	Make changes to your plans based on what you learn from the monitoring.

At the end of this intervention, all participants were able to:

- develop a specific plan of action for challenging stigma in their community
- make a commitment to identify, understand and challenge stigma.

7.0 CONCLUSION

The training exercises though not yet fully completed has generated a lot of excitement, energy and hope for stakeholders. Participants variously acknowledged the insight and the awareness it has generated amongst both themselves and the PLHAs. One of the outstanding achievements of the process is that it has stimulated stakeholder discussions and a consultative attitude. PLHAs recognise the need to collaborate and work together with media houses as a team rather than as separate entities who occasionally meet.

The challenge now is how to maintain and regularise the things that have been initiated in the campaign strategy. It is hoped that the CCG HIV team which has now been accepted to play a monitoring role would ensure the sustenance of the interest and commitment generated, recognising that the Advocacy Strategy is as important as the HIV anti stigma campaign

APPENDICES

Appendix A-TRAINING WORKSHOP

MEDIA ENGAGEMENT AND SENSITISATION AGAINST HIV STIGMA

Ampoma Tourist Lodge, East Legon, Accra, 9th – 11th Dec. 2009

Objectives:

- Establish the contribution of the media in HIV Stigmatization
- Set a new agenda for HIV and AIDS education and information dissemination by the media
- Develop a campaign strategy to challenge stigma and assist PLHAs to cope with effects of stigma
- Assist in reducing stigmatization of PLHAs in the three project areas – Ga West, Dangme West and Krobo Oduamse

Time	DAY ONE: Wednesday, 9th December, 2009			
	Activity	**Session Detail**	**Outcomes**	**Who?**
08h30	**Arrival and Registration**	▫ Arrivals, hotel registration, & Settling in	Names and designation of participants elicited	CCG[1]/KA[2]
09h00	**Welcome, Opening Ceremony**	▫ Short welcome address and overview CCG HIV programme in the Ga West, Dangme West and Krobo Odumase Districts	Participants gain insight into the overall programme to enable them see the linkages to their expected roles	CCG/JL[3]
09h30	**Introductory Exercises** 1. Participants Self Introduction 2. Expectations/Concerns 3. Objectives of Workshop/ Programme	▫ *Facilitators and participants introduce themselves using Adjectival names* ▫ Elicit participants' expectation and concerns for the workshop using meta-plan technique. ▫ Share workshop objectives / programme and discuss in relation to expectations and concerns	An open and friendly environment created to enhance the sharing of ideas. Participants concerns addressed and clarified Insight into expectations linked to objectives and	KA

[1] Christian Council of Ghana
[2] Kwesi Appiah
[3] Joyce Larko

			clarified.	
10h30	**Comfort Break**	Coffee/Tea		Hotel
11h00	**Introduction to Stigma –**Naming the problem	▫ Facilitators and participants discuss in plenary what stigma is? ▫ Participants put into groups to identify from pictures issues of stigma and brainstorm on ↳ what is happening in the pictures in relation to stigma ↳ Why it is happening ↳ Whether is happens in their work environment/communities Groups make presentations in plenary to firm understanding/lessons	Participants introduced to the basic elements of Stigma Essence and (negative) impact of stigma established. Process shared with participants.	JS[4]/JL
13h00	**LUNCH**			
14h00	**Experience of stigmatization**	▫ Participants think back to a time in their life when they had felt lonely or isolated. After a few minutes they share their experiences in pairs and then return to the large group to share their experience ▫ Facilitator and participants process and discuss experiential lessons from the exercise	Participants' understanding of different types or forms of stigma , causes and effects established/enhanced	JS/JL

[4] Josephine Sackey

15h30	**Overview of Media Programmes on HIV and AIDS**	▫ Facilitators and participants discuss in plenary the trends of HIV programmes in the media and identify stereotypes of stigmatization	Participants establish their contribution towards HIV stigmatization	KA
16h30	**WRAP UP DAY 1**			
	DAY TWO: Thursday, 10th December, 2009			
Time	**Session Title**	**Session Detail**	**Outcome**	**Who?**
8h30	**Recap of Previous Day's Work**	Each participant Shares his/her insights on days activities ↳ What was the most significant lesson from yesterday ↳ What contributed to the your learning ↳ How did you contribute your learning ↳ What worked very well for you ↳ What did not work very well for you	Establish link between previous day and today, and insights into participants learning	KA
9h00	**Image of HIV**	▫ Individual participants to sketch anything (including animals), which portrays their perception of HIV ▫ Individuals make presentations, highlighting why they associate HIV with such an image/drawing Individuals ask questions to process exercise.	Participants understanding and perception of HIV established	KA
10h00	**Comfort Break**			
10h30	**Fears about HIV**	▫ Participants discuss in pairs and then write down points on cards on the different fears they have on HIV. ▫ Participants pick out the cards they believe does not pose any threat to HIV transmission Facilitator introduces the Quality Quantity Route (QQR) of Transmission tool as the handy way of giving clear, unambiguous information about transmission.	▫ Participants' Fears and perceptions on HIV ascertained	JL/JS

13h00	**LUNCH**			
14h00	**Judging Characters**	Each participant selects a character. In pairs, they discuss the lifestyle of the characters with their partners. - What do the characters do for a living? - What is the individual's perceived HIV risk status of this person and why Each participant introduces their character -what they do and their perceived health risk- and then put the picture under category Participants are invited to make changes and explain their positions Facilitator and participants discuss at plenary - Their lessons from the exercise? - How do they/ community perceive or judge high-risk people? What words do they use? What are the attitudes behind the words? - What assumptions do they make about people? - How do they judge/misjudge people?	Participants gain insights into the effects of stigma on different players and institutions	JS/JL
15h30	**Judging Characters** (Cont'd)	Participants are put four groups: street child; sex worker; persons living with HIV; teenage girls. Each group lists all the 'things people say about their group- name, expressions, beliefs. The groups switch their lists until all groups have written/contributed to each list.	Participants gain understanding of the judgments that underlie stigma Participants gain understanding of people's attitudes and linkages towards sex and morality	KA/JL

		At a plenary a member from each group reads out the names/expressions tagged at the categories of people. The facilitator and participants discuss how they feel listening to the words used to describe them.		
16h30	**WRAP UP DAY 2**			
	DAY THREE: Friday, 11th December, 2009			
Time	**Session Title**	**Session detail**		**Who?**
08h30	**Recap of Previous Day's Work**	Each participant Shares his/her insights on days activities - What was the most significant lesson from yesterday - What contributed to the your learning - How did you contribute your learning - What worked very well for you - What did not work very well for you	Establish link between previous day and today. Highlight participants learning.	KA
09h00	**Using Advocacy to fight HIV Stigma** **Basic steps in developing an advocacy campaign strategy**	Facilitators and participants discuss at plenary 'What advocacy is?' - Facilitator introductory input - Individual participants level	Participants introduced to the basic elements in Advocacy Essence and purpose of advocacy established	KA
10h00	**Comfort Break**		Coffee/Tea	
10h30	**Action Plans Development**	Participants break up into 4 groups to design advocacy strategies on HIV stigma	Action plans designed to challenge stigma and assist PLHAs to cope with effects of stigma	KA
13h00	**LUNCH**	13h00 – 14h00		
14h00	**Action Plans Development** (cont'd)	Group presentation and plenary discussion on presentations	Action plans designed to challenge stigma and assist PLHAs to cope with effects of stigma	KA

15h00	**Strategizing for the way forward**	Discussions on action plan implementation, networking, promotion and enhancing advocacy on anti HIV Stigma	Implementation of action plans and way forward established and clarified	KA/JS
16h00	**Refection/Evaluation and Wrap-up**	Participants share their insights, feelings about the Process, Activities and Outcomes	An evaluation of what has been learnt and participants' impressions of how the workshop has proceeded	KA
	DEPARTURE			

Appendix B: Pre/post test Questions

Answer all questions

*From **Questions 1 to 10 Tick** the correct answers.*

1. Which one of the following is **NOT** a feeling associated with stigma?
   A. Fear

   B. Guilt

   C. Love

   D. Shame

2. The HIV can be found in large quantities in the following fluids EXCEPT
   A. Blood

   B. Tears

   C. Semen

   D. Vaginal fluids

3. Which of the under listed can **NOT** destroy the HIV in the body
   A. Bleach

   B. Soap

   C. Water

   D. All of the above

4. Fear can be addressed through:
   A. Distancing or running away from the object of fear

   B. Finding more about the cause of the fear

   C. Getting closer to the object of fear

   D. Stigmatizing

5. You can support a PLHIV by
   A. Assisting with household chores

   B. Providing accommodation for the PLHIV

   C. Spending time with him/her

   D. Doing A, B and C

6. As community workers what will be our role in changing the perception of people who stigmatize?

A. Counseling them on HIV

B. Educating them on good morals

C. Referring them to the pastors

D. Giving them a talk on HIV

7. Which of the following is a way of supporting PLHAs in the church?
   A. Asking them to openly declare that they are HIV positive

   B. Developing a policy document in the church

   C. Encouraging them to live moral lives

   D. Preach that the HIV is a consequence of immorality

8. Which of the following is a better way of presenting information to adults?
   A. Brainstorming

   B. Discussion

   C. Lecturette

   D. Role play

TRUE OR FALSE

From question 11 – 17 indicate whether the statements are true or false by circling the T or F

9. HIV can survive in dried blood at room temperature for six day True**/False**
10. People judge others because it makes them feel better **True/**False
11. If you do not agree to the lifestyle of a commercial sex worker, you should reject her True**/False**
12. Yaa is HIV because she was served some food and water by Shiella a lady who has been confirmed to be HIV positive True**/False**
13. Sex with a condom posses no risk to the user True**/False**
14. Adults learn to fill immediate needs. This is what motivates them to participate in the learning process at any particular time **True/**False

Answer questions 18 to 23

15. What is the difference between HIV and AIDS?

……

……..

16. How long can HIV fight off infections without the help of anti-retroviral?

……

……

17. When do we consider someone to have “AIDS?

……

……

18. What does the antiretroviral medicine do in the body?

……

……

19. Give one biggest fear for disclosing one’s status to his/her partner

……

……

20. How can counseling and testing services prepare people to cope with stigma?

……..

……

APPENDIX C - PHOTO GALLERY