

Stigma and Discrimination of People Living with HIV in Ghana

A Major Challenge in the Fight against AIDS

giz



Painting on Cover:

by Ghanaian artist

WIZ Kudowor

Title: Grey Image in Red Space

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This publication summarizes major results of the survey and provides additional information on stigma towards HIV positive people in Ghana. Special thanks are due to Mrs. Lucy Adoma Yeboah, journalist from the Ghanaian Daily Graphic, for her report on experiences of people living with HIV in Ghana, and to the Society for Women and AIDS in Africa (SWAA Ghana) for facilitating the testimony of a woman living with HIV

Foreword

The Ghana AIDS Commission (GAC) strives to “break the trajectory of HIV through bold actions and smart choices” by adopting an evidence-based and multi-faceted approach. The thrust of our national response to HIV and AIDS therefore relates directly to sources of new infections and how to avert these infections through results-oriented interventions. The National Strategic Plan (NSP) 2011-2015 seeks to prioritize and increase HIV services to those in greatest need. Reducing stigma and discrimination is a critical aspect of our National Response and we must continue to explore varied approaches by which to avert these.

Stigma remains one of the major barriers in the development of effective prevention and care programmes, to prevention of new infections, and to the provision of care and support for people living with HIV and AIDS. Because of stigma, some people refuse to disclose their HIV status while others refuse to get tested in the first place, for fear of testing positive and being rejected by their friends, families and society. Populations most at risk of acquiring HIV and whose behaviours are criminalized, e.g. sex workers (SW), men who have sex with men (MSM) and injecting drug users (IDU), suffer stigma both from without and within their sub groups, and most significantly from health workers who should be the channels for provision of critical prevention and treatment services. If diagnosed HIV positive, these groups face a double jeopardy, thus hindering access to HIV prevention services, treatment, care and support and further fuelling spread of infection.

It is the right of every Ghanaian to enjoy the highest attainable standard of physical and mental health as enshrined in our Constitution. We need to confront viscerally seated norms

and prejudices and remove all impediments to the right to health. Only then will Ghana make significant progress towards attaining universal access, towards achieving the health-related Millennium Development Goals and towards halving all new HIV infections by 2015. The law must work in favour of our HIV response, for which reason the GAC continues to partner with law enforcement agencies and the judiciary on issues of stigma and discrimination against persons living with HIV/AIDS (PLHIV) and most at risk populations (MARPs) which hinder progress. Following GAC's engagement with the Constitutional Review Committee in 2010, it is our hope that the necessary provisions will be made in our constitution for legal reforms; including a specific law against discrimination of all forms and to promote and respect the human rights of all Ghanaians including PLHIV MARPs, and other vulnerable groups.

The Commission fully identifies with the findings of this study and supports their use for further investment in interventions against stigma and discrimination. Once again, GIZ has provided excellent information to guide policy makers, PLHIV civil society organizations, and programme managers in their work. It is my hope that this sets the stage for more focused studies to investigate the concerns of society and stigmatized groups and how to mitigate these concerns. I thank GIZ for their continued support of the national response.

Dr. Angela El-Adas

Director General

Ghana AIDS Commission

Contents

Introduction	7
1.Report: People Living with HIV Tell Their Stories	11
2.Survey: Stigma towards People Most At Risk to Contract HIV	18
2.1 Sample and Data Collection	18
2.2 How many people belong to high risk groups?	21
2.3 Stigmatisation and Social Exclusion	21
2.4 Isolation from the Family	21
2.5 Imprisonment and Legalisation	22
2.6 Access to Resources and Services	22
2.7 Fear of HIV Transmission	23
2.8 Discriminatory Attitudes of Most at Risk Groups	24
2.9 General Trends in Discriminatory Attitudes	27
2.10 Recommendations	28
3. Facts: What Everybody Needs to Know about HIV and AIDS	30
4.Testimony: “My family was already preparing a coffin”	31
5.Examples: Successful Projects Against Stigmatization	33
6.Resources: Where to Get Information and Support	37
6.1 Organisations in Ghana for People Living with HIV	37
6.2 For Further Reading	38
Abbreviations	39

Introduction

HIV in Ghana

According to the National AIDS/STI Control Programme an estimated **267,069 HIV positive people were living in Ghana in 2009**. This figure included 25,666 children. Approximately 20,313 people died of AIDS or infections frequently related to the disease in the same year¹.

Although HIV-infections in Ghana have declined from a **prevalence** of 3.4% in 2004 to **1.5% in 2010**, the epidemic is firmly established within the whole society². Women are more vulnerable to the pandemic than men. There is still a **considerable demand for HIV/AIDS prevention measures** and a need to intensify intervention activities to keep the prevalence in further decline.

Particularly challenging are significantly higher rates of HIV infections in **high risk groups**. For example, studies conducted in the past have shown a considerably higher prevalence among **female sex workers**. Fortunately, prevalence has fallen from higher rates in the past to 25% in this high risk group.³ However, the higher infection rate among sex workers affects clients as well as **non-paying partners** of female sex workers who are at a higher risk of contracting the virus. Research suggests that HIV rates among **male clients** of female sex workers are generally higher compared to the average population. This, in turn, puts sex workers as well as girl friends or wives of clients at a higher risk of getting infected with HIV. With prevalence around 25% **men who have sex with men** (MSM) also constitute a group at higher risk of HIV infection in Ghana.⁴ The situation of **injecting drug users** (IDU) is poorly documented nationally even though they form a further high risk group as well as prisoners who have an HIV infection rate of approximately 5.9%⁵.

A variety of **social and economic factors** increase a person's vulnerability to HIV infections. These include poverty, lack of awareness as well as insufficient access to education, health and other services. These factors engender unsafe behaviour such as unprotected sex with multiple partners which put people at higher risk of becoming infected.

The **stigmatization** of and **discrimination** against HIV positive men and women is another major cause for sustaining the epidemic since it **prevents many people from HIV testing**: Too many people avoid getting to know their status because they are fearful of becoming a victim of the stigma attached to those living with HIV. And if people, who are actually HIV positive, do not know their status, they may continue to engage in risky behaviours, thus passing the virus to their partners. In addition, stigmatization **slows down efforts to protect those who are most at risk to contract the virus** such as sex workers and men having sex with men.

Since 2002, the Ghana AIDS Commission (GAC) has coordinated the implementation of HIV/AIDS prevention and treatment programmes as well as **anti-stigma campaigns**. However, people living with HIV are still being banished from their family, discriminated against in public, and laid off from work.

The **stigmatization of people living with HIV implicitly contributes to the spread of the pandemic**. Many people who discriminate against HIV positive people may not be aware that their attitudes and actions unintentionally play a role in fostering unsafe behaviour among the general population.

1 National AIDS/STI Control Programme Ghana: Annual Report 2009.

2 HIV Sentinel Survey Report 2010.

3 For example HIV prevalence in FSWs in Accra and Kumasi declined from 37.5% in 2006 to 24.5% in 2009, see Clement Ahiadeke, John Anarfi, William Ampofo, Kwesi Addo, Female Sex Workers Behavioural Surveillance Survey in Accra and Kumasi, Ghana: An Evaluation Report, 2010.

4 JEA VCO Associates Ltd Social Development Consultants, A Study on the Gender Dimensions of HIV and AIDS with a Focus on Men in Selected Districts in Ghana, 2010.

5 A.A. Adjey, H.B. Armah, F Gbagbo, Correlates of HIV HBV HCV and Syphilis Infections among Prison Inmates and Officers in Ghana: A Multicentre Study, Accra, University of Ghana Medical School, 2008.

„One of the problems associated with HIV and AIDS in Ghana is the high level of HIV related stigma... This situation directly affects the management of HIV and AIDS and reducing its spread. Stigma presents a significant barrier to accessing care and support services.”

(Preface of the Facilitators' Guide for Training on HIV & AIDS Stigma and Discrimination Reduction, published by the Christian Council of Ghana in 2010, p.iii)



„Since the beginning of the HIV epidemic, public health experts and practitioners have known that stigma, discrimination, and gender inequalities play an enormous role in furthering the spread of HIV”

(Stangl et al: Tackling HIV-Related Stigma and Discrimination in South Asia, a report published by the World Bank in 2010, p. 2)



Aim of this Publication

The publication at hand targets opinion leaders as well as the general public in Ghana. It has several purposes. First, it seeks to provide detailed information on HIV related stigmatisation and discrimination in Ghana. The publication presents results of an empirical study on attitudes towards most at risk populations in the context of HIV. It also gives an insight into the experiences of people living with HIV in the country. Second, the publication aims to replace prejudices with information. Fact based information is presented in order to enhance the public dialogue on HIV-related issues and people most at risk of getting infected with HIV. Third, the document wants to encourage readers to treat people living with HIV in a non-discriminatory way. Last, it advocates for policies which decrease the vulnerability of female sex workers, men having sex with men and injecting drug users towards HIV/AIDS.

In Chapter 1 Lucy Adoma Yeboah, a distinguished journalist from the Ghanaian newspaper 'The Daily Graphic' describes experiences of people living with HIV with stigma and discrimination. She has travelled around the country and asked HIV positive people to tell their stories. Chapter 2 presents results of a survey on stigmatisation towards high risk groups conducted in Tema and Accra in 2009. The study was commissioned by the Regional Coordination Unit for HIV and TB (ReCHT) of the German Development Cooperation in collaboration with the Ghana AIDS Commission (GAC). The results of the survey shed light on discriminatory attitudes and perceptions of the general population towards most at risk groups as well as attitudes and perceptions of the most at risk groups towards other most at risk groups in the context of HIV/AIDS.

In Chapter 3 common misconceptions about HIV/AIDS are compared with evidence based knowledge and facts related to the pandemic. The testimony of a woman living with HIV in Accra is presented in Chapter 4. Chapter 5 gives two examples of projects which used education-entertainment strategies to reduce HIV related stigmatization. Chapter 6 provides readers with further information on organisations and support groups for people living with HIV in Ghana.

The publication is supported by the Ghana AIDS Commission, the German BACKUP Initiative, and the Regional Coordination Unit for HIV & TB of the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ-ReCHT).⁶

GIZ-ReCHT has been involved in activities to combat HIV in Ghana on behalf of the German Federal Ministry for Economic Cooperation and Development (BMZ) since 2006. ReCHT promotes health related workplace programmes in partnership with the private sector (Employee Wellbeing Programmes) and is engaged in the implementation of HIV mainstreaming within the German Development Cooperation. ReCHT also supports prevention and care activities for sex workers and men having sex with men.

6. At the beginning of 2011 the German Technical Cooperation (GTZ), the German Development Service (DED) and Inwent were merged to form the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ).

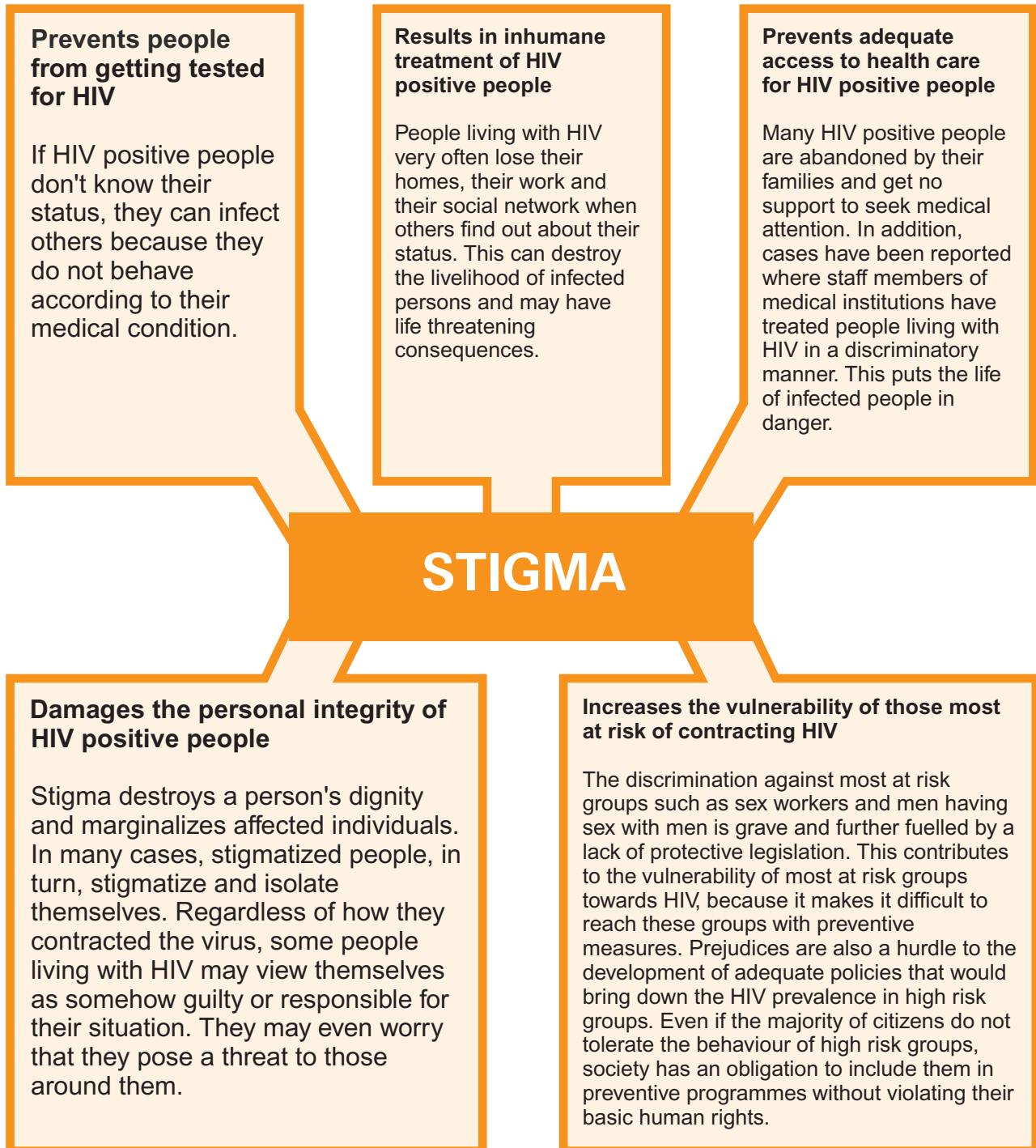
Effects of Stigmatisation

HIV related stigma has many different facets. The two most common misconceptions are:

(1) HIV positive people are visibly sick and pose a risk to anybody around them.

(2) All HIV positive people must have engaged in some kind of immoral behaviour and therefore have to blame themselves for contracting the virus.

These and other wrong beliefs have severe negative effects.



For all these reasons, it is crucial that stigma and discrimination be addressed and minimized in order to win the battle against HIV/AIDS.

1. Report:

People living with HIV tell their stories

If you know someone in your community who is HIV-positive, will you eat from the same bowl as he or she, work together in the same workplace, share the same toilet facilities, board the same bus or send your child to the same school where he or she is?

Without going through any scientific study, one could conveniently conclude that unfortunately many people would say 'No' to these questions. And this would include health professionals and others who are aware of how HIV is contracted, because in spite of their knowledge, they are afraid of having close contact with people infected with the virus.⁷

Susan Timberlake, Senior Advisor on Human Rights and Law for the UNAIDS, plainly declared that "stigma is a matter of attitudes. It only serves to demean other people"⁸. She confirmed that many of the negative behaviours and attitudes were coming from health care provid-

ers including doctors and nurses. But it is also true that sometimes the worst discrimination comes from those who are supposed to love the infected person the most - family members.

"When you are known to have been infected with HIV you are ostracised, gossiped about, denied services, criticised, thrown out of the house, thrown out of marriage, and blamed for bringing disease into the family or into the community; basically you are feared," says Ms Timberlake.

All over the world people living with HIV are discriminated against and stigmatised and Ghana is not different. Interactions with some HIV positive residents at different locations in the country have revealed how stigmatisation affects their lives. As a result, getting in touch with them is sometimes difficult. They need to win your trust before they talk to you.



Girls and boys of Chiuzira Orphan Care perform a dance representing the fight against AIDS stigma and discrimination on World AIDS Day 2010 in Malawi. (Courtesy UNAIDS)

7. Author of this report: Lucy Adoma Yeboah.

8. Orange Magazine, published during the 18th International AIDS Conference in Vienna, Austria, in July 2010.

The fear of knowing

To many HIV positive persons, the biggest fear is how to cope with those who see all HIV-infected persons as people with loose morals. This is grounds enough for many people who are suspected of having the virus to avoid going for testing to know their status. The fear of knowing is compounded by the allegations that some health workers go about telling others about the HIV status of people who access services at the various health facilities. Some people also believe that what one does not know cannot kill them.

Bad treatment from the family

The story of a 28-year-old resident of Koforidua, Maame Serwaa⁹, who tested positive in 2005, summed it all when she said: "If I will die, it will not come from the virus but from the bad treatment from my own family members."

She said she had been forced to leave a family house to move to the other side of the town where she has to pay rent. She currently works as a hairdresser and does all she can to hide her status from her clients and the girls she trains in her hairdressing saloon.

Maame Serwaa said she was not sure how and where she actually contracted the virus but she believed that she might have acquired it when she left home to live with a man who promised to marry her. She told me, that she realised after two years that the man had another girlfriend. So she left him.

She said she suffered frequent ill health only to be told after an HIV test that she had tested positive. "I was devastated at the initial stage and had wanted to commit suicide. Fortunately, a nurse at the hospital who happened to attend the same church as me paid me a visit one day and took me through a lot of counselling. It was

through her that I got to know that my condition could be managed through the use of anti-retroviral drugs."

With tears in her eyes, she told this writer that when her mother heard about her predicament, her mother became depressed and had to be admitted in a hospital for weeks. Her problems began, when people in her family learned about her situation.



HIV counselling and testing.

"At home, in church, at the public standpipe where people in my community gather to fetch water in the morning, I was always the topic for discussion and the most painful aspect of the issue was that they went about it in a way that I actually heard them talking about me. In the long run, I had to leave the family home to rent a place far from my own people", she indicated.

9. For fear of exposing them to stigmatisation, all names of the people living with HIV interviewed in this write-up were changed.

According to Maame Serwaa, shortly after she left home she fell seriously ill and was hospitalised for three weeks. In that condition, she said, apart from her old mother and younger sister, none of her four other siblings nor any of her numerous friends came to see her. She said her heart broke, but at a point in time, she remembered the counselling given to her by the nurse and, therefore, decided to “rise from her sick bed and live again”.

Recovery through medical help

Now on anti-retroviral therapy, Maame Serwaa looks healthy and when I asked her whether she still suffers stigmatisation, she smiled and said, “Not as it used to be. Where I live now, many people do not know my status and the few who knew about it look at me and believe I have been cured.”

Maame Serwaa said she expected society to accept her as any other person who finds herself in 'trouble' through no fault of hers. Regarding the government, she said, a policy should be put in place to protect persons living with HIV from harassment, especially from their own family members.

“There should be an institution where I can walk in to make a complaint if I'm discriminated against. The way things are, anybody can decide to treat you anyhow just because you are HIV-positive. It is not fair”, she stressed.

Travelling for miles to get medication

Joe, a 49-year-old man who had the opportunity to attend the 18th International AIDS Conference in Vienna in 2010, said he had done all he could to prevent his working colleagues from knowing his status. A public servant of many years experience, Joe told me over the phone that the experience of a lady who tested positive years

ago was enough to prevent him from revealing his status in the office. In order to avoid being 'exposed', Joe said he travels tens of kilometres away from where he lives and works to a health care facility for his monthly dose of anti-retroviral therapy.

He said his wife died but because no autopsy was conducted on her, he did not know whether she had the virus. “It was after I tested positive that I suspected that she might have suffered from AIDS”, he pointed out.

For eight years, Joe said he had lived with the virus and done all he could to keep it a secret until a health worker saw him in church one day and told his pastor about it.

“My pastor called me at dawn and demanded to know why I had that problem but had failed to inform him. He talked about it one day in church and though he did not mention my name, I felt bad and decided never to go to church again. What forced me to take that decision was that the next time I saw the pastor in my neighbourhood, he pretended not to have seen me, just to avoid a handshake from me,” he lamented.

Joe would want to plead with others who had not gathered the courage to go for a test and think that they do not have the virus, to respect HIV positive people and support them to manage their situation. He also appealed for free ARTs to enable all who need them to have access to them without any hindrance.

Joe told me: “Although we pay only GH¢5 for the monthly supply, if one is not working, that amount can be a problem and, therefore, stop one from going for his or her supply. If that happens, you can imagine what would happen.”

Baaba lost her husband and was stigmatised

Baaba said she was thrown out of her marital home when her husband, who also had the virus, died. She was accused of spiritually infecting the man with the virus and chased out of the town after the husband's death. Her schedule as a teacher was also changed to an administrative one, when her headteacher got to know of her status.

She was lucky to have been employed by the government since she could not be dismissed but the treatment from her superiors sometimes makes it hard for her to concentrate on her work.

"Everywhere I go, my colleagues look at me as if I could infect them with the virus by merely getting close to them. I cannot go to the canteen nor do I feel comfortable in the common room where we relax during break. Apart from one male teacher who usually comes to me, almost all the eight staff members stay away from me. I am thinking of applying for a transfer to a place where I can, at least, have my peace to work for a living", she stated.

Baaba believes people should understand that an HIV infection is like any disease which could infect anybody. She expects people to treat people living with HIV humanely and not discriminate against them.

The case of a young orphan

Fiifi, a 14-year-old boy at Kasoa in the Central Region belongs to a support group for HIV positive persons which his mother joined before she died three years ago. Though he did not seem to understand the issues involved, he was old enough to know that many people do not like his company just because his mother died of AIDS.

"When mother died I did not know what was wrong with her, but an auntie of mine who attended her funeral told her friend to my hearing that my mother had AIDS. I was scared and run away from home and it was the pastor who found me and brought me back home", he said.



Playground in Accra

Fiifi said the same pastor helped him to gain admission into a different school since pupils in his former school made things difficult for him. Although Fiifi is not HIV-positive, the fact that his mother was, was grounds enough for people to discriminate against him.

Speaking to this writer in the company of his grandmother, Fiifi said anytime he is playing with his friends on a field close to his house, their mothers would call and ask them to return home.

"Last Sunday when I was playing football with my friends on the school field, one woman came, insulted her son and asked him whether she had not told him not to play with me. Immediately the woman came around, all the boys stopped playing the game and left", he said with tears in his eyes.

When I asked why he thinks people treat him like that, Fiifi said “they have been saying that my mother died of AIDS and so I also have AIDS. I know I don't have AIDS because the doctor tested me when I fell ill and said I didn't have it”, said Fiifi.

Young Fiifi said he would appreciate it, if mothers in his community would accept him as one of their own and allow him to mingle with their children. He was, however, grateful to the pastor who, he said, provides him with most of his basic needs and added: “If everybody in this town will treat me like the 'Osofo' and his wife, life will be OK for me. People don't like me. I want to leave this place but I have nowhere to go”.

The situation of most at-risk groups

Just like in many other parts of the world, HIV related stigmatisation is even more serious in Ghana when it comes to members of groups that have a higher risk of getting infected with HIV such as men having sex with men and female sex workers. A 2009 UNAIDS report indicated that in Ghana more than 40 % of HIV infections occur through sex work, men having sex with men and injecting drug users, but only 0.24% of the national budget meant for the prevention of HIV is given to these groups. This shows that the most at risk populations are not being targeted appropriately by the existing measures. Very often, these groups are considered by Ghanaian society as “intentionally going out of their way to look for the virus by their activities”, a statement that makes the discrimination against members of these groups obvious.

Newton's whole world collapsed

As I went into town with the idea of talking to Newton, who said he discovered his homosexuality at the age of 16, I was not sure, if he would

want to share his experiences with me. I knew how difficult it would be for any person to openly admit that he or she is in a same-sex relationship because of the strong stigmatization of homosexuality in Ghana. I was introduced to Newton by a medical practitioner who is treating him and who had to convince him beyond all doubt that his identity would not be made public.

Newton said he got to know of his HIV-positive status when he applied to join a security agency and had to go for the test. He said his application was turned down and he was advised to seek medical care. “My whole world collapsed in front of me. I nearly committed suicide but later had the courage to live so I went on with my life as if nothing has happened”, he told me.

Newton said he realised his sexual preferences when he was 16 years old and in a senior high school which was a boys' school in Cape Coast. He said he had his first sexual experience with one of his seniors in school whom he shared a bed with during an athletics camp meeting organised by his school. The boys started a relationship after that. The senior, whose parents were rich, even invited him to his home during holidays.

Even though at one point Newton tried having relationships with girls due to societal pressure, he realised that that was not his nature. Newton has a male partner and has been in a relationship with him for the past five years. “The two of us belong to an all-male support group which teaches us to practise safe sex and how to take care of ourselves,” he told me.

At 28 years and unemployed, Newton relies on his mother for his basic needs. He indicated that even she did not know of his sexual preferences. According to him, a sister who sus-

pected him could not convince their mother to believe her. Fortunately for him, the sister travelled and now he is free and does not face any interference from anybody.

His main problem as a man having sex with men is how his parents, whose religious beliefs strongly oppose homosexuality, would take it when they find out about his HIV status. This puts a lot of pressure on him; his wish to please is so strong, that he sometimes wishes he could act against his nature.

Newton experienced stigmatisation even at health facilities. He said he once went to a hospital with the hope of getting professional help for his ill health. When he told the doctor about his sexual practices, the doctor asked him to leave. "He screamed at me and called a security man to force me out after I insisted that he should take care of me."

Newton finds it difficult to understand why people cannot just accept the fact that individuals have different sexual preferences, and allow men having sex with men to live their lives the way they want to. Newton advocated the establishment of a special medical centre for gay men so that they could comfortably go there for treatment and counselling.

"I am looking ahead to the day when people will accept us as we are and stop the stigmatisation. The case of people like me is even more serious because we are HIV positive. Life can sometimes be really, really terrible." Newton said his only friend and true family is his partner who he can share everything with.

Support MSM to practice safe sex

Ali, a 32-year-old man who is HIV positive said he used to sell kebab in front of a drinking spot in Accra but is currently unemployed. He lost his job because his landlord, who happened to know his status, had a problem with him and rushed to inform the owner of the spot to drive him out of the place. Now he is living in an uncompleted building as a caretaker and looks unwell.

Ali said he had never been attracted to a woman. He discovered his sexual preferences when he travelled to Abidjan where he was befriended by a man. He said he lived with the man for six months and returned to Ghana where he continued to have sexual relationships with other men.

Now HIV-positive, Ali said that he would not have contracted the virus, if he had gotten the correct information on how to practise safe sex. He is asking for the recognition for MSMs and said the Ghana AIDS Commission should take the necessary steps to reach this group and offer them the needed help. He also called for free ARTs and condoms to be given to MSMs to ensure that they practise safe sex.

Gina

Gina, who cried throughout the interview, said she started working in the sex trade after her former employers in a town in the Northern Region terminated her appointment as an attendant in a nursery school after it became known that she was HIV positive. She travelled to Accra and later joined some friends who introduced her to the sex trade to enable her to earn a living.

When asked how she got the virus, she said she is not sure but suspected an expatriate she once had an affair with. She said the man worked briefly as the head of an international non-governmental organisation (NGO). She added that at a point in time, the man got very sick and was taken back to his home country. "I never felt comfortable after I saw the condition of the man. He showed all the signs of an AIDS patient. For months I could not eat nor sleep. I got over it later but when I fell sick and was told I had the virus, though he was not the only man I had ever slept with, I knew he was responsible for my predicament."

Gina said her situation became worse when her employers got to know of her situation and asked her to leave the school. On the day that she was asked to leave, her closest friend could not come near, but had to stand at a distance to bid her goodbye. "That was the first time I really realised how hurtful stigmatisation could be. I felt bad and wept for days", she said.

Within a few days, she said many in the town got to know of her situation and virtually shunned her company. She said she was fortunate that the place was not her hometown but her workplace. After some time she used the little money she had to travel to Accra, with the hope of securing a job. After trying hard to find a job without success, Gina said she decided "to try her luck with men" which yielded some result.

After having worked for nine years with a good salary, Gina never thought she would be a sex worker until she found herself face to face with what she described as "naked poverty". For three years she has been earning her living as a sex worker and that is how she finances her medicine, food, clothing, and her rent.

She occasionally sends money home to her old mother who is not aware that she has the virus. "I cannot tell my mother about my HIV status. I look fine and there is no way I will tell her. My mother has a weak heart and she will die of heart attack if she knows", Gina said with pain in her eyes. "I'm afraid to go for another job where I will be forced to leave. I can't go through another trauma of being called names. I will continue with what I'm doing now."

At the age of 27, Gina said she would want to get married, have children and live in a home full of love. "Now that I'm on medication, I know I can have a baby without infecting her and also my partner will be free from the danger of being infected. All that I need is a man who will love me even with my status as an HIVinfected person", Gina said.

2. Survey:

Stigma towards People Most At Risk to Contract HIV

The stigmatization of groups most at risk of contracting HIV¹⁰ increases their vulnerability to HIV infections. In Ghana, sex work, homosexuality and drug use are illegal. In addition, people belonging to high risk groups such as female sex workers and men having sex with men are subject to human rights violations and aggression.

Before the onset of the HIV epidemic these groups were already victims of stigma and discrimination. The pre-existing stigma is compounded by the HIV-related stigma. However, little is known on how widespread prejudices of the general public against high risk groups are and on the issues the population resents most in the context of HIV

Therefore GIZ ReCHT in collaboration with the Ghana AIDS Commission commissioned a survey¹¹ in 2009 to provide an overview of the attitudes and perceptions of the general population towards high risk groups as well as on attitudes and perceptions of high risk groups towards themselves and other high risk groups in the context of HIV. The aim was to aid projects in planning and streamlining interventions for most at risk groups. This chapter presents a summary of the major results of the survey.¹²

2.1 Sample and Data Collection

The research was divided in two parts. The first part was a survey of the general population to elicit their views on most at risk groups in the context of HIV and AIDS. Most at risk groups include female sex workers (FSW), non-paying partners of sex workers (Non-PP), men who have sex with men (MSM), and injecting drug users (IDU). The second part was a survey

among high risk groups to find out their views on other high risk groups as well as their own groups.

The general population survey comprised adult males and females recruited at random in 24 churches, 16 mosques and 19 markets as well as personnel from 10 police stations located in Accra. All age groups were represented in the survey (age groups: less than 25 years, 25 to 29 years, 30 to 39 years, 40 to 49 years, 50 to 59 years, above 60 years). 46.2% of the participants in the survey were women (among the participating police personnel 43.2% were female).

The respondents formed a representative cross section of the general population with regard to religion and ethnicity. However, the 40 to 49 years age group was slightly underrepresented.

Definitions

Stigma can be described as a dynamic process of devaluation that 'significantly discredits' an individual in the eyes of others. HIV-related stigma towards most at risk groups is multi-layered and reinforces negative connotations through its association with HIV and AIDS with already-marginalized behaviours, such as sex work, drug use, and homosexual and transgender sexual practices.

Discrimination refers to any form of arbitrary distinction, exclusion, or restriction affecting a person, by virtue of inherent personal characteristics or perceived belonging to a particular group.

HIV/AIDS-related stigma and discrimination occur at various levels, for example in family and community settings or in institutional settings such as workplaces and health-care services.

10. In order to make this publication more accessible to non-specialists, abbreviations are avoided as much as possible.

Therefore, the technical term Most at Risk Populations (MARPs) is used only sparingly.

11. Nzambi, Khonde, Martin Bevalot, Holger Till, Agnes Dzokoto (2009) Study on Stigma and Discriminatory Attitudes and Perceptions in Accra and Tema Metropolis – How Does the General Adult Population See Most At Risk Populations and How Do Most At Risk Populations See Themselves in the Context of HIV/AIDS?, published by GTZ ReCHT Accra, August.

12. The research was funded by the German BACKUP Initiative and carried out in collaboration with the West Africa Project to combat AIDS and STI (WAPCAS), an NGO which provides clinical and preventive services for sex workers, their clients, and men having sex with men.

About 70% of the respondents were Christians and 24% were Muslims, while other religions formed about 6%. 70.6% of the people interviewed had secondary level or higher level education. Therefore, the level of education among those who participated in the general survey was higher than the average level of education in Ghana. More than half of the respondents had attended at least one HIV information session.

A total of 4,689 respondents were recruited for the study from the general population as well as 200 respondents from the police service. High risk group respondents comprised 606 female sex workers, 200 non-paying partners, and 200 men having sex with men.

indicate that contrary to the taboo surrounding these groups in public debates, high risk groups have a significant presence in Ghana.

Approximately half of the participants of the survey including the police personnel knew someone who is a female sex worker. About one third of the general population and the police personnel

knew somebody who is a man having sex with men.

The snowball technique and convenience sampling¹³ were used as sampling techniques to identify sex workers, their non-paying partners, and men having sex with men in the Accra and Tema area. The participating sex workers included women working in settlements (seaters) as well as women operating from informal prostitution sites (roamers). Due to the limitations of the sampling techniques, the findings from the survey are not representative of all sex workers, their non-paying partners and men having sex with men in Accra. Nevertheless, these techniques were used because of the challenges involved surveying 'hard to reach populations', given the illegal nature of female prostitution and of homosexuality in Ghana.

In contrast, injecting drug users appear to be less common in Ghana. Less than one third of the respondents from the general population knew someone who injects drugs. Three to six out of ten respondents from the different high risk groups interviewed in this survey knew someone who injects drugs. Assuming that each of those people knows only one injecting drug user different from the others, the minimum number of them will be at least 300. This population appears to be small. However, efforts must be made to provide them with HIV/AIDS control services because their behaviour may put them at a higher risk of contracting HIV.

Interviews were conducted using a structured questionnaire. Data was collected between November 2008 and January 2009 in Accra and Tema. Social workers and peer educators from the West Africa Project to Combat AIDS and STI (WAPCAS) and the Centre for the Protection of Human Rights in Ghana (CEPEHRG) were trained as field workers for data collection.

2.2 How many people belong to high risk groups?

Since sex work, homosexuality and drug use are illegal in Ghana, it is difficult to obtain verified information on the number of people belonging to these groups. However, results of the survey

13. Convenience sampling means that the sample of a survey is being selected through 'convenient methods' such as going to places where interviewees can be met or through the internet or phone. Snowball sampling is a similar technique, where existing respondents are used to recruit more respondents into the sample. Both techniques do not aim to create samples which are representative of the target group that is being researched. They are often used to carry out pilot studies or to reach 'hard to reach' populations.

Indicators to Assess HIV related Stigma

Fear

Fear of HIV transmission through day-to-day contact can be assessed by asking whether individuals fear contracting HIV in the following situations:

- If they touch the saliva of a person living with HIV or AIDS
- If they touch the sweat of a person living with HIV or AIDS
- If they eat food prepared by a person living with HIV or AIDS.

In addition, fear of HIV transmission to a child can be assessed by asking whether individuals fear their child would become infected with HIV from playing with a child who has HIV or AIDS.

Shame and Blame

Stigma and discrimination based on shame, blame, and judgment can be determined by assessing agreement with the following statements:

Shame

- People with HIV or AIDS should be ashamed of themselves.
- I would be ashamed if someone in my family had HIV or AIDS.

Blame and judgment

- It is women prostitutes who spread HIV in our community.
- HIV is a punishment for bad behavior.
- People living with HIV or AIDS are promiscuous.
- HIV is a punishment from God.

Discrimination (Enacted Stigma)

The level of discrimination can be assessed by asking people whether they are aware of or have seen incidents during which a person living with HIV or AIDS experienced the following:

Isolation (including physical and social exclusion)

- Being excluded from a social gathering
- Being abandoned by a partner
- Being abandoned or sent away by family members

Verbal stigma

- Being teased, insulted, or sworn at
- Being gossiped about

Loss of identity or role

- Losing respect or standing within the family, the community, or both

Loss of access to resources or services

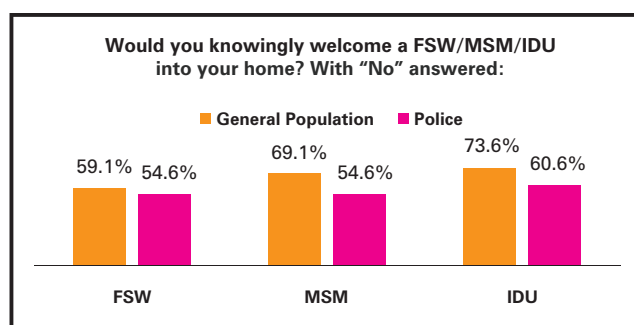
- Losing customers or a job
- Having property taken away
- Being denied health care services, social services, or education

Source: Stangl et al 2010 (pp. 32-33) and UNAIDS 2007.

2.3 Stigmatisation and Social Exclusion

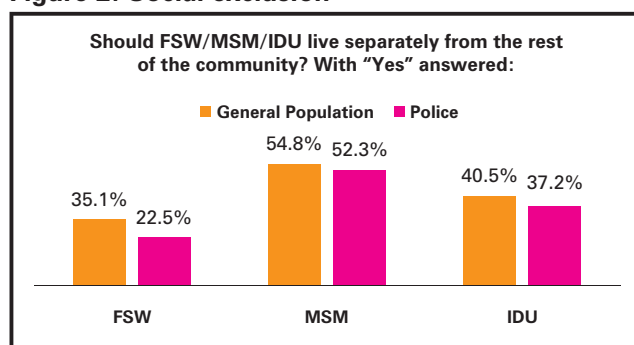
On the whole, stigma towards most at risk groups in Ghana is high, with a majority of respondents saying they would not freely welcome a member of these groups into their home. Negative attitudes were particularly high towards injecting drug users.

Figure 1:
Respondents attitudes towards high risk groups



But discriminatory attitudes go beyond stigmatization. They express consent with activities which enact the stigma towards persons such as isolation, exclusion, and maltreatment. An example of a discriminatory attitude would be the request to separate a person from his or her social environment. According to the survey, one third of the respondents from the general population would exclude female sex workers from the rest of the community while more than half of both general and police respondents felt that men having sex with men should be ostracized from the community.

Figure 2: Social exclusion



2.4 Isolation from the Family

Discrimination has even more serious consequences, if the person discriminated against is excluded from his or her own family. The survey included two questions with regard to isolation from the family. One question asked in general terms, if the respondent was in favour of excluding members of the respective high risk groups from their families. The other question asked more personally and specifically, if the respondent would exclude one of his relatives from the family in the case he or she was a member of one of the respective high risk groups.

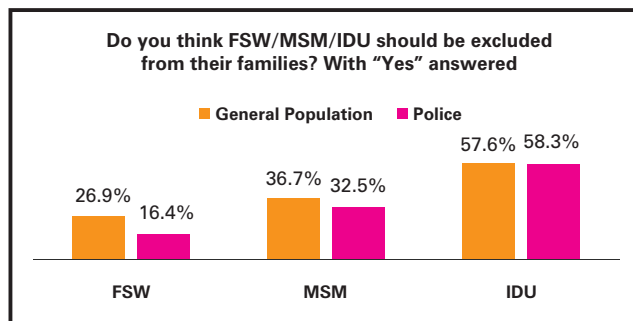
Interestingly, less people supported the exclusion of sex workers and homosexuals from their families compared to the segregation from the community. Apparently, family relationships are sometimes able to supersede discriminatory attitudes.

Approximately one quarter of the general population and less than a fifth of the police respondents thought that female sex workers should be excluded from their families. About one third of the interviewees

thought men having sex with men should be isolated from their families. However, isolating injecting drug users from the family gets higher approval rates compared to the exclusion from the community.

Approximately 60% of the respondents from the general population would not welcome a female sex worker into their home and 30.7% would exclude her from the family. However, 79.4% think she should have access to NHIS. But 63.3% would want the police to arrest her, if she was identified as a sex worker.

Figure 3: Isolation from the family



Yet, the picture changed again when interviewees were asked if they personally would exclude somebody from their family who was a member of a high risk group. Even if respondents did not agree with the exclusion from the family in general, they were not necessarily ready to accept a member of a high risk group as a relative. For example, only 26.9% of the general population thought sex workers should be excluded from the family, but 30.7% would exclude one of their relatives from the family if she were a sex worker. And 40.1% of the general population would exclude a man who has sex with men from the family.

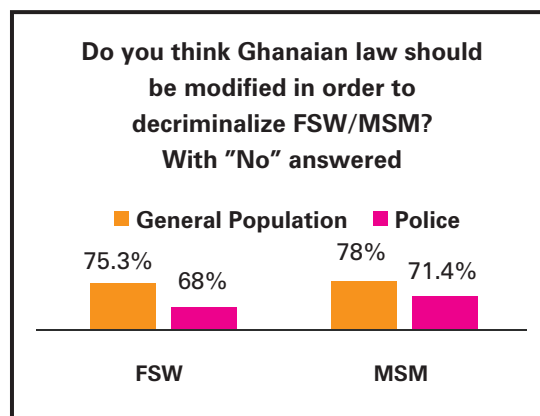
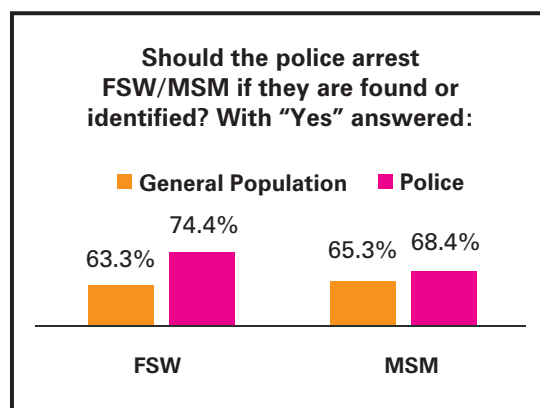
2.5 Imprisonment and Legalisation

Both sex work and homosexuality are illegal in Ghana and results of the survey indicate that a large majority of Ghanaians support these restrictions. Almost two thirds of the respondents thought the police should arrest female sex workers and men having sex with men when identified. Likewise, a large majority of the respondents were not in favour of amending the law to legalise or to decriminalize sex work or homosexuality. It appears that even if interviewees are willing to tolerate sex work or homosexuality to a certain extent, they do not support steps to improve the legal status of these high risk groups.

However, it is interesting to note that although it is the responsibility of the police to uphold the law, at least one quarter of the respondents from the police service did not think sex workers

and men having sex with men should be arrested.

Figure 4 and 5: Respondents attitudes towards legal issues related to MARP



2.6 Access to Resources and Services

It is interesting to note that the stigmatization does not necessarily translate into demands to exclude high risk groups from work or health services. For example, about two thirds of the respondents agreed that men having sex with men should be allowed to work. However, slightly less people agreed that they should be allowed to work, if they have HIV (with 'Yes' answered 60.6% of the general population and 78.1% of the police staff). In contrast, only about half of the respondents thought that injecting drug users should continue to work. This result could be due to concerns of the

general population that drug users may display addictive behaviour in the work environment.

69.1% of the respondents from the general population would not welcome a man who has sex with a man into their homes. But 69.7% believe they should be allowed to work.

A large number of participants of the survey also thought that most at risk groups should have access to medical care such as National Health Insurance (NHIS) as well as counselling

and testing for HIV. Four out of five respondents affirmed that high risk groups should have access to health care and the answers did not differ for sex workers, men having sex with men, and injecting drug users. The affirmation was slightly higher in the more educated category of the population.

All in all, responses to these questions are on the one side encouraging since they show that a large majority of Ghanaians believe in equal access to health care for members of high risk groups. But on the other side they show how long the road still is before social groups that differ in their sexual identity or their behaviour to the majority of Ghanaian society are accepted and not discriminated against any longer.

Figure 6: Access to Work

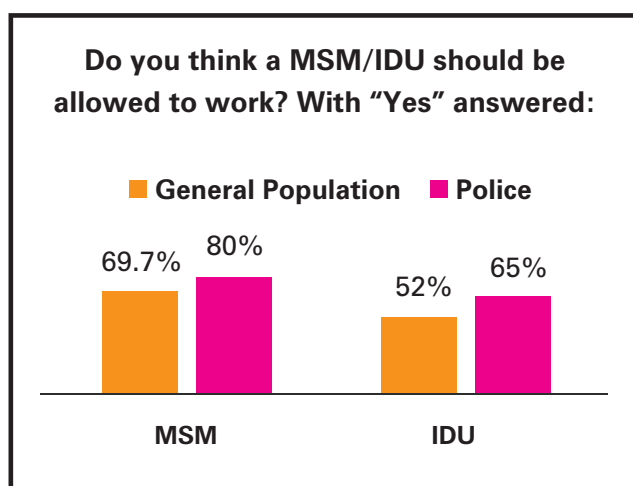


Figure 7: Access to Medical Care

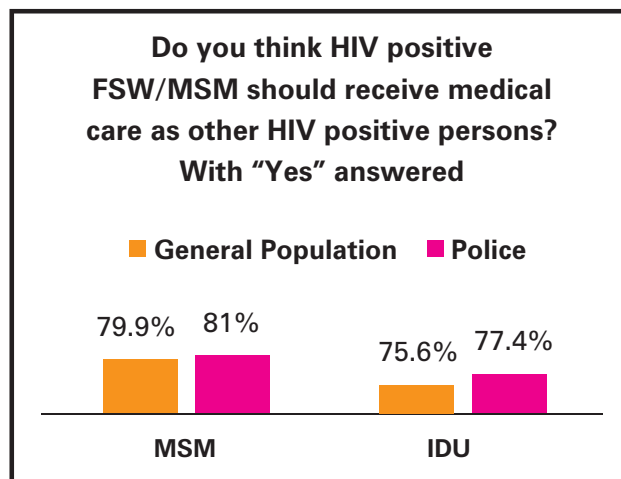
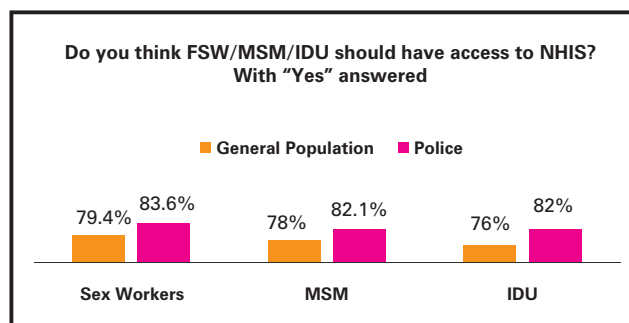


Figure 8: Access to Health Service



2.7 Fear of HIV Transmission

As already mentioned, previous research has found that female sex workers as well as men having sex with men living in Ghana have a higher HIV prevalence compared to the average population and are therefore at a higher risk of contracting the virus. In addition, evidence-based data suggests that for example in Accra a large number of new cases of HIV are acquired through unprotected sex with a sex worker.

However, many respondents mix facts with prejudices when forming an opinion about the ways HIV is transmitted in Ghana. Too often the finger of blame is pointed exclusively at high risk groups as a cause for the spread of the epidemic.

For example, three quarters of the respondents of the general population felt correctly that female sex workers were at a higher risk of getting infected with HIV compared to other Ghanaians. And almost two third believed men having sex with men were at a higher risk compared to the rest of the population.

However, 58.8% of respondents from the general population wrongly assumed that HIV in Ghana is mainly spread by men having sex with men. Respondents incorrectly thought that men having sex with men were a key driver in the transmission of HIV in Ghana.

Although high risk groups have a higher HIV prevalence, people need to acknowledge that HIV infections in Ghana are passed on through sexual intercourse not only with members of high risk groups, but also with people from all social backgrounds and all levels of society.

2.8 Discriminatory Attitudes of Most at Risk Groups

It may come as a surprise that attitudes of stigma and discrimination are prevalent in all high risk groups both inside the groups and between the different groups. Prejudice is about fear – fear of the unknown and fear of others who are perceived to be different. Members of most at risk groups have prejudices and need information about other groups, just like anyone else. In addition, some members may develop self-stigmatising attitudes incorporating discriminatory attitudes of the social environment.

Members of most at risk groups have discriminatory attitudes themselves. But they tend to stigmatize their own group less compared to the respondents of the general population. However, female sex workers opposed the right to work and the decriminalisation of men having sex with men more than the general population.

When minorities are uncomfortable with each other it is also not unusual for them to discriminate against one another. Certain situations, for example an HIV infection, may increase distrust and suspicion between members of most at risk groups. Discrimination is a disease that afflicts people regardless of colour, creed,

cultural and social background, sexual orientation, age or gender. Education through information is the only cure for the fear that is at the root of prejudice.

As an example of this inter group discrimination, the rights to belong to a family and community did not seem to be accepted by all survey respondents. One fourth of the seaters and the non-paying partners as well as one third of the roamers and men having sex with men would want female sex workers to be separated from their communities.

In some cases, rejection and exclusion are more prominent towards relatives and sex workers, if they are also HIV positive. For example, almost two thirds of the seaters who were interviewed said that HIV positive sex workers cannot live in the community. More studies may be needed to

better understand these attitudes. Promoting self-esteem and workplace solidarity among most at risk populations may be helpful in curbing these negative perceptions, and a way of reducing self-stigma. A positive result was that a large majority of respondents from all groups would be willing to care for a relative who is HIV positive.

“Self-stigma can be defined as an individual's internalisation of the societal attitudes s/he experiences, or anticipates, in society. Self-stigma incorporates feelings of shame, dejection, self-doubt, guilt, self-blame and inferiority. It leads to high levels of stress and anxiety, and contributes to denial.'... In extreme cases, self-stigma leads to self-harm... It prevents individuals seeking health treatment and care.”

(‘Living on the outside’ published by Health and Development Networks in 2006, p.23)

Regrettably, this study showed that most at risk groups themselves harbour negative attitudes and perceptions regarding the right to work for their members. For instance, only four out of ten sex workers indicated that men having sex with men should be allowed to work. The proportion dropped to three out of ten for men having sex with men who are HIV positive.

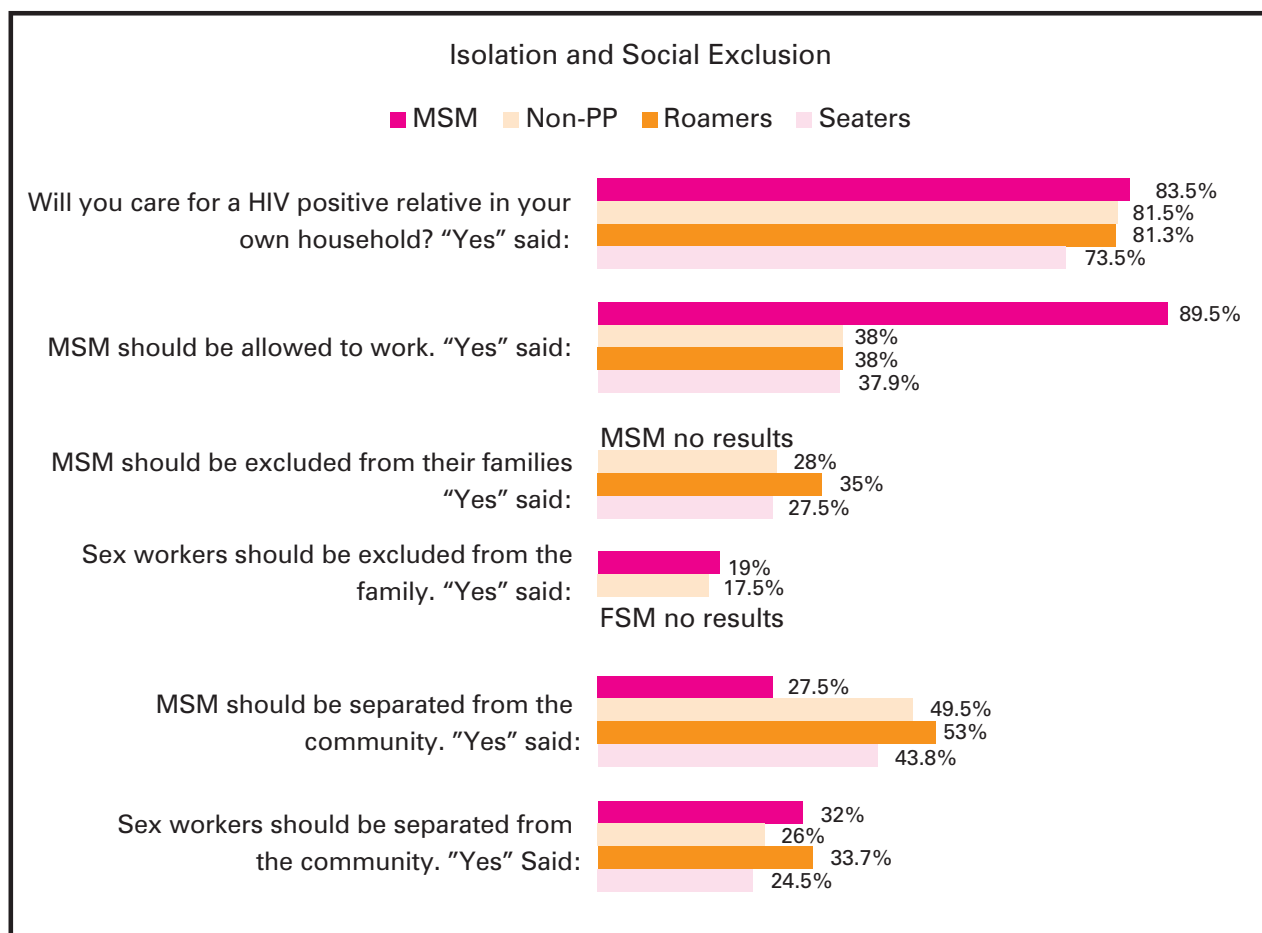
One striking finding is the overwhelming majority of seaters (more than 80%) and roamers (about 70%) who expressed that HIV positive sex workers must stop with sex work. The stigma and discriminatory attitudes and perceptions of interviewed members of high risk groups described above were also present towards injecting drug users.

In contrast, the right to health and the right to social security, assistance and welfare for all high risk groups were overwhelmingly acknowledged by the respondents.

One fifth of the seaters and almost one fourth of men having sex with men want sex workers to be arrested, a further indicator of intergroup discrimination. And an overwhelming majority of sex workers and non-paying partners support the arrest of men having sex with men when identified. This could point to the fact that probably stigma and discrimination towards homosexuals is much more prominent in Ghana compared to negative attitudes directed against sex workers. Similarly, whilst 61.1% of the seaters and 53.3% of the roamers would advocate for the legalization of sex work, those in favour of the legalization of homosexuality represented 8.8% and 16.7% respectively.

Many societies do not accept the legalization of sex work and homosexuality because, according to them, they are not consistent with societal values and norms. Nonetheless, in many other countries, sex work is legal, and sex workers are entitled to the same rights and benefits as other workers.

Figure 9: Isolation and Social Exclusion

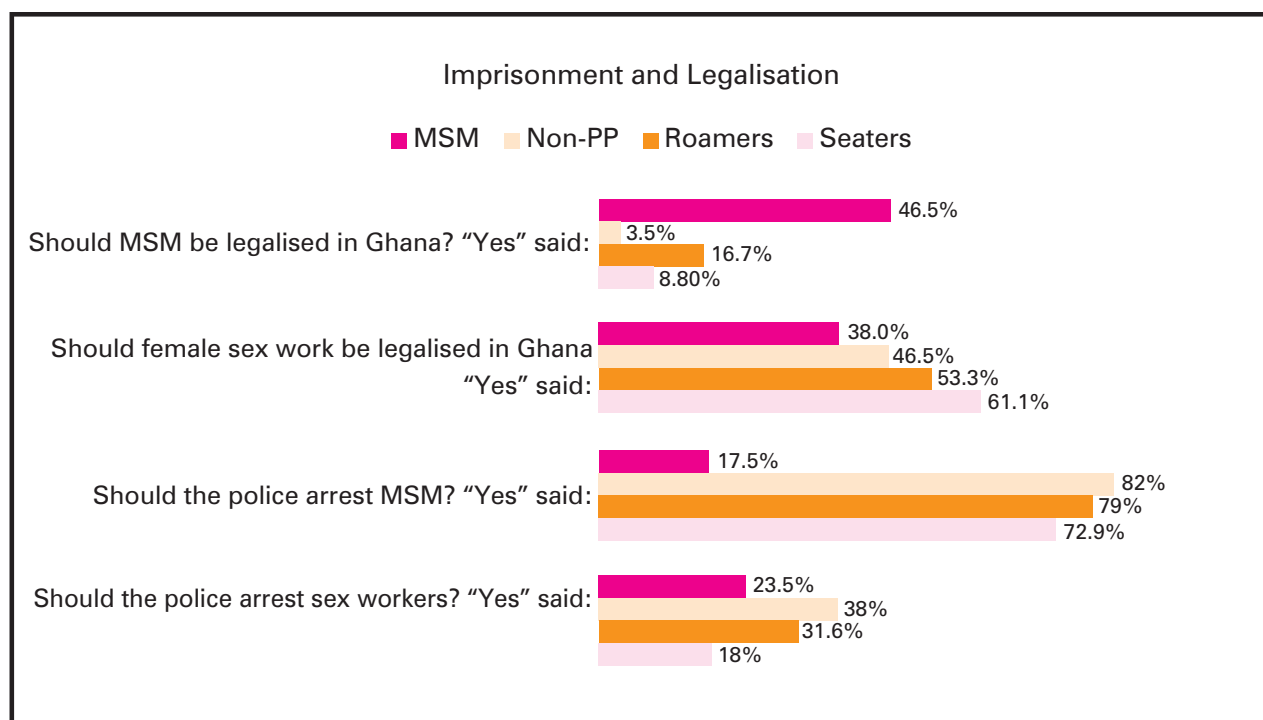


"Today, nearly 80 countries worldwide criminalize same-sex acts between consenting adults (...) In such punitive circumstances, MSM cannot disclose their sexual behavior to a service provider without risking criminal sanctions. This can hinder provision of vital MSM-appropriate prevention information, testing, treatment, care or support services (...) Criminalization of homosexuality can exacerbate HIV epidemics. HIV prevalence data across countries in the Caribbean offers a striking example (...) countries that criminalize homosexuality demonstrate higher rates of HIV among MSM than those that do not. This is a pattern that can be found across regions around the world."
 ('Social Discrimination against MSM' published by MSMGF in 2010, p.2)

In this context it is interesting to note that four fifths of the most at risk groups interviewees affirm that members of the police service have sex with female sex workers. Anecdotal evidence suggests that during operations like raids on sex work communities, some sex workers offer sex to the police in exchange for their freedom. This increases also the vulnerability of part of the police personnel to HIV infections, if the sex worker is HIV positive and condoms are not used.

Most importantly, where sex work has legal standing, laws against abuse and exploitation are more likely to be enforced, thus reducing the incidence of violence against sex workers, including violence perpetrated by some corrupt enforcement authorities.

Figure 10: Attitudes of MARP on Imprisonment and Legalisation



2.9 General Trends in Discriminatory Attitudes

All in all, the survey shows that attitudes which approve of discriminatory practices against members of groups most at risk are widespread and receive high levels of support among the general population. In particular, the research revealed the following trends:

- Respondents were more often in favour of excluding high risk groups from the community than to separate them from their families. Apparently, family relationships can supersede discriminatory attitudes.
- A large majority of respondents did not support cutting high risk groups off from access to work and health services.
- Female sex workers were less stigmatized compared to men having sex with men.
- Negative attitudes were most widespread against injecting drug users.
- Members of high risk groups are not only victims but also perpetrators of stigma and discrimination towards their colleagues. This suggests that discriminatory attitudes are deeply rooted in the Ghanaian society and influence in a rather complex way the identity and self-perception of sex workers and men having sex with men, and how they position themselves among other discriminated groups within the society.

The researchers also tried to find out if there were certain factors which influence discrimination and stigmatization. A cross sectional analysis of the responses from the general population identified the following statistically significant associations:

Level of education influences discriminatory attitudes.

A connection was noted between the level of education and discriminatory attitudes towards sex workers and men having sex with men. Attitudes were less discriminatory, the higher the educational level of the

respondents was.

For example, three out of four respondents who had attained tertiary education believed that sex workers should not live separately from the community, but only about half of the respondents with no education agreed that they should not live separately.

Similarly, approximately one third of the respondents who had not attended secondary school thought that men having sex with men should not be allowed to work, but only one fourth of those who attended secondary school were of the same opinion. And less than a fifth of interviewees with tertiary education were in favour of a ban on working.

Age matters as a factor that has an effect on stigmatization.

Generally discriminatory attitudes against sex workers and men having sex with men are the strongest among respondents younger than 25 years as well as respondents older than 60 years. Unfortunately, it appeared that younger people were more ignorant or reluctant to integrate most at risk groups than respondents between 30 and 39 years. Likewise, approval rates for the exclusion of men having sex with men from their families were highest among respondents older than 60 years, but also relatively high among the group of respondents younger than 25 years compared to the other age groups.

Results in the older age groups can be attributed to ingrained traditional values which have been taught over the years. High discriminatory attitudes in the 'under 25 age group' could perhaps be explained by a lack of knowledge or a lack of experience of people that age.

Gender, religious affiliations and ethnicity do not influence discriminatory attitudes towards high risk groups significantly.

All in all, there were no significant differences between the answers of male and female interviewees. Gender did not seem to affect the

Discriminatory attitudes increased with low levels of education as well as with age. However, also members of the 'under 25 years' age group showed a comparatively high level of stigma towards most at risk groups.

respondent's views.

Likewise, cross sectional analysis of the ethnic groups with the various variables showed no significant difference between their attitudes and perceptions.

With regard to religion, the survey revealed that approval rates for specific questions sometimes differed among religious groups covered by this research. However, the study could not establish any specific pattern or identify any specific link between certain religious groups and the level of stigmatization its members exhibited towards most at risk groups.

There are no major differences between discriminatory attitudes of the general population and police personnel.

On the whole, no significant differences could be identified between the level of stigmatization from the general population and members of the police force, although members of the police service sometimes show slightly less discriminatory attitudes or appear to be better informed than the general population. These differences can be explained by the higher level of education among the participating members of the police service compared to the participants from the general population. Fewer prejudices could also be a result of regular HIV information sessions the police is privy to.

2.10 Recommendations

The survey revealed high levels of stigmatization towards people living with HIV as well as discriminatory attitudes against most at risk groups which are deeply rooted in social norms and values within the Ghanaian society. Prejudices and misleading perceptions are obstacles which have to be overcome in order to successfully reduce the HIV prevalence of high risk groups, to win the battle against HIV in Ghana, and to respect the basic human rights of HIV positive people. The researchers suggested taking action in order to speed up the development of preventive measures for high risk groups and to reduce HIV-related stigma in general.

1. Creating Awareness and Reducing Discriminatory Attitudes

Awareness campaigns and Behaviour Change Communication programmes can successfully address discrimination and lead to increased knowledge about HIV-related issues. These programmes are able to change perceptions and attitudes towards people living with HIV as well as most at risk groups in the general population and should therefore be supported. It appears to be particularly important to target the youth in these programmes.

At the same time religious organizations, traditional and opinion leaders, women's groups, academia, politicians and media personnel should be encouraged to foster tolerance and social solidarity with HIV positive people using them as role models and applying approaches that are non-judgmental and not based on fear.

2. Developing preventive programmes for most at risk groups further

Several programmes targeting high risk groups have already been implemented in Ghana. However, more policies and programmes that successfully minimize the vulnerability of the most at risk groups to HIV are needed. For example, research has shown that long-term and comprehensive intervention programmes for and with

female sex workers are an effective tool to stabilize HIV infection rates and decrease infection rates of other sexually transmitted diseases among them.

Broad-based alliances need to be built and strengthened between the most at risk groups and organizations dealing with HIV prevention, care and treatment as well as those NGOs working in other fields such as gender equality, sexual and

"The most effective stigma reduction programming happens when people living with HIV play a central role. People living with HIV can provide firsthand experience to help design effective anti-stigma programs and share their lived experiences as co-facilitators and trainers."
(Tanzania Commission for AIDS 2009, p.9)

reproductive rights, and sustainable development.

The participation of people living with HIV including most at risk groups in the development of local and national strategies needs to be improved, since experiences in other countries have shown that this is critical for the success of preventive programmes and stigma reduction campaigns. The work has to be done with them, not only for them.

The support to organizations undertaking HIV programmes for sex workers, men having sex with men and injecting drug users has to be increased. The programmes have to focus on prevention, education and awareness (including condom distribution), home-based care for MARP members living with HIV/AIDS, and stigma reduction.

3. Defending human rights of most at risk groups

An advocacy group consisting of high profile personalities and with strong political backing should be established to advocate for the rights of most at risk populations. The group can act as a pressure group for the amendment of laws that alienate sex workers and men having sex with men from services they require to prevent and to manage HIV infections. The group can also play a role to ensure that anti-discrimination laws, policies, and codes of professional ethics in relation to most at risk groups are in place and that mechanisms for redress in circumstances where violations occur are properly designed.

The security agencies (Police, Immigration and Prisons Services) as well as the Judiciary should be involved at all levels in a series of workshops to explain how to protect the human rights of most at risk groups to reduce the ill-treatment of these groups.

Brochures and leaflets should be developed to document the rights of high risk groups and to advise them of what to do when they feel that their rights have been violated.

4. Supporting research

Further in-depth research on the situation of most at risk groups should be encouraged. It appears to be particularly important to commission additional research to obtain a better understanding of the numbers and situation of injecting drug users in Ghana.

"A national response which employs a range of approaches will have the greatest impact, e.g. "know your rights" campaigns; social change communication; social mobilization; participatory education; interaction between people living with HIV and key audiences; celebrity champions and media campaigns; legal support to those affected by stigma and discrimination."

(Reducing HIV stigma and discrimination, published by UNAIDS in 2007, p.6)

3.Facts:

What Everybody Needs to Know about HIV and AIDS

Despite extensive information campaigns in the past, many people still feel that they don't know all the facts they need to know about HIV-related issues. The following list aims to provide answers to some of the most important questions asked in the context of HIV

Can you get infected by touching HIV positive people or sharing food?	<p>No, you cannot get HIV by touching a person, eating together, sharing a glass or a plate, using the same bathroom or toilet, or working or playing with someone who is infected. The virus is also not transmitted by mosquito bites, touching the saliva, sweat, tears, urine or stools of an infected person. In fact, the virus cannot survive outside the human body for a long time.</p> <p>HIV is only spread from one person to another through blood or sex fluids. The most common way to get infected is through unprotected sex (sex without using a male or female condom). The virus can also be spread through infected blood, e.g. through injections with unclean needles, sharing used razor blades, or transfusions with unscreened blood. The virus can also be transmitted from an infected mother to a child during pregnancy, child birth or breast feeding.</p>
Are HIV positive people always visibly sick and die prematurely?	<p>There is no cure for HIV infections, but today medical therapies are far advanced and enable HIV positive people to live a normal, long and happy life.</p> <p>If the Anti Retroviral Therapy (ART) is successful and minimizes the concentration of the virus in the blood considerably, HIV positive people are not visibly sick and their life expectancy is not lower compared to the rest of the population.</p> <p>With support from the Global Fund to fight AIDS, TB and Malaria the Government of Ghana provides ART to people living with HIV against the payment of 5 GHc per month. There are at least 138 hospitals, clinics and medical centres in Ghana which offer ART treatment. A list of these health care facilities can be obtained from NACP.</p>
Can you have healthy children when you are HIV positive?	<p>Yes, you can. In 2009, 6,634 pregnant women tested HIV positive in Ghana. Still, these women can give birth to healthy children, if they receive ART to prevent the transmission of the virus from the mother to the child. The chances of having an HIV negative child are up to 80% or more, depending on the stage of the medical condition of the woman and other factors. For more information see: www.avert.org/pregnancy.htm or www.thebody.com/index/treat/pregnancy.html</p>
Is your sex life over, when you are HIV positive?	<p>No, HIV positive people can have sexual intercourse with their HIV positive or HIV negative partners, if they take certain precautions such as using a condom during sexual intercourse. For more information see: www.thebody.com or www.avert.org</p>

4. Testimony:

"My family was already preparing a coffin"

It is a Friday morning. The sun shines into the office of the 'Society for Women and AIDS in Africa' in Kokomlemle. Through the open window blows a fresh breeze carrying the voices of girls singing a song at a school nearby. Rose¹⁴ enters the room and takes a chair at the large conference table. She is a pretty woman, 32 years old, with braided hair. She appears to be calm. But from the way she swings her legs back and forth all the time, one can tell that she is agitated. Rose has agreed to recount what happened when she found out she had HIV

"I fell sick some years ago, but I didn't know why. Every two weeks I had a different sickness and I went to polyclinics all the time. One day, my legs were swollen and I couldn't walk." Rose's pastor advised her to go to the Tema General Hospital. At the hospital she met a counsellor who told her about a disease called HIV "I did a test and got my results: HIV positive. That very day I wanted to kill myself because there was nowhere I could go. I don't have mother and father, only a senior brother."

Rose started the HIV treatment, but her health deteriorated. "My mouth and throat started to pain me. I couldn't swallow, I couldn't drink. I couldn't eat. I had an oral rash and my mouth was swollen." Rose couldn't work any longer. Her landlady forced her to move out of the house. "She told me she didn't want to see me dying."

Eventually, Rose's brother brought her to the family house in Takoradi where her grandparents were living. "All my family members came. I couldn't speak. When I opened my mouth I was bleeding. I showed my HIV test to one of my aunties and she broke the news to my family." After that, Rose's family started to neglect her. Her relatives didn't want to come close to her any more. She recalls how her auntie once handed her some money. "She was holding the money up high in the air, between her fingertips, to make sure that she didn't touch me. Only my daughter came to me and sat beside me."

Rose's family started neglecting her. Sometimes her grandfather refused to pay for her medication and food supplements. Rose had open sores all over her body. Her clothes were sticking to her skin. Once the family forced her against her will to see a herbalist. He washed her several times, and she remembers how painful that procedure was. Her grandfather even told her that they were preparing a coffin for her. "I thought I would die. One day, at midnight, I ran away. I took a car and went back to Accra."

In Accra, Rose called a doctor she had met at the Tema General Hospital. She was the first person who really helped her. The physician invited her to her house for some weeks. Rose started taking ART drugs on a regular basis and joined an HIV support group. Through the group, she found somebody who offered to pay for her medication and the necessary food supplements for one year. "The first three months were hard but then I started feeling and looking better."

Eventually, Rose moved to the house of her boyfriend and his family although she didn't feel that she was welcome. Her boyfriend tested positive a week after she got her test result. "I told him that I have it from him. But he didn't want to respond. He didn't tell me where he got it from. He was a womanizer." At the beginning, her boyfriend did not even admit to his family that he was HIV positive too. He only told them about Rose's status. Ever since, the family has put the blame on Rose and stigmatizes her. "One day I came home and people in front of the house started to point their fingers at me. 'Look at AIDS!' they said, 'AIDS is coming!' "

Rose's eyes are now glazed with tears. Outside a rain shower has started pouring down and drowns her voice: "I don't have money to rent a

14. In order to protect the identity of Rose her name was changed. The interview was recorded by Griet Newiger-Addy in 2008.

house. That is why I stay with him. If I had money, I would go and find a place to get my peace.”

Despite these hardships, Rose is hopeful and optimistic about her future. “I keep on praying. Everything God gave is good.” Rose works as a peer educator on HIV for villages and communities and helps other women with HIV. She also sells pancakes in the market. The ART drugs have successfully suppressed the virus. “Once, I did a HIV programme in the market and shared my experience. But most people don't believe that I have AIDS because I look so healthy. Also my family is coming again, because I am not dying.”

Rose has learned a lot through her advocacy work. She has met influential people and even travelled to other countries. It is important for her to give her daughter a good education. “Only the God-fearing people and the educated people don't stigmatize us. I wish people in Ghana would not be so ignorant about HIV and understand that it is a disease like any other.”

5.Examples: Successful Projects Against Stigmatization

Combating HIV/AIDS is to a large extent about changing people's behaviour through providing them with accurate information and ensuring that they translate this knowledge into the desired behaviour. An essential ingredient affecting behavioural change is well planned and coordinated communication work.

Communication plays an essential role in public health and specifically in the fight against HIV

Innovative approaches which use a combination of diverse communication channels, modern communication technologies, entertainment-education strategies, peer education, and community mobilisation have become increasingly important. It appears that cultural and media approaches are particularly effective in addressing sensitive topics related to HIV/AIDS and the causes of stigmatisation.

This chapter highlights two projects which applied different communication strategies to address HIV related stigma and discrimination. They are only two out of the many examples of powerful and creative approaches which have been developed by initiatives all over the world to raise awareness on HIV/AIDS and discrimination.

TV Drama Wetin Dey in Nigeria

Wetin Dey? ('What's Up?') is a 30-minute weekly HIV/AIDS television drama series exploring social realities of younger people in Nigeria.¹⁵ 52 episodes were broadcast by the Nigerian Television Authority's network of television stations between 2007 and 2008.

The TV drama was part of a broader campaign supported by the BBC World Trust Service and

the United Kingdom's Department for International Development between 2005 and 2008. The initiative included radio talk shows as well as TV and radio spots on HIV/AIDS. In addition, partnerships with the Nigerian video film industry were developed to incorporate HIV

related messages into the story lines of a number of film productions. Training courses were offered to media personnel to promote accurate coverage of HIV and AIDS. The objective of the campaign was to raise HIV and AIDS awareness and to counter HIV related stigma across regional, ethnic, and class divides in the country.

"Theater, music, dance, and other cultural art forms proved to be an effective way to bring messages about HIV prevention, care, and treatment and the stigma and discrimination faced by vulnerable populations to the general community. Cultural approaches can foster empathy in audiences, which is key in reducing stigmatizing attitudes and behaviors."

(Stangl et al 2010, p.20)



The fish seller Bilikisu, one of the most well known characters in Wetin Dey.

Set in peri-urban Nigeria, the drama was designed to focus on the daily lives of ordinary Nigerians. While each Wetin Dey episode was crafted with a message brief in mind, the drama was not necessarily always directive in determining what meanings viewers should take away. For example, some characters in Wetin Dey were shown to abstain from sex, while others used condoms.

15. See for the following the information on the website of The Communication Initiative Network (www.comminet.com/en/node/304367/304; www.comminet.com/en/node/305803/347), the article 'Good Girls/Bad Girls in TV Drama in Nigeria' by Emily LeRoux-Rutledge et al. (www.comminet.com/en/node/304342/347), and the information provided on the website of the BBC World Service Trust (www.bbc.co.uk/worldservice/trust/whatwedo/where/africa/nigeria/2008/03/080219_nigeria_hiv_project_overview.shtml).

The BBC World Trust Service trained a Nigerian team to produce *Wetin Dey* through workshops that focused on script-writing, editing, and production of TV programmes. The series was shot entirely on location in Nigeria. Formative research helped to establish the objectives of the campaign, to design the story, and to gather information on media preferences of the target group. Results of the research guided the formation of dramatic concepts and were used to refine the drama in terms of tone, language, relevance, appropriateness, and to develop characters and plotlines. In addition, the production team produced a pilot of the drama to be pre-tested with the intended audience and their parents across Nigeria.

Knowledge, attitudes, and practices (KAP) surveys were conducted at several points in time in order to evaluate the campaign. Results showed that the awareness of HIV related knowledge, the desire to be tested for HIV and the acceptance towards people living with HIV had increased among those who had been exposed to the campaign. The surveys also found that no single part of the campaign reached as many people as the combined elements. Moreover, qualitative research in the form of focus group discussions revealed that viewers saw *Wetin Dey* as educational and entertaining at the same time. Participants across all focal groups found the idea of reducing stigma against HIV positive people important. "The programme appears to have humanised the virus, and increased viewer's tolerance and acceptance of people living with HIV/AIDS."¹⁶

Characters of *Wetin Dey*

"The characters speak to the diversity of the intended audience, (...) For instance, Yetunde is a character from a lower socio-economic class whose mother dies of HIV/AIDS. Because of this, she faces frequent discrimination, and struggles to find work and care for her younger sisters. Aisha is a rich girl whose father wants her to marry the son of a senator, yet she already has a boyfriend, named Hakim. Bilkisu is a female sex worker, who 'sells fish' as a cover. Chike is a mechanic who falls for Bilkisu and wants to keep her from prostitution. Bayo is a 17-year-old aspiring football player who has run away from home. Chris is a policeman who is diagnosed with HIV/AIDS. He is in a troubled marriage, and both he and his wife Stella are, at times, unfaithful to each other."
(www.comminit.com/en/node/304367/304)

16. LeRoux-Rutledge et al. 2008.

Theatre Against Stigma Towards Men Having Sex With Men in India

Lotus Integrated AIDS Awareness Sangam is an organization that supports men having sex with men in Tamil Nadu in Southern India. The organisation is community owned and managed and has about 1,500 members. Lotus is one of the few groups in India working with men having sex with men in rural and semi-urban areas. The initiative developed the Advocacy by Cultural Teams (ACT) project, a strategy that uses dramatic performances to reduce stigma and discrimination. In their theatre plays, the group members describe themselves as 'pen manam konda aan', a Tamil term which can be translated as 'man with the feelings/thoughts of woman'.



Performance of Lotus Sangam in a village.
(Photo by Lotus Sangam / lotus_sangam@yahoo.co.in)

"The project has given us the courage that we too can rise up. Prior to the project I used to timidly stay at home. Now I have confidence that others can accept us; and that we can share the details of our lives with even more people. (...) Our audience expressed appreciation for the topic (...). Many of our actors were really crying from the heart during the performance. The themes of discrimination at home, exploitation for sex, harassment from local rowdies, extortion of money: all of these really hit home. When acting those scenes, the audience was captivated because we acted from our lived experience."

Ranjit, – Beautician and Dance Teacher
(Lotus Integrated AIDS Awareness Sangam, p. 14)

The theater programme aimed at changing harmful attitudes and practices preventing men having sex with men and transgender persons from accessing legal redress through their municipal governments known as panchayats. Panchayats are powerful local bodies that regulate the socio-political norms at the village and semi-urban levels. Panchayat leaders are in a unique position to model new attitudes and behaviours for the broader community.

Lotus used a careful process to develop and implement the theatre intervention. They conducted focus group interviews with men having sex with men and panchayat leaders to inform script development and provide baseline data for an evaluation. A member of Lotus wrote the script. Preparations also included organizing training for panchayat leaders about HIV and AIDS, men having sex with men, and transgender populations. Since public drama performances are a visible and important part of day-to-day cultural life in rural India, the project successfully built upon strengths the communities already had thus affirming community identity as valid and valuable. In total, Lotus organized 75 performances, reaching 270 panchayat leaders and approximately 11,250 villagers.

The project successfully opened a justice channel through panchayat leaders and achieved a number of unanticipated outcomes. Panchayat leaders reported changes in their attitudes and behaviours, while members of Lotus confirmed positive changes in their lives. The project also strengthened Lotus itself, improving its ability to use theatre, improving the health, wellbeing and sense of self worth of its members, and leading to the mobilization of additional funds.

**Advocacy by Cultural Teams Project:
The Story Line**

"Lotus's play tells the story of a young man who has sex with men and whose parents are determined to get him married. It follows the protagonist, Ranjith, through daily life, depicting the stigma and discrimination he experiences at home, in his neighborhood, and from his friends. In one pivotal scene, Ranjith stands alone on the stage and expresses how what he experiences makes him feel, how much it hurts, and how he was born with feelings he cannot change. Crying out to God, he asks, 'Why have you given me this life?' At that moment in the play, the audience always becomes silent and attentive. In another pivotal scene, the parents take Ranjith to meet his future bride and parents-in-law. The prospective bride, Susila, recognizes the situation and explains, 'Your son is a man with a female heart.' She refers the family to Lotus Sangam counseling, explaining that Lotus is a support organization for men having sex with men and transgender persons. Susila also asks the father not to force his son into marriage, which would spoil the life of both his son and a potential bride. In the final scene, Ranjith and his parents visit the counselor at Lotus, who answers all of their questions. These questions clearly mirror those of the audience, because at this point they usually lean toward the stage in anticipation of the answers."

(Stangl et al 2010, p.46)

6.Resources: Where to Get Information and Support

The main responsibility for coordinating the national response to the HIV pandemic lies with the Ghana AIDS Commission (GAC). The lead agency responsible for implementing the health sector's response to HIV is the National AIDS/STI Control Programme (NACP). However, other government agencies, businesses, labour organisations, faith based and other international and national NGOs as well as donor organisations are active in the fight against HIV in Ghana. Some of them are listed in this chapter.

6.1 Organisations in Ghana for People Living with HIV

Ghana AIDS Commission (GAC)

PO. Box CT 5169, Accra
Location: 4th Floor, Ghana Olympic Bldg, Ridge
Phone: +233 0302 218 278
Email: info@ghanaims.gov.gh
Web: www.ghanaims.gov.gh

National AIDS Control Programme (NACP)

PO. Box KB 493 Korle-Bu, Accra
Location: Korle Bu Hospital-Accra
Phone: +233 0302 678 458
+233 0302 660 023
Email: info@nacp.org.gh

Joint United Nations Programme on HIV/AIDS (UNAIDS)

PO. Box 1423, Accra
Location: Cantonments-Accra
Phone: +233 0302 238 256
Email: ZekengL@unaids.org
Web: www.unaids.org

National Association of People Living with AIDS Ghana (NAP+)

PO. Box PMB MD 145 Madina-Accra
Location: Achimota-Accra
Phone: +233 0261 777 257
Email: napghana2005@yahoo.com

West Africa Project to Combat AIDS and STI (WAPCAS)

PO Box TA 1010, Achimota
Location: Adabraka Polyclinic-Accra
Phone: +233 0302 233 340
Email: comfort.asamoah@yahoo.com

Society of Women and AIDS in Africa - Ghana (SWAA Ghana)

PO Box KD 293, Kanda, Accra
Location: 12 Wawa Road, Kokomlemle, Accra
Phone: +233 0302 250 912
Email: swaaghana@hotmail.com
Web: www.swaagh.org

Planned Parenthood Association (PPAG)

PO. Box AN5756
Location: 59/3 Nasia Rd, Laterbiokorshie, Accra
Phone: +233 0302 310 368
Email: ppag@africaonline.com.gh

West Africa AIDS Foundation (WAAF)

PO. Box KD 130, Kanda, Accra
Location: Ecomog Road, Plot 650, Haatso
Phone: +233 0243 362 447
+233 0244 271 983
Email: info@waafweb.org
Web: www.waafweb.org

Adventist Development and Relief Agency

PO. Box 1435, Accra, Ghana, West Africa
Location: Ringway Estate
Phone: +233 0302 220 779 / 255 686
Fax: +233 0302 220 243
Web: www.adraghana.org
Head: Dr. W. Y. K. Brown

Ghana Center for Democratic Development

PO. Box LG 404, Legon-Accra, Ghana
Location: No. 95 Nortei Ababio Loop, North Airport Residential Area, Accra
Phone: +233 0302 776 142 / 763 029 / 784 293
784 294 / 777 214
Fax: +233 0302 763 028
E-mail: info@cddghana.org
Centre for Democratic Development (CDD)

Ghana Police Service

PO. Box GP116, Accra
HQ: LOCATION: Ring Road East, Cantonments, Accra, Near Ako-Adjei interchange.
Phone: +233 0302 761 250 / 773 906
Web: www.ghanapolice.info

Hope for Future Generations

Location: Kaneshie, Accra and Cape Coast

Drama Network

Location: Akosombo

6.2 For Further Reading

Beyrer, Chris et al 2011: The Global HIV Epidemics Among Men Who have Sex with Men, Washington DC, USA: The World Bank, Directions in Development, Human Development

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Christian Council of Ghana 2010: Facilitators' Guide for Training on HIV & AIDS Stigma and Discrimination Reduction, Accra, Ghana

Health and Development Networks 2006: Living on the outside. Key findings and recommendations on the nature and impact of HIV/AIDS related stigma, www.hdnet.org

HIV Sentinel Survey Report 2010, published by National AIDS/STI Control Programme and Ghana Health Service, Accra, Ghana

LeRoux-Rutledge, Emily et al 2008: Good Girls/Bad Girls in TV Drama in Nigeria, (www.cominit.com/en/node/304342/347)

Lotus Integrated AIDS Awareness Sangam: Advocacy by Cultural Teams (ACT) Project, Kumbakonam (download: <http://villagelotus.wordpress.com>)

MSMGF 2010: Social Discrimination Against Men Who Have Sex with Men, Implications for HIV Policy and Programs, published by The Global Forum on MSM and HIV (MSMGF), Oakland, USA

National AIDS/STI Control Programme Ghana 2009: Annual Report 2009, Accra, Ghana

Nzambi, Khonde, Martin Bevalot, Holger Till, Agnes Dzokoto 2009: Study on Stigma and Discriminatory Attitudes and Perceptions in Accra and Tema Metropolis – How Does the General Adult Population See Most At Risk Populations and How Do Most At Risk Populations See Themselves in the Context of HIV/AIDS?, published by GTZ ReCHT, August 2009, Accra, Ghana

Stangl, Anne; Dara Carr; Laura Brady; Traci Eckhaus; Mariam Claeson; and Laura Nyblade (2010) Tackling HIV-Related Stigma and Discrimination in South Asia, Washington, DC, USA: The World Bank, Directions in Development, Human Development.

Tanzania Commission for AIDS 2009: National Guide on the Integration of Stigma and Discrimination Reduction in HIV Programs, February 2009, Dar es Salaam, Tanzania

UNAIDS 2007: Reducing HIV stigma and discrimination: a critical part of national AIDS programmes: a resource for national stakeholders in the HIV response, Geneva, Switzerland

Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
BCC	Behaviour Change Communication
CEPEHRG	Centre for the Protection of Human Rights in Ghana
CT	Counselling and Testing
FSW	Female Sex Worker
GAC	Ghana AIDS Commission
GDC	German Development Cooperation
GHS	Ghana Health Service
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit (now GIZ)
HIV	Human Immunodeficiency Virus
HRG	High Risk Groups
IDU	Injecting Drug Users
MARP	Most at Risk Population
MSM	Men Who Have Sex With Men
NACP	National AIDS/STI Control Programme Ghana
NGO	Non-Governmental Organization
NHIS	National Health Insurance Scheme
Non-PP	Non-Paying Partner
PLHIV	Person Living With HIV/ AIDS
ReCHT	Regional Coordination Unit for HIV&TB
SHARP	Strengthening HIV and AIDS Response Partnership
STI	Sexually Transmitted Infection
SWAA	Society for Women and AIDS in Africa/Ghana
WAPCAS	West Africa Project to Combat AIDS and STI

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