

MODULE 2

SESSION 1

HIV Stigma, Discrimination and Self-awareness

Purpose

Participants will discuss people's attitudes and perceptions of PLWHAs and the effects of these on PLWHAs. They will also explore ways to help change the current situation of stigma and discrimination for PLWHAs in religious communities in Ghana.

Objectives

By the end of the session, participants will have:

- Defined stigma and discrimination
- Discussed personal experiences with discrimination
- Identified myths, misconceptions about HIV/AIDS, PLWHAs and their families
- Discussed the need of eliminating stigma and discrimination against PLWHAs (infected and affected).

Time: 90 minutes

TOPIC	TIMING	METHODS	MATERIALS
Stigma & Discrimination Definition	20 minutes	Group Work/Plenary Discussions	Flip chart, markers, sticky note pads, session notes
Individual Discrimination Experience	20 minutes	Reflection & Recall, Experience Sharing, Plenary Discussions	Flip chart, markers, session notes
HIV/AIDS Moral Dilemma	20 minutes	Group work, Plenary Discussions	Flip chart, markers, session notes
Stigma & Discrimination Awareness Exercise	25 minutes	Group Work, Plenary Discussions	Flip chart, markers, handouts, session notes
Summary	5 minutes	Highlight Main Points	Session notes

PARTICIPANT TRAINING MANUAL

CONTEXT

This session challenges participants to think about the concept of stigma and discrimination and to examine their relationship with and impact on HIV/AIDS transmission and prevention.

ACTIVITIES

STIGMA AND DISCRIMINATION DEFINITIONS

The aim of this activity is to define stigma and discrimination, how it has been associated with HIV and explores its roots and manifestations.

Definition:

- Stigma is literally a negative “mark” or “blemish” upon someone or something. The original term stigma referred to a visible **marking** on the body, which was made by a branding iron or pointed instrument. This visible mark carried with it social ostracism and shame. The original term could also be a non-physical characteristic.

Another definition of stigma:

- Attributing undesirable qualities to those who are perceived as being “shamefully different” and identifying and **labelling** them as deviant from the social ideal. Years ago, Leprosy and Lepers were stigmatised in many parts of the world, they were forced to live in colonies separated from the community, as there was no cure for leprosy.

According to Peter Miller, UNAIDS, HIV-related stigma is often layered upon pre-existing stigmas concerning socially marginalized and vulnerable groups (injecting drug users, men who have sex with men, commercial sex workers, women and children). Conversely, people living with HIV/AIDS may become implicitly associated with stigmatised behaviour, regardless of how actually they became infected.

Definition of discrimination:

- Discrimination is treating a person or group differently (usually worse) than others. Its purpose is to leave out, restrict or give preference which is based on exclusionary perceptions or structures (e.g. re: race, beliefs, sexuality, gender) It nullifies or impairs their basic rights and freedoms.
- Actions or treatment based on the stigma and directed towards the stigmatised.
- Sanctions, harassment, scape-goating and violence based on infection or associated with HIV/AIDS

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Underlying Factors

Fear
Ignorance
Misconceptions

Conduits

Moral Values
Inequalities
Prejudice

Manifestations

Disregarding
Denial
Rejection
Social Distance
Underrating
Subtle/Overt
External/Self

Stigma is an attitude; discrimination is an act.
Stigma reinforces power relations and existing inequities.
Stigma arises from and is maintained by ignorance, moral systems and fear.
(Peter Miller, UNAIDS)

PERSONAL DISCRIMINATION EXERCISE

The aim of this activity is to encourage participants to remember personal experiences with discrimination and their feelings about being discriminated against.

HIV/AIDS MORAL DILEMMA – MYTHS & MISCONCEPTIONS ABOUT HIV/AIDS

The aim of this activity is to review common myths and misconceptions of HIV AIDS and attitudes towards PLWHA.

Myth –a story about the origins of ideas or beliefs, or that gives explanations of natural events. The story is not true, although it may contain elements of truth (e.g. the way the Golden Stool was given to the Ashanti)

Misconception – having the wrong idea or understanding (e.g. AIDS can be cured)

Morality -One of the earliest meanings of ‘morality’ is behaving according to custom. Morality can be seen as a type of social glue.

The Greeks came to make a distinction between morality and ethics. Morality is behaviour according to custom and not reason or reflection.

Ethics implies reflection on morality with the possibility of changes based on this analytical reflection. It provided the justification for customary behaviour.

Religious Ethics is a reflection on morality based on scriptural teaching. The Bible and Qur’an are central to our thinking and reflection at this seminar on Marriage and Family Life.

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Common myths about PLWHAs and HIV/AIDS might be:

- If you have sex with only one person that you love, you will not will not get HIV
- AIDS is a social taboo and infected people should perform certain rituals to cleanse themselves
- AIDS is a curse from God or from witches
- You can catch it in the toilet
- You can get it from kissing
- You can cure it by having sex with a virgin
- If someone looks healthy they cannot have AIDS
- AIDS is caused when someone gives you the evil eye
- There is a cure for AIDS, etc.
- Prayers and devotion can reverse an HIV positive test result into a HIV negative test result.

Common beliefs about morality's connection to HIV might be:

- Morally upright people do not get AIDS
- AIDS is a disease that only the promiscuous or immoral get
- Muslims/Christians or church-goers do not get AIDS
- AIDS is God's punishment for the immoral

Common views about how morality and HIV are not connected:

The innocent, i.e. babies contract HIV/AIDS from breastfeeding or the umbilical cord or whilst still in the womb of the infected mother

- Even if one is faithful to ones partner, he or she can contract HIV/AIDS if one partner has been exposed to it in a previous relationship
- People who use contaminated razorblades, toothbrushes, etc. can contract HIV/AIDS
- If you come into contact with the body fluids of an HIV positive person through cuts, it is possible to contract the disease
- If you receive an injection from contaminated needles, you can contract HIV/AIDS
- If you receive a blood transfusion that was unscreened, you can contract HIV/AIDS

It is the myths and misconceptions that people have about HIV/AIDS and the PLWAs that commonly lead to the issues of stigma and discrimination.

STIGMA AND DISCRIMINATION AWARENESS EXERCISE

The aim of this activity is to identify stigma and analyse its effects in discrimination towards those affected by HIV AIDS in different settings.

Scenarios

1. *"I fetch water from the river, I am the only one who takes care of the maize field, the only one who is expected to do work around the house"(girl orphaned by AIDS, living in the rural area)*

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2. *“They treat you badly: you don’t feel like walking in the street. They give you names. They whisper when you pass. They take it that when one person in the house is sick, all of you in the house are sick too.”*

3. *“The other day my child was in pain. I went to the clinic and the nurse said there was no medicine. I was hurt because I could see the medicine behind her.”*

4. *“and sometimes a priest / imam doesn’t understand AIDS and he influences the congregation.”*

One reason HIV AIDS is stigmatised in Ghana is because it is related to sex.

Prejudice and stigmatisation frequently lead people to do (or not do) something that denies services or entitlements to another person. Example: denying PLWHAs health services, or terminating employment on the grounds of HIV status. This is discrimination.

Due to stigma and HIV/AIDS related discrimination, the rights of PLWHAs and their families are frequently violated simply because they are known or presumed to have HIV/AIDS. This violation of rights increases the negative impact of the epidemic.

The Principle of Non-discrimination is central to human rights thinking and practice. Therefore discrimination against people living with HIV/AIDS or those thought to be infected is a clear violation of their human rights.

Research with HIV/AIDS affected children and adults showed that they identified acts of discrimination in the family, as well as in the community - in school, in church/mosque, in the health care system, to include Home Based Care providers.

MODULE 2

SESSION 2

Behaviour Change

Purpose

To understand the principles of behaviour change and the factors that influence behaviour change.

Objectives

By the end of the session, participants will have:

- Examined the factors that affect behaviour
- Discussed the process of behaviour change
- Reviewed the Journey of Hope Kit
- Identified a JOH sketch that deals with ways in which PLWHAs can live positively and longer

Time: 120 minutes

TOPIC	TIMING	METHODS	MATERIALS
Introduction	5 minutes	Mini Lecture	Session notes
Key Factors affecting human behaviour	20 minutes	Brainstorming, plenary	Flip chart, markers, session notes
Behaviour Change Process	25 minutes	Plenary Discussions, Brainstorming	Flip chart, markers, session notes, handout
Journey of Hope Kit	40 minutes	Demonstration, Practice, Plenary discussions	Journey of hope kit
Living Positively with HIV/AIDS	20 minutes	Plenary discussions Story Telling	Handout

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CONTEXT

This session encourages participants to understand and explore factors affecting behaviour, the process of behaviour change and the Journey of Hope Kit.

ACTIVITIES

STIGMA AND DISCRIMINATION AWARENESS EXERCISE

The aim of this activity is to help participants understand key factors influencing and affecting behaviour.

Behaviours can be acquired based on environment, culture setting, religious beliefs, etc.

Definitions:

Behaviour – Anything that an individual, group or species does in action and response to either internal or external stimulation or pressure.

Values – The underlying ethical and moral principles which influence individuals and groups (Honesty, Respect, Fidelity, Responsibility, Self control, Social justice, Trust).

Attitude – A habitual mode of thought or feeling; Attitudes are largely based on our personal values and perceptions. Attitudes are mental views, opinions, dispositions, postures or behaviours (Self-righteousness, understanding, pride, compassion, empathy, feeling of superiority).

Perception – To perceive is to become aware directly through the senses to achieve understanding. Thus perceptions lead to insight, intuition or knowledge. (Good people can not get AIDS; It is offensive to God and clergy to talk about sex, a person who looks health does not have HIV,)

Knowledge – The state or condition of knowing facts or ideas, acquired through study, investigation, observation or experience. The reduction of uncertainty.

Behaviour Change

Keep in mind that simply knowing something does not lead to behaviour change. (How many doctors smoke, knowing full well the negative consequences it has on health!) There are many more factors and influences that impact behaviour change.

Factors that cause people to change their behaviour

- **Physical Stimuli** - based on a person's current physical state as well as fear of future pain discomfort, or memory of past pain.

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- **Rational Stimuli**- based on knowledge and reasoning (if people have the facts they may choose to do the right thing)
- **Emotional Stimuli** – based on intensity of feelings of fear, love or hope.
- **Skills** – based on the person’s capacity to adopt and continue a new behaviour.
- **Family and Personal Networks** – based on the influence from family and peers.
- **Social Structures** – based on the impact of social, economic, legal, and technological factors on the daily life of a person.

BEHAVIOUR CHANGE PROCESS

The aim of this activity is to help participants understand of the process of behaviour change.

We have positive and negative behaviours. The negative ones (those that go against the smooth running of the society or the individual) that necessitate behaviour change. Behaviour Change is a process. It is most often gradual, but it can also be an immediate response based on the specific circumstances.

The Steps of Behaviour Change

We cannot force anyone to change. Therefore, to change others we may have to change ourselves first. It is helpful to understand the phases people go through when they do change their behaviour. There are several theories on behaviour change. This is one theory on behaviour change.

Behaviour change is a slow process by which individuals progress through several stages. However, these are not stages necessarily a linear process. Some individuals may experience all five stages but not necessarily in the same order. At times people change their behaviour because of social pressure or the desire to conform to social norms, not because they have personally been convinced that it is the right thing to do. After a period of practising the new behaviour, they may become persuaded of its advantages. This encourages them to approve of the new behaviour and continue practising it.

Knowledge: One first learns about a new behaviour, gather information about the behaviour.

Approval: One then approves of the new behaviour.

Intention: One believes this behaviour is beneficial and intends to adopt it.

Practice: One then decides to carry out and practices the new behaviour.

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Advocacy: One can then promote the new behaviour through one's social networks.

Other theories also begin with Information that is transferred to knowledge. Generally, the challenges/obstacles that most people face are between the approval and practice stage. There are obstacles (peoples negative behaviour that need to be changed) that necessitate the behaviour change.

Basic approaches to behaviour change:

Fear – Shows all the frightening aspects of what will happen if the change is not made. Often, fear is short-lived and is not the best way to bring about permanent behaviour change. It also leaves one feeling hopeless.

Positive – Presents you with all the facts, reinforces hope, regardless of the particular situation and it shows all the benefits and blessings of making the change. This approach encourages and empowers people to seek additional Information or skills needed and ultimately to make the necessary changes.

Negative – Reinforces hopelessness and doing nothing about the situation.

The Positive Approach is what the Journey of Hope seeks to encourage participants to utilise during their training. The Journey of Hope has been used in Ghana successfully as a way to promote behaviour change related to HIV AIDS. There are many groups and non government organisations that have trained staff in the use of the Journey of Hope to encourage people to change their behaviour to prevent HIV/AIDS.

THE JOURNEY OF HOPE KIT

The aim of this activity is to review and demonstrate the Journey of Hope kit components.

The Journey of Hope resource provides:

The original concept of the Journey of Hope was known as 'the Fleet of Hope' (the boats and characters segment) which was the idea of a Catholic Father, Peter Labouchere, who was inspired by the Bible story about Noah and the Ark.

The kit offers a series of options and is a positive approach to fostering change and helps to generate discussions on topics such as HIV AIDS that might otherwise be difficult. The kit offers multiple options, non-prescriptive information and the basic facts.

The Journey of Hope Kit includes:

Narrow bridges (that can represent abstinence, faithfulness and condoms or other support systems)

Characters (that can represent members of the community)

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Trigger sketch booklet (multiple stories and situations that can be carried out by different groups on several topics connected to HIV AIDS prevention.)

Blue cloth (representing “the flood” and the turbulent nature of the world and HIV/AIDS) with the boats on one side (representing abstinence, faithfulness and condoms or instead of condoms other support systems such as peer educators, counsellors, prayer, etc.)

The crocodiles (representing STIs including HIV)

The future island (representing the goals, hopes and dreams)

Penis Model

Male condoms

An instruction manual

LIVING POSITIVELY (AND LONGER) WITH HIV/AIDS

The aim of this activity is to reinforce that PLWHAs can indeed live positively and longer if they receive the love, care and support they need.

Highlights of “Living Positively” handout by Peter Labouchere

It is important to encourage HIV positive people to remember that long-term survivors must:

- Have a clear focus
- Continue to do things that are challenging and exciting
- Think about what they want and make a plan to take action towards getting it
- Continue to dream
- Challenge limiting beliefs and think: “I must!” “I can!” “I will!”
- Talk to the virus and command the virus to “behave”. Think and speak positively.
- Reduce the amount of “bad” stress in their lives (there is both good stress and bad stress). Good stress is motivating and exciting.
- Deal with the fear and eliminate it, remembering that fear causes the release of the hormone cortisol and it is not good for the overall health and well being of the body. Facing up to fear releases the power it has to debilitate and weaken us.

Behaviour change takes time and is a gradual process of building consensus and making people aware by giving them knowledge. Change is more likely if people initiate the processes themselves, so they become the change agents. But it takes time to build consensus, to accept, approve and have the intent to do something. The people themselves have to consent to adopting a new normative practice while still maintaining their culture. Example: In one Kenyan community, that at one time practised widowhood rites by having the woman to sleep with the brothers of her deceased husband. Today, after Johns Hopkins University/Center for Communications Programs officers visited the community and began sharing information about HIV/AIDS risks, etc., the people have changed that practice and adopted the new practice. Now, the widowhood rite consists of having the woman to jump over a cow to cleanse her from the spirit of her dead husband.

Remember: To change others, we must change ourselves first.

MODULE 2

SESSION 3

What is Compassion? Who is Compassionate?

Purpose

Participants to define 'Compassion' and to understand compassionate behaviour.

Objectives

By the end of the session, participants will have:

- Discussed the meaning of compassion related to care and support for PLWHA
- Described the Compassion Campaign in Ghana
- Examined cultural, social and religious issues that influence a compassionate response
- Identified compassionate behaviour as practised by faith- based persons/communities
- Reviewed religious texts that conceptualise compassion for the needy

Time: 120 minutes

TOPIC	TIMING	METHODS	MATERIALS
Introduction	5 minutes	Mini lecture	None
Compassion, Care and Support	20 minutes	Mini lecture, individual/group work, plenary	Flip Chart, Markers, Session notes
Compassion Campaign In Ghana	20 minutes	Mini Lecture	Compassion Campaign Documents
Compassionate Responses	30 minutes	Story telling, group work, plenary	Picture Story Kofi and Kweku Flip Chart, markers
Compassionate Behaviours	20 minutes	Mini Lecture Group work	Flip Chart, markers
Religious Texts that address Compassion	20 minutes	Mini Lecture Group Work	Flip chart, Markers, Session notes, Bible, Qur'an, (Haddith)
Summary	5 minutes	Highlight main points	

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CONTEXT

This session encourages participants to define compassion, explore its relationship to care and support and identify compassionate responses especially as they relate to HIV and PLWHAs, the infected and affected.

ACTIVITIES

UNDERSTANDING COMPASSION

The aim of this activity is to define 'compassion' and to discover how it relates to care and support.

In the light of the current situation regarding the levels of stigma and discrimination about HIV/AIDS, the religious communities have recognised the overwhelming need to cultivate a compassionate response in society towards HIV and PLWHAs, both those who are infected and those who are affected. But what does 'compassion' actually mean and how do 'compassionate' people behave?

Definitions:

Sympathy – A feeling of sorrow, pity or regret for the distress of another. Sharing the feelings or interests of another.

Empathy – The ability to enter into another person's world and imaginatively experience that person's feelings, thoughts and emotions.

Compassion – Having concern for the suffering and distress of others with a desire to alleviate it, moving one to help. Feelings PLUS Action.

Passion is a root part of the word compassion. It has the sense of 'feeling with' that is very deep and powerful and it is the ACTION inside of the Compassion. Compassion is an attribute of God, therefore we as human beings created in the image of God, should also show compassion. Compassion MOVES one to go beyond sympathy and empathy and to respond/ to act. **Compassion without Action IS NOT compassion.**

Compassionate Response

The aim of this activity is to imaginatively explore a situation that requires a compassionate response and to examine the cultural social and religious issues that can influence it.

Below is a list of responses that many who disclose their HIV/AIDS status may receive from family, friends, church members, employers, co-workers, landlords and others:

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- Discrimination
- Rejection
- Isolation
- Poverty
- Lack of love
- Denial
- Loss of self esteem
- Despair
- Suicidal Feelings
- Feelings of worthlessness and being despised

If these are the experiences that someone who is HIV positive could face in Ghana, WHY would they want to know their status? There is no benefit (nothing to look forward to, no advantage) if this is the case. There is no positive future; no Island.

THE COMPASSION CAMPAIGN – GHANA

The aim of this activity is to familiarise all participants with the Compassion Campaign and to see the role that religious leaders play in this campaign.

What is the Compassion Campaign in Ghana?

The Compassion Campaign for people living with the HIV/AIDS is the next phase of the Ghana National HIV/AIDS campaign. The Compassion Campaign is a partnership comprising Christian Council of Ghana, CCG, Johns Hopkins University/CCP and Ghana Social Marketing Foundation with CCG as the coordinating body for the religious groups – Christians and Muslims. Since both Christians and Muslims form about 86% of the religious bodies it was decided that at the initial stages it will focus on these two communities. The major components of campaign would be emphasising compassion for people living with HIV/AIDS, developing Church policy on HIV/AIDS, looking at the theological issues, human rights issues and the importance of organising voluntary testing for HIV.

In November 2000, Christian Council of Ghana convened a meeting with key organisations as well as with Love Life Partners (Ghana AIDS Commission, Ministry of Communications & Ministry of Health Ghana Social Marketing Foundation and Johns Hopkins University/Center for Communication Programs) to design and implement a strategy emphasising compassion for people living with HIV/AIDS.

During 2001 a working group was set up to work on designing a Compassion Campaign training manual for pastors, imams, and lay persons and decided to include the

“The Journey of Hope,” a teaching resource for HIV/AIDS prevention and behaviour change as an important tool in the Compassion Campaign.

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Advocacy is an important component of the Compassion Campaign for Christian and Muslim leaders. This component was launched at Volta Hotel, Akosombo for Church leaders from 17th to 19th April, and for Muslim leaders from 22 to 24 April 2002. The meetings were extremely successful and each group came up with its own communiqué. Later a joint communiqué was issued out of the two, which were made public during the Compassion Campaign launch November 6, 2002.

In mid October the Compassion Campaign Training of Master Trainers workshop took place and following the training came the media campaign. It is our hope and expectation that a total of 900 participants will be trained throughout the country. These will go down into the churches and mosques to educate people about the campaign. It is expected that the follow-up activities in the religious communities will continue into the year 2003 when the Compassion Campaign will be evaluated.

What is the goal of the Compassion Campaign?

The goal of this intervention is to create a compassionate and supportive societal response to those infected and affected by HIV and AIDS to give them hope.

One of the key barriers observed is the stigma associated with a congregation that openly addresses HIV issues. The paradox of the stigma seems to be that many people associate HIV and AIDS with immortality. Therefore, if a congregation admits to having persons living with HIV and AIDS among them, or are seen to be concerned about the issue, it may be perceived in the community as admitting that the congregation is immoral and weakening the religious faith they profess. This “fear of association” becomes a barrier to congregations coming out openly to address the issue of HIV and AIDS.

Other barriers identified include the following:

- Lack of knowledge about transmission
- Ignorance of facts about magnitude of the HIV/AIDS problem in Ghana
- Perception that HIV is a punishment from God for immortality
- Belief that only people who are immoral get HIV, therefore people are judgmental
- Lack of knowledge about how the congregation can provide meaningful support.
- Congregations have not perceived how their existing support structures could be applied to issues about HIV and AIDS
- Lack of clear policies within the religious communities on how to respond to HIV/AIDS

Compassion is a key to de-stigmatisation and also as one of the central tenets of humanitarian and religious groups. This is the main reason that religious groups have been called upon to embark on this process. We expect that the following will be achieved:

- Reducing the social stigma associated with HIV and AIDS

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- Improving care and support for those with HIV and AIDS by reducing the numbers of infected individuals who are abandoned by their families, friends, employers, landlords, and the like
- Sustaining HIV prevention behaviours over a long period of time by, among other things, helping people move beyond a state of denial about their own risk of HIV and AIDS
- Having successful implementation of large-scale voluntary testing and counselling programme by creating a positive social environment. More people will be willing to be tested for HIV if the social ramifications of finding out one's status are less severe.

Therefore, this training is a main component of the Compassion Campaign and the religious leaders, religious communities as well as the general public are asked to give their full support to the Compassion Campaign for people living with HIV and AIDS.

COMPASSIONATE RESPONSE

Small Group Exercise - Picture story

- Why do you think Kofi's family deserted him?
- Why do you think Kweku's family supported him?
- Under what circumstances would Kofi's family have reacted differently?
- Why do you think that Kofi's community and friends did not become too involved?
- What do you think will happen within each of their families after the person dies?
- What do you think will happen in both cases (Kofi and Kweku)?
- What possible assistance can you be in a situation such as Kofi's? Kweku's?
- What were the cultural, social and religious issues that Kofi/Kweku faced?
- What affect did these issues have on Kofi/Kweku receiving a compassionate response from family, friends, church/mosque? community?

Compassionate Behaviours

All faith-based individuals in communities can practice compassionate behaviours.

The aim of this activity is to identify compassionate behaviour being practised by faith-based individuals and communities

Examples of Compassionate Behaviours:

- Giving transport to hospital for PLWHAs check-ups
- Providing accommodation for a PLWHA who has been ejected from his/her home
- Funding medical costs for PLWHAs
- Visiting / spending time with PLWHAs
- Sharing a meal with PLWHAs

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- Church/Mosque 'Open-door' policy on PLWHAs
- Church/Mosque specialised HIV/AIDS counselling service
- Fund for covering VCT costs
- Setting up Home-based Care Teams or other forms of care giving support
- Helping PLWHAs form an HIV/AIDS-Support group

RELIGIOUS TEXTS ADVOCATING COMPASSION FOR THE NEEDY

The Aim of this activity is to identify Christian and Islamic texts that show that compassion is a fundamental feature of each religion.

The following scriptural references can be used:

Bible: Genesis 1:26-31; Psalm 103: 1-6; Matthew 8:1-17; 3 John 2; Luke 8: 42b-48; John 11:32-44; Matthew 15: 29 –39; 25:31-46; I John 3:11-24, Galatians 6:1-10

Qur'an: Sura Al-Ma'un 107:1-7; Sura 4:2-; Sura 2:240; Sura 89:15-20; Sura 93; Sura 7:156.

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SPEECH BY VERY REV. DR. ROBERT ABOAGYE MENSAH, GENERAL SECRETARY OF THE CHRISTIAN COUNCIL OF GHANA GIVEN DURING THE OPENING CEREMONY OF THE MASTER TRAINERS TRAINING FOR THE COMPASSION CAMPAIGN ON 21ST OCTOBER 2002

UPDATE REPORT OF STOP AIDS-LOVE LIFE COMPASSION CAMPAIGN COORDINATED BY CHRISTIAN COUNCIL OF GHANA

The Compassion Campaign is the next phase of the Ghana national HIV/AIDS campaign. The seeds of this campaign emerged from conversations between Mr. Ian Tweedie, the then Country Representative of the Johns Hopkins Center for Communication Programmes and the General Secretary of the Christian Council of Ghana, the Rev. Dr. Robert Aboagye-Mensah around August 2000. It was understood then that the Compassion Campaign will be a partnership comprising CCG, Johns Hopkins U/CCP and Ghana Social Marketing Foundation with CCG as the coordinating body for the religious groups – Christians and Muslims.

At a follow-up meeting on 22nd August 2000 we began to consider the strategic role of the Christian Church and Muslim community in Ghana in such a campaign. We realized that bringing together all the religious bodies in Ghana for the campaign at the initial stages would be a difficult task. Since both Christians and Muslims form about 86% of the religious bodies it was decided that at the initial stages we will focus on these two communities. It was further decided major components of campaign would be emphasising compassion for people living with HIV/AIDS, developing Church policy on HIV/AIDS, looking at the theological issues, human rights issues and the importance of organising voluntary testing for HIV.

On November 2000 Christian Council of Ghana convened a meeting to look at the communication strategy for the campaign, and it was devised under the guidance of Ian Tweedie. The following key organisations were represented at the meeting:

- Christian Council of Ghana
- Ghana Pentecostal Council
- National Catholic Secretariat
- Council of Independence Churches
- Federation of Muslim Councils
- Ahmadiyya Muslim Mission
- Ghana Association of Christian and Charismatic Churches
- PPAG-Mrs. Phyllis Kudolo

The following Love Life Partners were also represented:

- Ghana AIDS Commission
- Ministry of Communications & Ministry of Health Ghana Social Marketing Foundation

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- Johns Hopkins University/Center for Communication Programs

By July 2001, a working group had been set up with representatives from PPAG, JHU, NACP, AMM, and 4 from CCG. The main aim of the working group was to begin designing a Compassion Campaign training manual for pastors, imams, and lay persons.

The working group continued to have regular meetings, but because progress on the manual was very slow, it was decided that there should be a residential Manual Development Workshop to prepare it. This was held at the Coconut Grove Hotel, Elmina from 10th-14th February 2001. The General Secretary of Christian Council of Ghana participated in this work.

Seven modules were prepared there in outline and since we at CCG have been working to pull together all the segments.

Meanwhile, during August and September 2001, there was a series of workshops for delivery of "The Journey of Hope," a teaching resource for HIV/AIDS prevention and behaviour change. 30 "Master Trainers" from Accra and the southern sector of Ghana, including 2 CCG staff, 30 from Central and 30 from the northern sector have now been trained. JOH is seen to be an important tool in the Compassion Campaign.

An important component of the Campaign is the advocacy for Christian and Muslim leaders. This component was launched at Volta Hotel, Akosombo for Church leaders from 17th to 19th April, and for Muslim leaders from 22 to 24 April 2002. The meetings were extremely successful and each group came up with its own communiqué. Later a joint communiqué was issued out of the two, which will be made public when the Compassion Campaign is launched nationally before the end of the year 2002.

Today, Monday October 21, 2002 begins another important aspect of the Compassion Campaign for people living with HIV/AIDS – the training of the Training of Master Trainers, where a total of 30 people are being trained. The composition is 20 Christians and 10 Muslims. Following this training will be the official media campaign. It is our hope and expectation that a total of 900 participants will be trained throughout the country. These will go down into the churches and mosques to educate people about the campaign.

It is expected that the follow-up activities in the religious communities will continue into the year 2003 when the Compassion Campaign will be evaluated.

What is the goal of the Compassion Campaign? The goal of this intervention is to create a compassionate and supportive societal response to those infected and affected by HIV and AIDS to give them hope.

One of the key barriers that we have observed is the stigma associated with a congregation that openly addresses HIV issues. The paradox of the stigma seems to be that many people associate HIV and AIDS with immortality.

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Therefore, if a congregation admits to having persons living with HIV and AIDS among them, or are seen to be concerned about the issue, it may be perceived in the community as admitting that the congregation is immoral and weakening the religious faith they profess. This “fear of association” becomes a barrier to congregations coming out openly to address the issue of HIV and AIDS.

Other barriers identified so far include the following:

- Lack of knowledge about transmission
- Ignorance of facts about magnitude of the HIV/AIDS problem in Ghana
- Perception that HIV is a punishment from God for immortality
- Belief that only people who are immoral get HIV, therefore people are judgmental
- Lack of knowledge about how the congregation can provide meaningful support.
- Congregations have not perceived how their existing support structures could be applied to issues about HIV and AIDS
- Lack of clear policies within the religious communities on how to respond to HIV/AIDS

We see Compassion then, as a key to de-stigmatise and also as one of the central tenets of humanitarian and religious groups. This is the main reason that religious groups have been called upon to embark on this process. We expect that the following will be achieved:

- Reducing the social stigma associated with HIV and AIDS
- Improving care and support for those with HIV and AIDS by reducing the numbers of infected individuals who are abandoned by their families, friends, employers, landlords, and the like
- Sustaining HIV prevention behaviours over a long period of time by, among other things, helping people move beyond a state of denial about their own risk of HIV and AIDS
- Having successful implementation of large-scale voluntary testing and counselling programme by creating a positive social environment. More people will be willing to be tested for HIV if the social ramifications of finding out one’s status are less severe.

We call upon the general public and the religious communities in particular to give their full support to the Compassion Campaign for people living with HIV and AIDS. We believe that with God’s help and guidance, we will succeed.

Thank you, for your attention

Rev. Dr. Robert Aboagye-Mensah
General Secretary, Christian Council of Ghana
October 21, 2002

PARTICIPANT TRAINING MANUAL

SPEECH BY MR. EMMANUEL FIAGBEY, COUNTRY DIRECTOR, JOHNS HOPKINS UNIVERSITY CENTER FOR COMMUNICATION PROGRAMS GIVEN DURING THE OPENING CEREMONY OF THE MASTER TRAINERS TRAINING FOR THE COMPASSION CAMPAIGN ON 21ST OCTOBER 2002

“THE PLACE OF TRAINING IN THE STOP AIDS LOVE LIFE COMPASSION CAMPAIGN”

The Stop AIDS love Life Campaign

On the 10th of February 2000 a national campaign dubbed Stop AIDS Love Life was launched with the aim of creating a national focus for the mobilisation of all Ghanaians in the fight against HIV and AIDS. The three main objectives of this campaign are to:

1. Successively address the needs of different segments of the Ghanaian population on issues related to HIV/AIDS Communication and education;
2. Improve and increase the use of community-based HIV/AIDS communication approached in Ghana; and
3. Increase the quantities and access of HIV/AIDS communication materials to government agencies and NGOs in the promotion of mass education on HIV/AIDS in Ghana.

Phase One: Shattering the Silence

So far we can confidently say that, the implementation of this campaign according to the planned phases to meet the needs of the key target audiences is on course.

The first phase focused on the youth as a priority audience with the overall objective of increasing the levels of adoption of preventive behaviours among them. This implies more specifically encouraging our young people to improve their perception of personal risk and take steps to avoid any behaviour, which would expose them to the risk of being infected by HIV.

Various theme programmatic activities have so far been implemented to support this phase. These include:

- The production and promotion of the Love life video and song
- The testimonial Radio and TV spots
- The popular soap “Things we do for love,” which will return to the screens in the first week of November
- The Road Shows and ISD Vans that reached over 4.5 million Ghanaians in rural communities.
- The Commercial drivers, barbers, and hair dressers programs
- The development and continued use of JOH Participatory HIV/AIDS Education Kit
- The Chiefs and Queen mothers speak out on mass media and in their communities

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These programs and activities have contributed to the present level of impact the Stop AIDS love Life Campaign has made on the population as revealed in a study carried out earlier this year.

- Higher levels of exposure to HIV/AIDS information among the Ghanaian populace
- Growth in more positive attitudes and perceptions about preventive behaviours among Ghanaians
- Higher levels of acceptance and use of condoms; and
- More faithfulness among married men

Phase Two: Caring Communities: Why the Compassion Phase?

In spite of these initial impacts however, certain key areas of meeting the behaviour change needs of Ghanaians continue to remain as major concerns to the Stop AIDS love Life Partners. These are:

1. Lack of increases in the use of Abstinence and Reduction of multiple partnerships among unmarried Ghanaian young men;
2. The continued change in the nature and intensity of popular culture (music and dance, cinema and video as well as the internet) which since 1998 has been impacting negatively on the attitude and behaviour of the youth in terms of their sexuality and reproductive health; and
3. The unchecked stigmatisation of PLWHAs, their families and even their communities with the accompanying evils of discrimination.

Ladies and gentlemen, these are the issues the Second Phase of the Stop AIDS Love Life Campaign soon to be launched is meant to address. This Phase dubbed the “Compassion Phase” has as its theme, the Creation of “Caring Communities” – Communities in which stigmatisation will be reduced to the barest minimum and social acceptance of the infected and the affected will be strengthened. There is no doubt that reducing the social stigma associated with HIV/AIDS is an absolutely critical element to HIV programs as de-stigmatization can help us to achieve:

1. Improved care and support for those with HIV and AIDS by reducing the numbers of infected individuals who are abandoned by their families, friends, employers, landlords, and the like;
2. Sustained HIV prevention behaviours over a long period of time by, among other things, helping people move beyond a state of denial about their own risk of HIV and AIDS
3. Successful implementation of large-scale voluntary testing and counselling programme by creating a positive social environment. More people will be willing to be tested for HIV if the social ramifications of finding out one’s status are less severe.

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Target Audience

Compassion is a key to de-stigmatization and one of the central tenets of humanitarian and religious groups. In view of this, the Compassion campaign will focus on working with humanitarian and religious groups throughout the country to stress on compassion for those living with HIV and AIDS in Ghana.

The goal of this intervention therefore is to create a compassionate and supportive societal response to those infected and affected by HIV and AIDS to give them hope. The main behavioural objectives we shall strive to achieve include:

1. Increasing the proportion of religious bodies and congregations with well-defined and active systems engaged on HIV and AIDS issues;
2. Increasing the proportion of those infected and affected who experience a compassionate response from their families and the community in which they live, work, and worship; and
3. Reducing the proportion of people in the Ghanaian population with misconceptions about how HIV is transmitted

For the purpose of focusing the intervention, our priority audiences will be categorised into three basic groups:

1. Religious hierarchy
2. Clergy, imams, and lay leaders, and
3. Congregations and Communities

Each of these audiences we are aware has inter-related, but slightly different needs and issues and different interventions would be targeted to each of them.

Audiences, Interventions and Activities of the Compassion Phase

AUDIENCE	MAIN INTERVENTIONS	ACTIVITIES
Religious Hierarchy	Advocacy and Education	Meetings, Seminars, Forums, Advocacy Materials
Clergy and imams Lay Leaders	Training & Activity Packets	1 National Master Trainers Training 30 – 5 day trainings 5000 Activity and Reference Packets
Congregations Community	Mass Media & Group and Interpersonal Communication	Television, Radio, Print, Music Video Congregational Responses: eg. <ul style="list-style-type: none"> • Counselling • Welfare & Support Groups • Home visits • Palliative Care • Sermons • Fellowship Groups, etc.

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It is important to note that each of these interventions will be expected to influence all of the audiences.

The Master Trainers Workshop

Ladies and gentlemen, the Compassion Master Trainers Training for which we are gathered here is therefore an important foundation on which this campaign will stand.

We view education and training of our religious leaders as the means for ensuring continuity and sustaining the activities that will keep the compassion campaign running and maintain its impact. This therefore reveals the significance of your position and role as Master trainers in rolling down the knowledge and skills you will be acquiring during this training to about 900 other Ghanaian Pastors, Priests, and Imams who will be leading various HIV/AIDS Compassion activities throughout the country.

I wish to quickly point out that the effective performance of your role as Master Trainers however, depends on your ability to assume a new position of discipleship/learner ship and at the same time assume mastership when the need arises in sharing practical knowledge and experiences with your fellow participants and the resource persons during this training program.

Finally, I wish you to bear in mind that as Master Trainers on the Compassion Campaign yours is a special mission, a mission to:

1. Change behaviour
2. Persuade others to be able to promote behaviour change;
3. Inform others to be able to provide needed information;
4. Stimulate the thoughts of others to be creative on issues concerning HIV/AIDS prevention and its management;
5. Entertain when the need arises to encourage learning and adoption of relevant skills; and
6. Motivate our Religious leaders and their followers to take action in creating a positive climate for removing HIV/AIDS stigma and discrimination from our society.

Ladies and gentlemen, this is the action that will lead to the creation of the caring, loving and supportive; and in sum compassionate communities in which HIV/AIDS will continue to be positively checked and finally prevented from wreaking any further havoc on our dear nation Ghana. I wish you a successful program, which will lead to the production of the special Master Trainers we require for the promotion of the needed compassion activities in all Christian and Muslim communities.

Thank you.