Review of HIV counselling and testing related stigma in Ghana

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Ghana

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Review of HIV counselling and Testing related stigma in Ghana

A thesis submitted in partial fulfillment of the requirement for the degree of Master of Public Health

By:

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Ghana

Declaration:

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Signature: ……

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
CABA	Children Affected By AIDS
FSW	Female Sex Worker
HCT	HIV Counselling and Testing
HDI	Human Development Index
HIV	Human Immunodeficiency Virus
HPI	Human Poverty Index
IDU	Injecting Drug User
LGBT	Lesbian, Gay, Bisexual, Transgender
MSM	Men having Sex with Men
NACP	National AIDS Control Programme
PABA	People Affected By AIDS
PLHIV	Person Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
SSA	Sub Saharan Africa
CT	Counselling and testing

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It is by God's grace that I am alive today, and I am most grateful to Him.

Thank you to my thesis advisor and the entire staff of the Royal Tropical Institute, Amsterdam, for the knowledge imparted to me. May God richly bless you in all your endeavours.

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Abstract

Background: Ghana a country located in West Africa has a median HIV prevalence of 1.9% (2007). There is a wide inter-regional variation; ranging from 1.7% in the northern region to 4.2% in the eastern region. Although, the epidemic is low-grade generalized, its impact on the health and socioeconomic status of the infected and affected is enormous (NACP, 2007).

The government of Ghana has recognized HIV Counselling and Testing as the point of entry for HIV prevention, treatment, care and support, hence the focus on making HCT services accessible. However, the effort is undermined by low-uptake of the HIV services; in 2007 the uptake was less than 5%, (Amenya, 2008).

Among other factors HIV related stigma is a recognized driver as well as a factor militating against the uptake of HCT services. For the HCT programme to make a progress root causes of stigma and its effects has to be understood and addressed, hence the aim of this topic.

Methodology: To achieve the objectives of the study available literature was reviewed. Forty-two articles were found eligible for the review and findings presented using adapted model of the dynamics of HIV stigma by Holzemer, 2007.

Findings: The analysis revealed gender inequality, shame, lack of anti-discriminatory policies, criminalization of Female Sex Work, MSM and drug use are found to be the possible root causes of stigma in Ghana. Breech of confidentiality, vertical HIV programme and lack of anti-discriminatory policy within the health care system are the likely drivers of health care related HIV stigma.

Conclusion: While the study has revealed some likely root causes of HIV related stigma in Ghana and its effects on the up-take of HCT services more needs to be done to contextualize some of these factors. As in-depth knowledge is generated evidence-informed interventions could reduce the level of stigma and possibly improve the up-take of HCT services.

Key words: Ghana, Stigma, HIV, Counselling, Testing
Words Counts: 9, 550

Introduction

AIDS remain a complex global challenge despite efforts made at all levels in reducing the spread and improving the quality of Person Living with HIV (PLHIV), People Affected By AIDS (PABA) and Children Affected By AIDS (CABA). While HIV prevalence is stabilizing, the number of people living with HIV is increasing due to new infections; as at the end of 2007 about 33million people are living with the virus of which 67%lives SSA. (UNAIDS 2007)

The HIV epidemic in Ghana is low-grade generalized (2007 median prevalence 1.9%) with a wide inter-regional and inter-site variation. The 2007 sentinel site prevalence ranges from 0.3% to 8.9%, indicative of the multiplicity of country's epidemic. Similarly, by the end of the same year here were 264,481 and 16,947 adults and children respectively living with HIV, 155,782 AIDS orphans in the country (HSS NACP, 2007).

The recognition of knowing one's HIV status as an entry point for prevention, treatment, care and support led to the establishment of HCT sites across the country. However, this effort is thwarted by poor up-take of the services due to high level of HIV related stigma among other fundamental causes.

Having worked as a nurse at district, regional and presently at the national level at the Counselling, Care and Support Unit, HIV related stigma is the major challenge I face in the discharge of my duties. Hence, the drive to analyze HCT related stigma, with the aim of understanding the root causes and providing recommendations for evidence-informed on stigma reduction strategies.

The output of the thesis will be used by National AIDS/STI Control Programme and its partners in the development and implementation of evidence-informed HCT related stigma reduction strategies, with the overall aim of increasing the up-take of HCT and other HIV services like ART. Personally, as a practicing HIV counsellor and national trainer lessons learned from this thesis will be transferred to fellow trainers, counsellors and caretakers across the country, which may hopefully contribute to better up-take of HIV services.

The review consist of five chapters: the first chapter is the background information on Ghana, the second, the problem statement and methodology, the third, the result or findings, the fourth, the discussion and the fifth is the conclusion and recommendation.

CHAPTER ONE Background

This chapter consists of the geographical information on Ghana, governance, demography, ethnicity, religion, socio-economic characteristics, health care and the HIV situation and response.

I.1 Geography and Governance

Ghana is centrally located on the west coast of Africa with a total land area of 238,537 square kilometres surrounded by three francophone countries with the Gulf of Guinea lying to the south stretching across 560 kilometres of the coastline. On the east by the Republic of Togo, with HIV prevalence of 3.2%, 2007: the north by Burkina Faso 2.7%, 2006: the west by Ivory Coast 4.7, 2005, (UNAIDS, 2008).
Ghana is presently operating a multi-party, democratic, presidential system of government following the promulgation of the 1992 fourth Republic Constitution of the country.

The country is divided into 10 administrative regions; the regions are further divided into 138 districts to ensure efficient and effective administration at the local levels (GDHS, 2003).

1.2 Demography

The population of Ghana in 2007 was estimated at about 22.9 million a projection from the 2000 population census with an average annual growth rate of 2.7 percent and a population density of 79.3%. Urban: rural population by sex is 21.4%:28.1% for males and 22.4%:28.1% for females, 43.8% of the population is urban. The proportion of population under 15 years and 65 years and older were about 41.3% and 5.3% respectively. Ghana has a young population with a dependency ratio of 87.3%, making it a vulnerable country. The sex structure ratio is about 97.9 males to 100 females (GSS, 2002).
The infant mortality rate (per 1000 live births) and Under 5 mortality rate (per 1000 live births) for 2006 were 76 and 120 respectively and maternal mortality ratio (per 100 000 live births) was 560 in 2005 (WHO, 2008).
The adult literacy rate for female and male is 42.3% and 65.8% respectively and for the youth 62.9% for female and 74. 5% for male (GSS, 2003)

1.3 Socio-economic characteristics

Agriculture, mining, logging, and retail trade are the most important areas of economic activity. Agriculture is the main sector and employs about 50 percent of the population (GSS, 2002).

A greater proportion of the working population are in the private informal sector (80.45%), 7.8% the private formal with the public sector bearing 5.9% (GSS, 2002). The implication of this employment pattern is that, most of the populations do not have a regular income.

Gross national income per capita for the year 2006 was international $1240 (World Bank), and per capita total expenditure on health for the year 2005 was international $93 and general government expenditure on health as percentage of total government expenditure on health was international $6.9 (WHO, 2008), Human Poverty Index (HPI) ranking and Human Development Index (HDI) ranking for 2007/2008 was 65 and 135 respectively (UNDP, 2008).

The leading and traditional commodities exports of the country are cocoa, gold, and timber and non traditional commodities such as pineapples, bananas, yams, and cashew nuts. Tourism is fast gaining prominence as a foreign exchange earner (GDHS, 2003).

1.4 Ethnic and Religious Composition

Ghana is a multi-ethnic, multi-religious and multi-cultural country. The country has over a hundred ethnic groups with varying cultures and traditions; however, no part of Ghana is ethnically homogeneous. Ethnically mixed areas are the urban centers because of migration in search of employment as well as rural areas, cocoa-growing areas which attract migrant labour. The main ethnic groups are the Akans, which constitute the largest ethnic group (about 49 percent) followed by the Mole-Dagbon (about 17 percent), Ewe (about 13 percent), and Ga/Dangme (about 8 percent). Numerous smaller ethnic groups can also be found in many parts of the country constituting 13% of the population (GSS, 2002).

Majority of the populace practice Christianity (about 69%); about 15.6% are Muslims while about 15.4 percent adheres to traditional indigenous religions or other faiths, approximately 6.2 percent of the population does not affiliate itself with a particular religion (GSS, 2002).
The populaces live in harmony with each other irrespective of one's religious affiliation, and major Christian and Muslim celebrations are national holidays. Traditional festivals are also celebrated by the various ethnic groups.

Traditional religion still has a strong hold on society formal religions. Many Christians and Muslims, for example, hold traditional religious beliefs whiles adhering to religious practice.

There is no significant link between ethnicity and religion; geographically the majority of the Muslim population is concentrated in the three

northern regions of the country. While the majority of the followers of traditional indigenous religions reside in rural areas, and the Christians are found across the length and breadth of the country (GSS, 2002).
However, some of the cultural and religious practices act as barriers to effective HIV prevention strategies.

1.5 Health Care System

Ghana's health care system was ranked 135thby WHO in the year 2000 in the world ranking.

The health care system is the delegation type of decentralization. It has been delegated to Ghana Health Service (GHS) in 1996 by the GHS and Teaching Hospitals act. There are three levels of administration: the National Governing Council, with relative control over the regions and the districts, ten regional and a hundred and ten district health administrations (MOH, 1998).

There are 286 hospitals (tertiary, regional and district) and 1487 health centres and clinics. The pattern of the incidence of diseases in the population has not shown any appreciable change. Malaria continues to top the list at the out-patient departments of hospitals and clinics (44%), upper respiratory track infections (7.2%), diarrheal diseases (4.3%), skin diseases (4.1%) and hypertension (2.7%). The major causes of morbidity and mortality are malaria, tuberculosis and HIV/AIDS (GSS, 2005).

Financing of the health system is mainly through revenues, user-fees, National Health Insurance Scheme (NHIS), as well as government budgetary allocation.
Human resource is inadequate, poorly distributed (in terms of urban and rural) and poorly motivated (GHS, 2007).

Geographical access to health facilities is not the best, 72.7% for urban and 27% for rural though there has been some improvement over the years. On the average more than 95% of pregnant women in the urban areas had antenatal care as compared to 86.5% of rural pregnant women. Supervised delivery (assistance of doctors, nurses and midwifes) is low, only 51.8% of children aged under five years, were delivered with the assistance of a trained health professional in 2003 (GSS, 2005).

1.6 HIV Situation and Response

HIV was first identified in Ghana in March 1986 and since then the epidemic has spread slowly but steadily. Initially the response was HIV and AIDS as a health rather than a developmental issue; as such the Ministry of Health (MoH) had the mandate to address the problem. National Technical Committee on AIDS was formed within the MoH in 1985, which later became National Advisory Council on AIDS (NAC).

The NAC in 1987 also evolved into the National AIDS Control Programme (NACP). The NACP was to implement and coordinate the country's HIV and AIDS programme which saw to development of the National HIV, AIDS and STI Policy for national response. Since then the MoH through the NACP has spearheaded various strategies to contain and limit the spread of the HIV infection (GDHS, 2003).
A short term plan for the prevention and control of HIV and AIDS was developed in 1987 to ensure systematic approach to the response. Two medium term plans; one from 1989 to 1993 and the other from 1996 to 2000 were also developed.

In the year 2000, the Ghana AIDS Commission (GAC) was established for effective resource mobilization, management, and co-ordination of multisectoral response of HIV/AIDS activities in the country. The first national HIV/AIDS Strategic Framework for 2001-2005 was developed. Presently the second strategic framework covering the years 2006-2010 is in operation (NACP, 2007).

In the 2003 demographic and health survey, questions were asked to determine the level of awareness and practices regarding the transmission of HIV, Mother-to-Child Transmission, stigma and discrimination, prevention and testing. HIV antibody testing was done for those who consented to it after counselling. Ninety six percent (96) of 1,800 cohabiting couples were tested for HIV in the 2003 GDHS, tested negative, 1% were both positive, whiles there is discordance in fewer than 2% of couples. Discordance whereby the man is positive and the woman is not is more common than situations in which the woman is positive and the man is not.

The epidemic has being monitored through HIV Sentinel Surveillance (HSS) since the year 2000. The first Behavioural Sentinel Surveillance was also undertaken in 2006, (NACP, 2008).

Presently, there are over a hundred facilities providing antiretroviral services and over five hundred facilities for HCT/PMTCT services being operated by public, private, Non Governmental Organizations (NGO), Faith Based Organizations (FBO), Ministries, Departments and Agencies and Civic Societies.

Financing of the country's HIV programme comes from the government of Ghana the Global Fund, World Bank (TAP),WHO, DFID, MSHARP, NERICA PROJECT and USAID.

As a downward trend of prevalence is now being observed it is hoped that key populations at risk will be targeted for preventive activities so as to maintain the downward trend (NACP, 2007).

CHAPTER TWO Problem statement, objectives and methodology

This chapter describes and justifies the problem under investigation, the study questions, objectives and methodology employed in the study

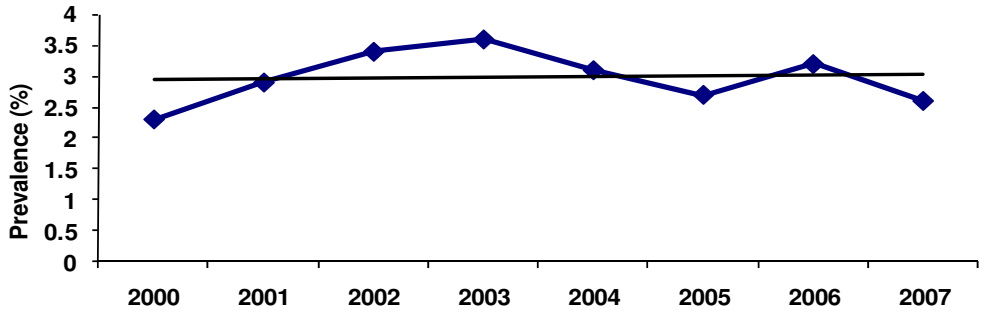
2.1 Problem Statement

Although the HIV prevalence in Ghana (1.9%) is lower than many African countries, the disease is well established in the general population and threatens the health and socioeconomic development of the country (HSS NACP 2007).

The realization of the potential benefit of CT in curbing HIV transmission leads to rapid expansion of the services. However, the effort is not commensurate with the 4.2% uptake recorded in 2007, while targeting 30% by 2010.

Studies have identified stigma among other factors as the fundamental cause of low-uptake of HCT services. However, the root and process of HCT-related stigma in Ghana have not been explored by the available literature. Identification and addressing such the root-causes of HCT-related stigma is crucial for improving the uptake of HIV services in the country.

Figure 1: Trend of HIV Prevalence among pregnant women. Ghana



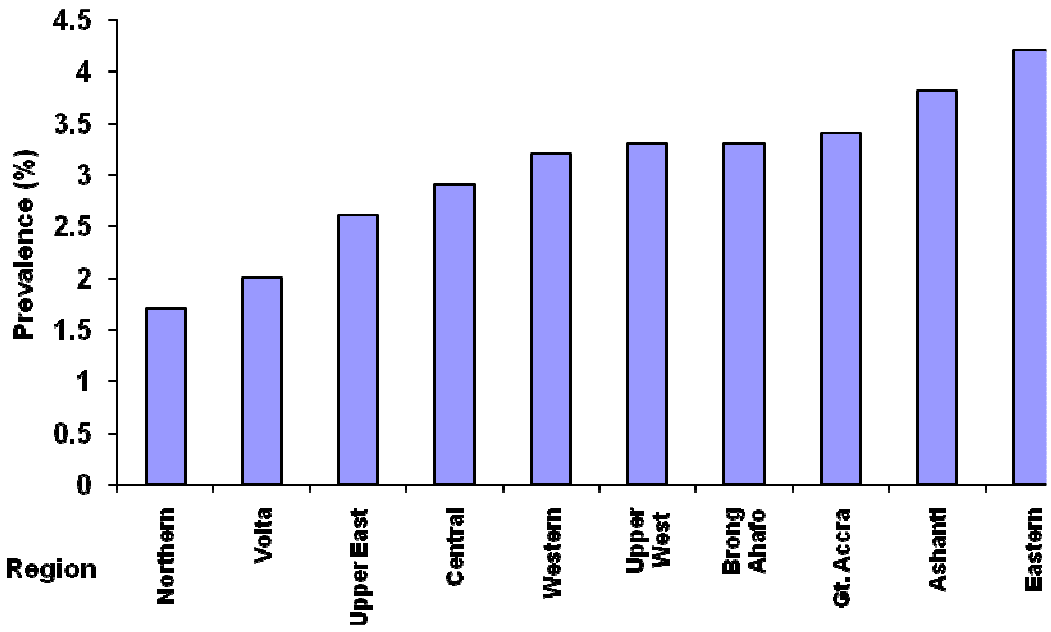
2.2 Setting of the problem:

Ghana's HIV epidemic is low-grade generalized epidemic sustained through sexual networking among the general population. However, key population at higher risk also drives the epidemic through sexual mixing. (NACP IBBS, 2007) The trend of the HIV prevalence among pregnant

women is stable (see figure1) but the overall umber of People Living With HIV (PLHIV) is on the increase. (HSS NACP 2007)

However, the low endemic pattern of the epidemic is masked at the regional level, where HIV prevalence ranges between 1.7% in the northern to 4.2% in the eastern region (see figure 2). This regional variation may be a consequence of sociocultural differences that may directly or directly affect the level of stigma and ultimately the utilization of HCT services.

Figure 2: HIV Prevalence by Region, 2007. Ghana



Eighty percent of HIV infection in the country is acquired through heterosexual intercourse and women bears the brunt of the epidemic contributing about 64% of the overall number of PLHIV in the country. (Holmes et al, 2008) The pattern of transmission and the feminization of the epidemic impact negatively on the level of HCT-related stigma in the country as women living with HIV are commonly associated with promiscuity and immorality (Turmen, 2003).

Key population at higher risk has the highest HIV prevalence in the country and contributes substantially to the epidemic. HIV prevalence among Female Sex workers (FSW) and Men having Sex with Men is 38% and 25% respectively. These sub-groups suffer double stigmatization the country because of their socially unacceptable sexual orientation, even before the AIDS epidemic.

HCT has been acknowledged as an effective means of curbing the spread of HIV infection through improvement of behaviour and access to treatment if an individual is eligible. There are 422 health-facility linked HCT sides spread across the country (1 HCT facility/54,000 population). The service delivery points poorly are not fully utilized even where available. Figure 3 below depicts the meagre proportion of men and women who had access to HIV services from 2005 to 2007. (NACP 2007)

Figure 3: Up-take of HCT services among men and women age 15 to 65 years. Ghana

	2005		2006		2007	
	Male	Female	Male	Female	Male	Female
Pop. 15-65years	5,937,979	5,820,395	5,981,907	6,102,753	6,147,900	6,272,100
No. client tested	13,358	16,688	16,083	55,224	24,433	137,470
	0.2	0.3	0.3	0.9	0.4	2.2

In spite of the decentralization of HCT services, refresher trainings of counsellors, supportive supervision and mobilization activities obviously the level of up-take of HCT is intolerable. It also affects the uptake of ART and care services.

By the end of 2007 only 16.5% of the estimated 81,409 (HSS NACP, 2007) PLHIV eligible for ARV were commenced on treatment, this is partly attributed to lack of awareness of HIV status by majority of people in the country.

Stigma related to HCT is a recognized barrier to uptake of HCT services in many African countries (Luginaah, 2005) and equally the process, quality and the manner CT is conducted affects level of individual and community stigma.

Stigma is a complex psychosocial phenomenon that is an "attribute that is deeply discrediting" which reduces the bearer "from a whole and usual person to a tainted, discounted one" (Goffman 1963).

Generally, stigma is entrenched in the sociocultural fabrics of Ghana, but the finding that over two-thirds of respondents in GNDHS 2003 opined accepting attitude towards PLHIV. However, only one-tenth of the respondents expressed accepting attitude towards the four measures asked. Equally, 88% and 90% of women and men respondents respectively have not ever tested.

Culture and religion has been cited as root causes of HIV related stigma. Virginity is highly cherished by most Ghanaian culture, this lead to the institutionalization "Miss virgin HIV" pageant and mandatory pre-marital screening by Churches, which reinforces discrimination, creates fear and refusal to access HIV services (Luginaah, 2005). However, the reasons and extent behind such practices has not been elucidated.

Stigma and discrimination is a manifestations as well as a cause of the soaring level of gender inequity in Ghana. Women are more susceptible and vulnerable to HIV; secrecy due to fear of disclosure is the hallmark of gender-HCT-stigma complex (Turman 2003). This complex relationship warrant further exploration within the context of Ghana.

Rural Ghana is particularly delineated from easy accessibility to HCT services, because of the health facility based nature. Approval for the use of lay counsellors in rural areas was confronted with fear of confidentiality breech and stigma (Baiden 2007)n in addition to socioeconomic factors, which are themselves root causes of stigma. Understanding such factors is vital to the success of HCT programme in Ghana.

Castro (Castro and Farmer, 2005) describes poverty as representing all forms of stigma. Alcoholism, substance abuse that is ubiquitous in Ghana is also mentioned as the root causes as well as facilitators of stigma.

Unaccommodating legal structures, lack of social acceptability especially of key population at higher-risk and ostracized populations may also drive stigma and impedes uptake of HCT, hence the need to analyze such factors.

From the foregoing, it is therefore imperative to understand and contextualize HCT-related stigma in Ghana for a meaningful HIV control programme and achievement of 30% universal target for HCT in 2010. Therefore, this study seeks to review of HIV Counselling and Testing related stigma in Ghana and proffer strategies for reducing HCT-related stigma.

2.2 Study questions:

- What are the root causes of HIV related stigma?
- What are the effects of stigma on the uptake of HIV counselling and testing?
- What has been done in the area of HIV-related stigma reduction interventions in Ghana?
- What are the recommendations for HIV-related stigma reduction in Ghana?

2.3 General objective:

To describe the extent of HIV related stigma, explore the root causes and their effects on the uptake of HIV counselling and testing in order to give recommendations for the reduction of HIV services related stigma in Ghana.

2.4 Specific objectives:

1. To describe the extent of HIV related stigma.
2. To explore the root causes of HIV related stigma.
3. To explore effects of HIV related stigma on the uptake of HIV services.
4. To document HIV related stigma reduction interventions in Ghana
5. To provide recommendations for the reduction of HIV services related stigma.

2.5 Target beneficiaries:

The recommendations from this review will benefit policy makers, donors, programme managers and implementers working on HIV and AIDS in Ghana and the people of Ghana.

2.6 Limitations of the study:

- Literature on HIV related stigma on Ghana was not substantial.
- Specific areas like wealth, poverty, socio-economic etc were difficult to get.
- Most if not all, the studies done on small scale.
- Most of the literatures that were cited in the study are coming from parts of Sub Saharan Africa where HIV prevalence is high.

2.7 Methodology

Based on the framework for analysis, review of available literature in the form of research reports and journals on HIV services related stigma was conducted. Literature, reports and journals on HIV services related stigma from Sub Saharan African countries and Ghana were searched for

- **Searching:** Data from existing studies on HIV and AIDS related stigma and concepts related to stigma, counselling and testing were used in the database searches. References from identified papers were also examined to identify additional studies.

- **Search Strategy:** Published studies were identified by using different key word search strategies. The databases searched included PubMed, Embase, Popline, Google scholar, Vrije University database and WHO, UNDP, UNAIDS, the Ghana AIDS Commission and the Ghana Health Service websites were also searched. There were a few hand searches. Combinations of key words using

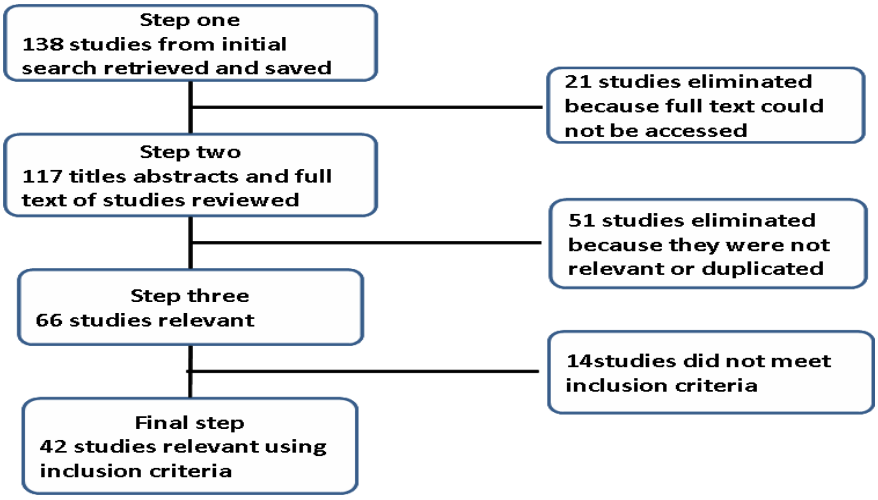
truncation symbols were used to identify articles relating to keywords.

- **Search words used:** HIV, AIDS, Attitude, Knowledge, Culture, Gender, Stigma, Discrimination, Perceived, Enacted, Internalized, Laws, Policies, Religion, Socio-economic, HIV Counseling and Testing, Prevention of Mother to Child Transmission, PLHIV, Sex, MSM, IDU, Ghana, Sub Saharan Africa.

- **Inclusion criteria:** Articles in English addressing either implicitly or explicitly HIV counselling and testing related stigma and well referenced were included in the study.

- **Screening process**
  - ***Step one*:** The initial search of databases retrieved 138 articles which were saved, 21 articles were eliminated because their full text could not be accessed
  - ***Step two:*** Following the elimination of some studies because their full text could not be accessed, 117 articles remained for further review.
  - ***Step three:*** 51 studies eliminated because they were not relevant or duplicated, 66 studies were relevant and were subjected to further review using the inclusion criteria
  - ***Final step:*** using the inclusion criteria 14 studies were eliminated, while 42 studies were retained for the study.

Figure 3: Flow-chart of the process of literature search.



- **Results:** The search strategy identified 138 titles and abstracts. A total of 117 full text papers were obtained and had inclusion criteria applied, 42 studies met the inclusion criteria and are included in the review.

- Framework for literature review and analysis: The study's framework of analysis will be based on a modified conceptual

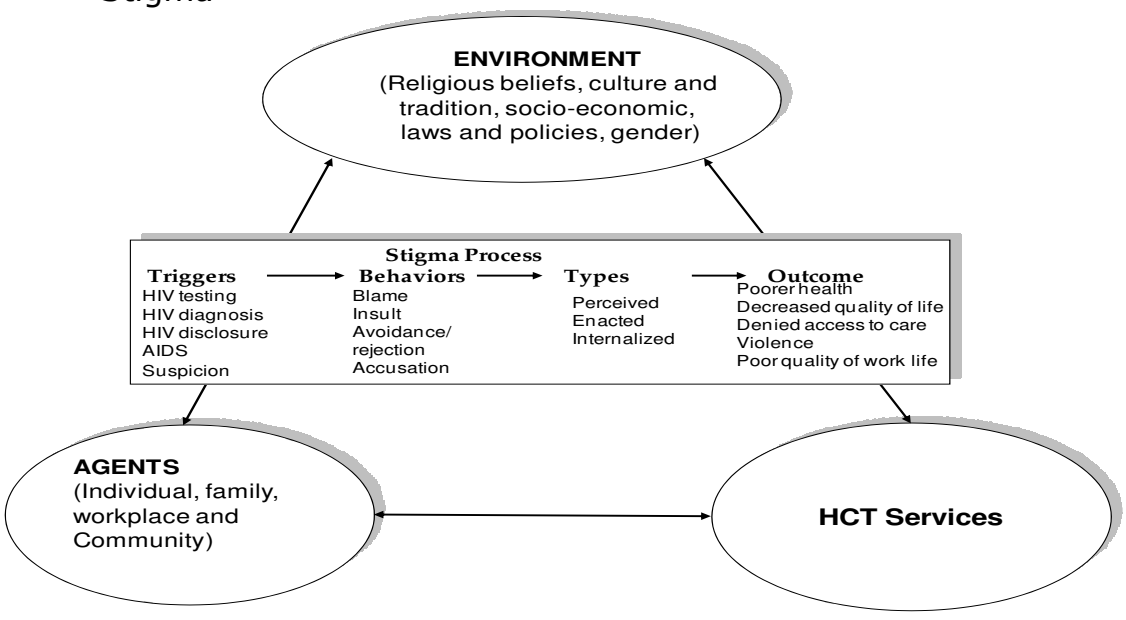
framework of the dynamics of HIV and AIDS stigma developed by Holzemer W. L. et al. in 2007. This model identified contextual factors influencing the stigma process in a four part iterative process; triggers of stigma, stigmatizing behaviours, types of stigma and outcomes. Apart from the stigma process being iterative, there is also an interaction between the environment, agents and HIV services which brings about the stigma process. The components of the modified conceptual framework are indicated in figure two.

The framework projects stigma as a process occurring within a context where the environment, agents (people) and HCT services interact. The process of stigma is best explained within the framework in a linear manner, suggesting a causal order. The stigma process includes the triggers of stigma, stigmatizing behaviours, types of stigma and the outcome of stigma. The stigma process even though in a linear manner, in practical terms may become cyclical, where the outcomes of stigma may become the triggers of stigma.

Analysis of the literature findings was undertaken using the modified framework of the dynamics of HIV and AIDS stigma developed by Holzemer et al. in 2007. It is adapted for analysis and discussion of the findings of the literature review.

The HIV Services under the framework has been modified to be specific for HCT. Innocent-guilt continuum has been introduced as a separate framework (introduced in chapter 3) to visualize the extent of stigmatization among sub-populations.

Figure 4: Modified Framework of the dynamics of HIV and AIDS Stigma



by Holzemer et al., 2007.

CHAPTER THREE Literature analysis

Analysis of the literature findings was carried out using the modified conceptual model of the dynamics of HIV and AIDS stigma developed by Holzemer, 2007. The analysis starts with the description of the stigma process followed by the presentation of the environmental influencing factors, the agents of stigmatization and last but not the least the HCT services.

3.1. Stigma process

The stigma process normally occurs within the environment, agent and HCT services. The process is made up of four dimensions represented in a linear format suggesting a causal order (one part leading to the other).

The stigma process consists of the actions that ignite stigmatizing behaviours, which are seen as stigma affecting health related outcomes (Holzemer et al., 2006). HIV related stigma is often targeted at already stigmatized individuals or groups in societies (Chesney and Smith, 1999), this is also the case of Ghana, where Men having Sex with Men (MSM), Female Sex Workers (FSW) and Injecting Drug Users (IDU) are stigmatized. The MSM and FSW, they are stigmatized because of their sexual orientation and the IDUs, because drug use is and our society perceive these people as social deviants.

3.1.1 Triggers: These are factors which activate different actions. These factors are going in for testing, testing positive, disclosure of test result to another person, being diagnosed as having AIDS or suspected of going in for testing or having features synonymous to an AIDS patient. Decisions about disclosure are weighed against the impact of stigma. Sometimes just a visit to an HCT centre will spark suspicion of risky behaviours and trigger stigmatizing behaviours'. Where a person is suspected to be infected, family members do not want to associate with the infected person (Anarfi, 1995).

3.1.2 Behaviours': In reaction to the triggers, stigmatizing behaviours are formed and these may harm or alienate the stigmatized individual from the society. Some forms of stigmatizing behaviours are blaming the individual for getting infected. The consequences of disclosure can be very severe and challenging to a woman, since for some women that will expose behaviours like sex work or drug use (Pizzi, 1992). For others they will be wrongly accused of behaviours they have never indulged in. These behaviours may range from having different crockery for the infected person, to verbal attacks, to dissolution of marriage (Laryea, 1993) and end in social rejection by social networks. As a result of actual or anticipated avoidance or rejection, HIV positive persons will not want to disclose their status.

3.1.3 Types of stigma: In reaction to the real or apparent negative behaviour the PLHIV goes through one or more of the types of stigma. There are various forms or types of stigma but for the purpose of this review, perceived, enacted and internalized stigma will be analyzed**.**

3.1.3.1 Perceived stigma: Perceived or apparent HIV-related stigma may influence reasons whether a PLHIV will or will not disclosure his or her sero-status and to whom. This is because the PLHIV considers what people feel about his/her condition and the responses it will evoke from them. If a person perceives a high level of stigma, then there will be fears of negative attitudes towards him or her (Derlega et al., 2002) making disclosure difficult.

3.1.3.2 *Enacted stigma*: This denotes actual occurrences discrimination (e.g. divorce, denying someone access to public transport) or negative behaviours (e.g. gossiping). Suspicion of getting infected often force PLHIV to be discriminate against; PLHIV having their own crockery and cutlery etc. for his or her sole use; at worst locking the infected in or out of their rooms (Anarfi, 1995). Enacted stigma goes beyond perceptions and attitudes into actions.

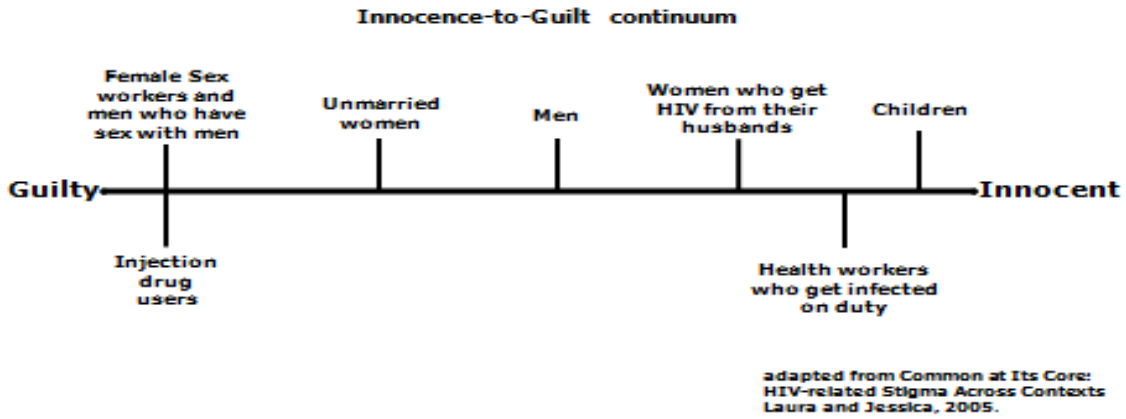
3.1.3.3. *Internalized stigma*: This refers in particular to the negative attitudes both the community and the PLHIV felt. Such persons have lowered self esteem, accompanied by a sense of hopelessness and worthlessness. Sometimes there are feelings of guilt or self-blame

3.1.4 Outcomes of stigma: The stigma outcomes are invariably the result of the types of stigma. Stigma will prevent a person from accessing any form of HIV related service. HIV testing is the entry point to other HIV related services and most often testing is delayed especially by populations at high risk (IDUs, MSMs, SWs), this being due to the fact that they are already stigmatized and marginalized in the society. Delay in initiating testing only to be tested positive in the AIDS stage (Chesney, 1999), the individual now experiences poorer health, compromising the quality of life. More often than not women suffer violence at the hands of their spouses since they have limited ability to support themselves (Mill, 2002). The outcome of stigma is a determinant of the extent to which an individual may be stigmatized.

3.2 The extent of stigma:

The illustration below on the innocence-to-guilt continuum adapted from Laura and Jessica (2005), depicts how an infected person is viewed from the cultural, traditional and religious lens in Ghana. The first question that comes to minds people when they get to hear of an infected person is how the person got infected, and then speculations will follow concerning the infected persons behaviour.

Figure 5: Innocence-guilt continuum



This continuum depicts the stigma various groups of people go through. Where an individual is placed on the continuum depicts the extent of stigma attached to that group of people.

Children are most innocent, because they acquire the infection from their mothers; health workers who get infected on duty are more innocent, since they get infected in trying to help others and women who are infected by their husbands are seen as innocent.

Unmarried women are who get infected are guiltier, this is because society views such people as immoral and FSW, MSM and IDU are the guiltiest, they are already a marginalized group in our societies before the HIV epidemic.

Men lie at the centre of the continuum, being neither innocent nor guilty, that is how society sees them, yet in Sub Saharan Africa heterosexual transmission accounts for most of HIV infections (Lamptey, 2002).

HIV sero discordance was recorded during the GDHS, (2003). A situation whereby the man is positive and the woman is not, was more common than situations in which the woman is positive and the man is not. Ninety six percent (96%) of 1,800 cohabiting couples tested negative, 1% were both positive, whiles there is discordance in fewer than 2% of couples.

3.3 Environment

Power relationships between the environmental factors and the PLHIV are contributing to the increase of stigma.

3.3.1 Religious, cultural and traditional beliefs

Religion (Garner, 2000), cultural and traditional beliefs play an important role in the life of an individual, families, communities as well as the country as a whole. The interaction of these three plays a vital role in shaping an individuals behaviour.

In Ghana some religions are obstacles in the promotion of the use of condom and see users of condom as being immoral (personal observation). Most often, secular proposals and religious and cultural beliefs are divergent. HIV infection and AIDS are seen as a curse from God resulting from immoral sexual behaviour, as such in the context of religion PLHIV is stigmatized (Taylor, 2001; Links & Phelan, 2001). Immorality is preached against by Pentecostal and Evangelical churches in Ghana since they see themselves as right before God (Addai, 2000)

In the traditional setting in Ghana, it is believed that both natural and supernatural factors cause diseases (Senah, 1997). Where the disease is debilitating or how an individual contracted it or the mode of transmission is not known, or when the disease is perceived or seen as serious, it is then believed to be due to the violation of cultural norms. There is the potential of HIV infection and AIDS being classified as such and stigmatized, because the mode of transmission was not well understood and the progression of the disease which was too drastic (Takyi, 2002).

3.3.2 ***Socio-economic:*** Three interrelated structures play important roles in an individual's socio-economic status: education, wealth or poverty and gender, these are also drivers of not stigma but also the HIV epidemic.

Women are more socio-economically disempowered than men in Ghana. More often the poor are more stigmatized than the wealthy. These disparities may be due to the fact that, literacy in women is low (GSS, 2002), making women dependent on their male counterparts and vulnerable.

3.3.3 ***Laws and Policies:*** There are various National Policies on HIV, AIDS, Tuberculosis (TB) and Sexually Transmitted Infections (STI) prevention, treatment, care and support in Ghana; however, these

policies are silent on their operational environment. The policies do not take into consideration their target population(s) and the environment of operation.

The 1992 Constitution of Ghana talks about the rights of individuals and where to go for redress in case ones right is trampled upon. In theory it is there but practically it does not happen. In Ghana the rights of PLHIV are trampled upon, they are dismissed from employment (private), evicted from their homes either by family members or landlords and insinuations cast at them (Constitution, 1992).

In the name of policies in making the PLHIV have better life, various associations of PLHIV were formed (NACP, 2007). Most of these associations are formed by persons who are not PLHIV, squander monies for the PLHIV and the association is dissolved without any course of redress.

Article 105, of the Ghana criminal code states that "whoever is guilty of unnatural carnal knowledge (a) of any person without his consent is guilty of first decree felony, or (b) of any person with his consent or of any animal, is guilty of a misdemeanour" of this law. These offences fall under the third category and take into consideration offences against public order, health, morality, etc. (Ghana Criminal Code 1960).

This law hinders the progress of HIV prevention activities in working with Lesbians, gays, bisexuals and transgender (LGBT) as well as FSW. Whiles promoting condoms use for sexual acts to these groups of people, those same condoms are used as evidence against them when arrested by law enforcement agencies.

Every individual under the 1992 Constitution of Ghana is granted freedom of association, yet the LGBT and FSW are discriminated upon because of their sexual orientation. In their communities the LGBT and FSW are treated as outcasts or lowered to beatings from people who call themselves straight. They are also brutalized by the law enforcement agencies. As such it is very difficult for them to access HIV and AIDS services due to their sexual orientation which is frowned upon by both society and the law (LGBT, 2004). Such criminalizing policies breed stigmatizing attitudes towards persons within their social settings making it difficult to accept persons who engage in acts contrary to what society deem as “right”.

These helps in discriminating against PLHIV and key population at higher risk, affecting their access to health care services.

In Ghana the laws do not work in favour of the PLHIV, LGBT or FSW. This is because the very people who are to uphold the laws to protect these marginalized groups of people are a part of the stigmatizing community.

3.4 Agents of stigma

This is identified as the PLHIV, who might have a self-stigmatizing nature, family members, community members as well as work mates (Holzemer et al., 2007).

3.4.1 ***Individual*****:** Women are more stigmatized than men in Ghana. A man may decide to disclose his HIV positive sero-status without much of a problem, unlike a woman, who might even go through rejection, dissolution of marriage as well as violence (Laryea, 1993, Mill, 2003).

Individuals may be stigmatised against differently depending upon where they fall in the continuum.

Stigma which is described as a discrediting attitude towards another person (Link, 2001), makes access to HIV services difficult thereby fuelling the spread of the virus. It affects the individual; socially, psychological, economically and health wise. Women living with HIV are more stigmatized than men as well as populations at higher risk of HIV infection (Mill, 2003).

The aftermath of being diagnosed HIV positive comes the battling with ones socio economic status.

Most HIV positive women will prefer to hide their status due to negative reactions from their family members. Family members may no longer have that close relationship that existed before the diagnosis (Mill, 2003). This may make them self-stigmatize and isolate themselves.

3.4.2 ***Family:*** The family is one of the factors under the agents, it can be stigmatized or stigmatizes. Families are much more than just a group of people sharing genetic traits. Families should be a source of support and encouragement for its members at all times; in times of need, illness, loss of job etc. Caring for a sick person irrespective of the sick person's ailment is normally done by family members. Surprisingly the women normally take care of their sick husbands, but that is not reciprocated when they are sick. Some relatives abandoned their relations (Anarfi, 1995)

3.4.3 ***Community:*** This is made up of a group of people, in a geographical area, sharing some social facilities, having group or individual identity, sharing some similarities.
In a study by Stephenson, (2009), it was observed that, where in communities in which the elderly had less supportive attitude towards PLHIV, the youth also do likewise.

3.4.4 *Workplace:* Even though HIV is not readily transmitted at workplaces yet varied forms and degrees of stigma may be present at workplaces. The size as well as the social networking at the workplace may also have an impact on the positive individual. There can be discriminatory acts where the PLHIV cannot sit anywhere else in the office apart from the place allotted to him, will not be able to mingle freely with peers because of perceived stigma. The worst that can happen to the PLHIV is dismissal from the workplace (Chesney and Smith, 1999).

3.5 HIV Counselling and Testing (HCT):

For the purpose of this review the Client Initiated Counselling and Testing, which is the voluntary counselling and testing, and the Provider Initiated Counselling and Testing (PICT) - the routine offer of counselling and testing in antenatal care settings will be explored.

Counselling and testing for HIV is the only way individuals will know whether they are infected or not. Less than 10% of PLHIV are aware of their positive sero-status, since CT is the entry point to access HIV services, there is the need for individuals to know their HIV status, (WHO, 2006).

WHO recommends the need for commitments in terms of resources; time allotted for the counselling session, infrastructure as well as trained personnel to conduct the counselling. There should be innovative services which should be expanded to cover the vulnerable as well as populations at higher risk to curb legal and cultural barriers (WHO, 2003).
The decision for an individual to decide to go for counselling and testing depends on various factors. Inclusive in these factors is the benefit of testing, is the availability of Anti Retroviral for treatment if need be.

Voluntary Counselling & testing: HIV and AIDS Stigma affect the uptake of Voluntary Counselling and Testing for HIV. Due to the stigma attached to the infection, individuals will not want to go in for the test. Coverage for Counselling and Testing among 15-59 year olds, for as 2007 in Ghana, was 4.1% which is too low if the 30% target set for the year 2010 is to be achieved (Amenya, 2008).

The fear of being stigmatized may limit the important role of HCT programmes across Sub-Saharan Africa (Campbell, 2007, Neville, 2007, Ulasis, 2007). This is because it is easy to know who has visited a HCT and when, (Muyinda, 1997, Nyblade, 2001), no matter what one does, you will be identified. Some individuals, will prefer not go in for testing, since they think it is better not to know one's HIV sero-status. A study in Botswana on attitudes, practices and human right concerns of routine HCT showed a third of the respondents did not go for HCT, since a positive result may warrant a change of behaviour (sexual practices) which they

were not ready to do (Weiser, 2006). As such most people preferred to do away with testing, since it is better not to know ones status.

Mother to Child Transmission can be prevented to the barest minimum, but the question is how this can be achieved with the feminization of HIV infection and its attending stigma. Women are marginalized group in Sub Saharan Africa due to cultural, educational and socioeconomic environment they find themselves. A subordinate group, whose responsibilities are to fulfil sexual desires of their spouses, get pregnant, give birth and take care of the home, women are subjected to beating should they refuse their spouses sex or ask their spouses to use condom (Messer, 2004) and this disempowers women the more.

Low uptake of antenatal services by women (Maedof, 2007) is a consequence of HIV/AIDS stigma. Stigma seriously hampers preventive strategies because people do not want to go for HCT services (Greeff, 2008, Duffy, 2005, Weiser, 2006) and even those who go would not disclose their HIV sero status to their sexual partners for fear of being stigmatized.

The HCT setting: This has to do with where the service is provided (the environment) and the provider of the service. These two should be conducive to allow counselling to take place; confidentiality is paramount.

A study in Tanzania among care givers in health care settings revealed gossip with colleagues about the HIV status of their clients and also disclosing their clients' status to their relatives and not to the clients (Mbwambo et al., 2003), another study with university students in South Africa revealed that participants have no trust in health care workers and fear that they will inform others about their sero-status (Meiberg et al., 2008), these are unethical since confidentiality is not upheld. Although perceived benefits to go for HCT were related to prevention and access to care as well as being pregnant, yet fear of stigmatization seem to be a major obstacle for people to go for the HIV test to know their status (Meiberg et al., 2008).

Sometimes the non integration of HCT services within the health care settings also brings on stigmatization by just going towards the direction of the counselling room you are seen as someone with a problem.

The impact of stigma on HCT, results in negative consequences for the epidemic, delays in testing means infected individuals will unknowingly be transmitting the virus to others.

3.6 The effect of stigma on HCT services

Less than 10% of PLHIV are aware of their positive sero status, since CT is the entry point to access HIV services, there is the need for individuals

to know their HIV status, (WHO, 2006). The services are to be provided in the context of confidential counselling and testing with the consent of the client.

- ***The HCT setting:*** The service provider and environment in which the service is provided can impact either negatively or positively on the uptake of HCT. HIV infection already comes along with its attending stigma and if HCT is the entry point to prevention, care, treatment and support, then there is the need to avoid issues that will prevent people from accessing the services.

  The epidemic has put a lot of pressure on the already fragile health care system, where human resource is inadequate, poorly distributed and poorly motivated. HCT services are added on duty, apart from a handful who is full time HCT service providers. HCT services put a lot of psychological strain on not only the client, but the health care worker as well. When nothing is done about the psychological strain then the service provider becomes burnt out and cares about no one again. There is the need to evenly distribute work.

  In Ghana most of the HCT centres are non-integrated facility based, and this makes it really difficult for most marginalized people to access.
  PMTCT, has a very low coverage; less than 17% of positive pregnant women were put on ART in 2007

3.6 Strategies for reducing HIV related stigma in Ghana:

At the onset of the epidemic, when it was believed to be a health problem, the MoH was given the mandate to manage the epidemic. When it became apparent that it was not just a health problem but also a developmental one, there was then the need for other stakeholders to come on board.

- ***Stop AIDS love life in Ghana "Shatters the Silence :*** The country's first national communication program focusing on HIV and AIDS. It was between February 2000 and June 2001, this emphasized on the use of HIV-protective behaviours, the focus being on abstaining from sex, being faithful to ones partner and condom use. The slogan at that time was Stop AIDS Love Life. The launching of the programme was done by the then first lady and some members of parliament. It was more on the preventive aspect of HIV.

  Presently, a greater emphasis has been placed on compassion for those living with HIV and AIDS, including the involvement of tribal

chiefs in the second phase and religious leaders in the third phase of the media (television) campaign.

- ***Religious Leaders Support Ghana's HIV/AIDS Campaign Against Stigma***: Religious leaders have embraced Ghana's national program encouraging compassion and support for PLHIV. In a communiqué presented to the then Vice President, 23 Muslim and 25 Christian religious leaders promised to work alongside the government and other stakeholders in a united front in the war against HIV/AIDS. "Reach Out, Show Compassion" for people living with HIV/AIDS is the second phase of the high profile "Stop AIDS Love Life" (Religious leaders, 2003).

- ***Sensitization of health workers of public health institutions providing ART- by NACP:*** Funds as well as logistics were provided by National AIDS Control Programme sensitization of staff at institutions providing ART on HIV and AIDS and availability of HIV services. This was to make the staff aware that HIV services has been added to the services being provided by the facility in other to prevent the occurrence of stigma and discrimination (NACP, 2008).

- ***"Know your status" campaign on going- NACP:*** Funds provided by National AIDS Control Programme to all the ten regions to organize outreach HCT, using the slogan know your status (NACP, 2008), this is still on going.

- ***Training PLHIV as peer adherence counsellors on going by SHARP/NACP*****:** PLHIV trained as peer adherence counsellors to counsel their peers before being put on ART as well as on going counselling, they also help their peers to cope with the infection (SHARP, 2008).

- ***HIV stigma and discrimination reduction in health facilities in Ghana:*** Engender Health's Quality Health Partners (QHP), Ghana project scaled-up a stigma reduction initiative at care and treatment centres across Ghana in 2007. This intervention included training providers on stigma reduction and infection control, and use of quality improvement processes to address stigma. An assessment of the initiative was conducted from November through December, 2008 (QHP, 2008).

The aforementioned interacting structures, which have been illustrated in the framework and analyzed, will be discussed to come out with the root causes of stigma, its effect on HCT services.

CHAPTER FOUR: Discussion

This chapter discusses the findings of the literature analysis. Even though there was not many studies done in the area of HCT related stigma in Ghana, the little that was analysed will be discussed and recommendations given. The discussion will focus on the ex tent of HIV-related stigma, root causes, the effects of stigma on the uptake of HCT and outcomes of HIV-related stigma reduction interventions employed in Ghana to date.

4.1 The root causes of stigma

- **Gender:** Some root causes identified from the analysis has to do with gender, sexual and social inequalities. Social, cultural and economic factors as those that influence the vulnerability of Ghanaian women to HIV infection was documented by Mill & Anarfi (2002).

  Gender is socially constructed and has to do with roles that men and women play and the relations that arise out of these roles. Gender refers to socially and culturally determined characteristics of men and women; the roles and characteristics co-exist and these are further explained through relationships between men and women (PAHO, 2007). Some gender related factors which make females vulnerable are polygyny, early marriage, marital instability, remarriage, domestic violence, and all sorts of culturally imposed traditions and norms that discriminate against women (Isiugo-Abanihe, 2006, Luginaah et al., 2005). There is the notion that women are sexual objects who lack the ability to dictate behaviours that would protect their sexual health thus the inequality of women in heterosexual relationships must be acknowledged. All these socio-cultural practices pave way for gender inequality, which may manifest as gender based violence. Gender based violence in all forms increases the susceptibility of women and girls to HIV.

  There is the need to end the feminization of HIV and AIDS in Ghana which is now a problem to women of African descent (Anrudh, 2009). Most Ghanaian women are at the receiving end of such social injustices due to the feminization of HIV. The solution to the problem lies principally in changing societal beliefs and practices within families, communities and the country at large.

- ***Laws and Policies*:** Poor implementation of policies influences the spread of HIV. Only 16% of eligible PLHIV are on ARV at the end of 2007, and only 20% of HIV positive pregnant women received ARV, implying that majority are living with high viral load for effective transmission. The national HIV policy although comprehensive is silent about key populations at higher risk.

Provision of enabling environment through formulation and implementation of relevant policies as well as decriminalization of some laws which make access to services by particular groups of people difficult is very important in the fight against the HIV epidemic. An enabling environment should be provided to aid smooth access to HIV, AIDS, TB and STI prevention, treatment, care and support services by all persons.

- ***Religious, cultural and traditional beliefs, socio-economic, laws and policies*:** There is the need to tackle the power relationships within the environment. Our cultural and traditional beliefs are so deeply rooted and as such need to be revisited when solutions are needed for issues that have cultural, traditional and religious implications.

  Culture is a part of our developmental process and gives an identity to group(s) of people and a nation as a whole. Unfortunately, it is the quantitative aspect of growth that is thought about but there is the qualitative aspect which has to do with satisfaction of man's spiritual and cultural aspirations (UNESCO, 1982).

  As cultural beings, it is not possible to negotiate any level of human change without confronting culture.

  The course of the HIV infection, gave room for cultural, traditional and religious beliefs to be read into it: the natural and supernatural cause of diseases (Senah, 1997) was revisited.

  The mode of transmission in the early years was not clear, and when it became apparent that the main mode of transmission is through sexual intercourse and was first detected in a sex worker, and then the cultural, traditional and religious beliefs became rife. Sex work is abhorred by those beliefs, as such it punishment for the sin of sex work and hence the entrenched HIV-related stigma, where any one who got infected, must have engaged in illicit sex.

  People with inappropriate behaviors (FSW, IDU, MSM), are culturally, traditionally and religiously already a stigmatized groups, and the advent of HIV has made the situation worse. The GDHS, (2003), notes a high level of awareness of HIV, but this does not translate into knowledge on mode of transmission and prevention which are low.

  Mill, (2001) in a study in Ghana with PLHIV (males and females) at an antiretroviral therapy (ART) out-patient clinic, summed it all up. The belief about HIV transmission during the early days of the epidemic, one ought travelled outside Ghana and led an immoral life; this is still the perception of most Ghanaians. How did these

women get infected if they had never led an immoral life, some of these women had heard about AIDS and not of HIV. Health workers even associated HIV infection with living an immoral life, the question here now is how then can these health workers give the necessary care to those infected when they are already prejudiced.

4.2 The effect of stigma on HCT services

Less than 10% of PLHIV are aware of their positive sero status, since CT is the entry point to access HIV services, there is the need for individuals to know their HIV status, (WHO, 2006).

- ***The HCT setting:*** The service provider and environment in which the service is provided can impact either negatively or positively on the uptake of HCT. HIV infection already comes along with its attending stigma and if HCT is the entry point to prevention, care, treatment and support, then there is the need to avoid issues that will prevent people from accessing the services.

  The epidemic has put a lot of pressure on the already fragile health care system, where human resource is inadequate, poorly distributed and poorly motivated. HCT services are added on duty, apart from a handful who are full time HCT service providers. HCT services put a lot of psychological strain on not only the client, but the health care worker as well. When nothing is done about the psychological strain then the service provider becomes burnt out and cares about no one again. There is the need to evenly distribute work.

  In Ghana most of the HCT centres are non-integrated facility based, and this makes it really difficult for most marginalized people to access. PMTCT, has a very low coverage; less than 17% of positive pregnant women were put on ART in 2007

4.3 Findings of HIV Related Stigma Reduction Strategies in Ghana

No studies have been done to analyze the stigma reduction strategies to find out if they impacted on the general population.

The stop AIDS love life was aired on television. It was a musical programme which made use of young musician stars and actors as such from the author's personal view and that of a few health and non-health workers, the programme did not impact on the population. This is because the artiste used were a delight to watch before the programme. Hence most people were actually viewing the TV programme because of the artiste. The medium of communication was English, which was not comprehensible to most

people who watched since the literacy rate is low and for most people in the rural areas did not get the message.

Religious Leaders Support Ghana's HIV/AIDS Campaign against Stigma: It is on going, a television programme.

Sensitization of health workers of public health institutions providing ART- by NACP; was done once for each health facility, this was just a day's activity, it did not bring about change. Health workers who were not into provision of HIV services will simply tell a patient, "I don't take care of AIDS patients, go to the HIV nurses". Sometimes when a patient comes, before the patient will even sit down, the comment will be, this is not your place and will shout out to the nurses who offer HIV services, "your patient is in" or you have a visitor. Such is the situation in some of the health facilities.

"Know your status" campaign; this is on-going organized by NACP; this has chalked some success since some people will not want to visit a HCT centre in an area where he or she is known but rather prefer a mobile one. It is been undertaken in all the regions with support from NACP.

- Training PLHIV as peer adherence counsellors on going by SHARP/NACP; this is also on going but one set back is that, these PLHIV are trained on volunteer basis as such no remuneration. There is the need to see how best the PLHIV can be motivated for them to continue providing support to their whiles at the same time mitigating stigma.

- HIV stigma and discrimination reduction in health facilities in Ghana: Training was done for only those in working in the HIV care and treatment sites within the health facilities, it did not take into account that the PLHIV, visit other units in the health facilities.

CHAPTER FIVE: Conclusion and recommendations

5.1 Conclusion:

Globally, HIV and AIDS-related stigma impact negatively on the life of an individual, families and community at large. The review of the HCT-related stigma reveals a complex situation. HIV- related stigma is deeply entrenched in the society; within the societies, the manifestations are equally varied, and this depends upon who is being stigmatized and who is stigmatizing.

There is the need for us to understand that reducing stigma has to be done holistically, and this is because stigma impacts negatively on accessing HCT services. This implies that there will be a greater number of people who may not be aware of their sero-status and engaging in high risk behaviours.

Key populations at higher risk who are already stigmatized in the society bear the brunt of stigmatization making it difficult for such groups to access HCT and other services.

Issues pertaining to gender was apparent, in determining the extent of stigma, it was observed that, society sees some as innocent, some guilty and for the male group, they were neither innocent nor guilty. Some of the root causes identified has to do with gender, sexual and social inequalities as well as some social, cultural and economic factors as those that influence the vulnerability of women.

5.2 Recommendations

While the root causes of HCT-related stigma have been explored, the thesis could not explore evidence-based interventions for the identified root causes. Therefore, the recommendations given below should be failed short of the ways to go about implementing them.

Recommendations for policy makers:

- Decriminalization of laws that perpetrate stigmatization especially those that impede access to HCT services. Also HIV and AIDS policies should be proactive and not silent on such groups if we hope to attain universal access by 2010.

- Enacting anti-discriminatory law

- Implementation of gender-related international policies and declarations Ghana has ratified.

- Policies prohibiting compulsory HCT e.g. pre-marital CT and before employment

Research and documentation:

- Contextualization of identified root causes in different settings and communities
- Documenting good HCT-related stigma reduction strategies

Interventions:

- Directed to religious and community leaders:
    - Avoidance of stigmatizing words and denouncing such practices
    - Mobilizing the community to accept PLHIV and access HCT services through community dialogue
    - Supporting self-help groups
    - Denouncing gender-based violence

- Directed to National AIDS Control Programme, Ghana AIDS Commission:
    - Training of non-governmental organizations, faith-based organizations on stigma reduction using participatory approaches.
    - Enhancing the module on stigma by using participatory and projective approaches in the HCT training manual.
    - Establish complain mechanism by appointing ombudsmen in health facilities
    - Integration of HCT services
    - Mainstream gender in HCT trainings and activities

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