

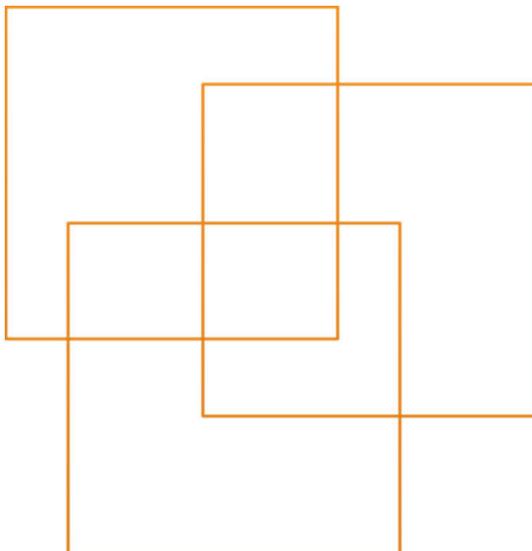


International
Labour
Organization



Communicating CHANGE

*Behavior Change Communication (BCC) Strategy for CHANGE,
E-Learning Modules & Reference CD*



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Communicating CHANGE

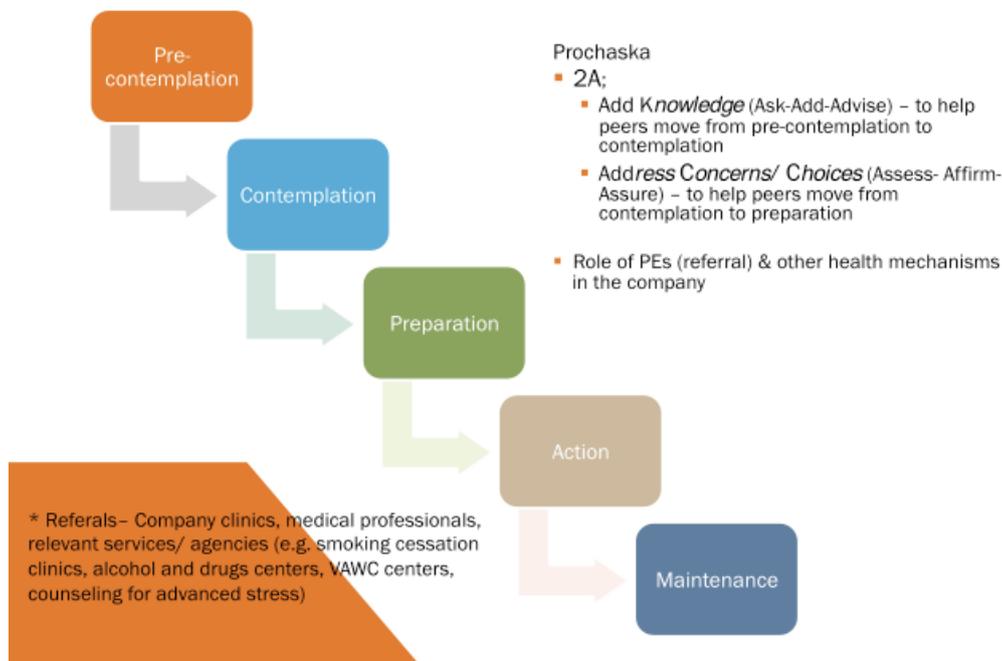
While it may seem simple and easy to encourage workers and employers to adopt healthier lifestyles, CHANGE implementers must keep in mind that risky behaviors and unhealthy practices are deeply rooted in personal traits, routines, even customs and traditions. In fact, while people are knowledgeable of health risks, they often continue practicing risky behaviors.

How does behavior change happen?

Behavior change theories¹ began to be built into the design of health promotion programs, particularly in communicating the ill effects of risky behaviors and in persuading key affected groups to practice healthy habits. The premise of health promotion is that diseases can be prevented only if people will stop practicing risky behaviors. Still, factors that cause people to change their behavior are under debate. Nevertheless, the popular consensus is that communicating for behavior change does not merely involve a one-time message blast but is a dynamic, continuous process of communication and feedback.

Perhaps the most utilized theory of behavior change is that of Prochaska's Stages of Change Theory², which explains how a person moves from pre-contemplation phase to practicing and maintaining desired behavior.

TRANSTHEORETICAL CHANGE FRAMEWORK : REASONABLE TARGETS



¹ <http://www.fhi360.org/nr/rdonlyres/ei26vbslpsidmahxc332vwo3g233xsqw22er3vofqvrjvubwyzclvqjcbdgexyzl3msu4mn6xv5j/bccsummaryfourmajortheories.pdf>Last accessed: 31 May 2012

² Prochaska J.O. and DiClemente C.C. (1982).Trans-theoretical therapy - toward a more integrative model of change. *Psychotherapy: Theory, Research and Practice* 19(3):276-288

This model describes five stages of human behavioral change:

1. Pre-contemplation, where people are unaware of the problem and have no intention to change;
2. Contemplation, where people recognize the need for change and are considering change;
3. Preparation, where they intend to change and plan for change; and
4. Action, where they initiate change and put new behaviors into practice; and
5. Maintenance, where they sustain new behaviors and address relapses to earlier stages in the change process.

Movement from each stage to the next is determined by different cognitive processes and levels of emotional readiness. For example, to move from pre-contemplation to contemplation, awareness of the behavior's consequences and availability of a support system must be raised.

The Stages of Change Theory was used to develop the Behavior Change Communication (BCC) strategy for CHANGE, but most especially applied to the peer education training program prescribed in this initiative. Peer education is a vital component of any BCC program for health promotion because lifestyle and habits are often dictated by peer pressure, and target audiences have been found to turn to peers for information and support.

This theory sets reasonable targets that peer educators may aim for, which involves moving people from a pre-contemplation stage of healthy lifestyle change through a knowledge and awareness phase, to a contemplation stage where people at risk begin to recognize the need for change. It is hoped that, at some future time, the consistent presence of support and availability of peer educators in the workplace may contribute significantly to facilitate movement of individuals to higher stages and eventually to actual positive changes in behaviour.

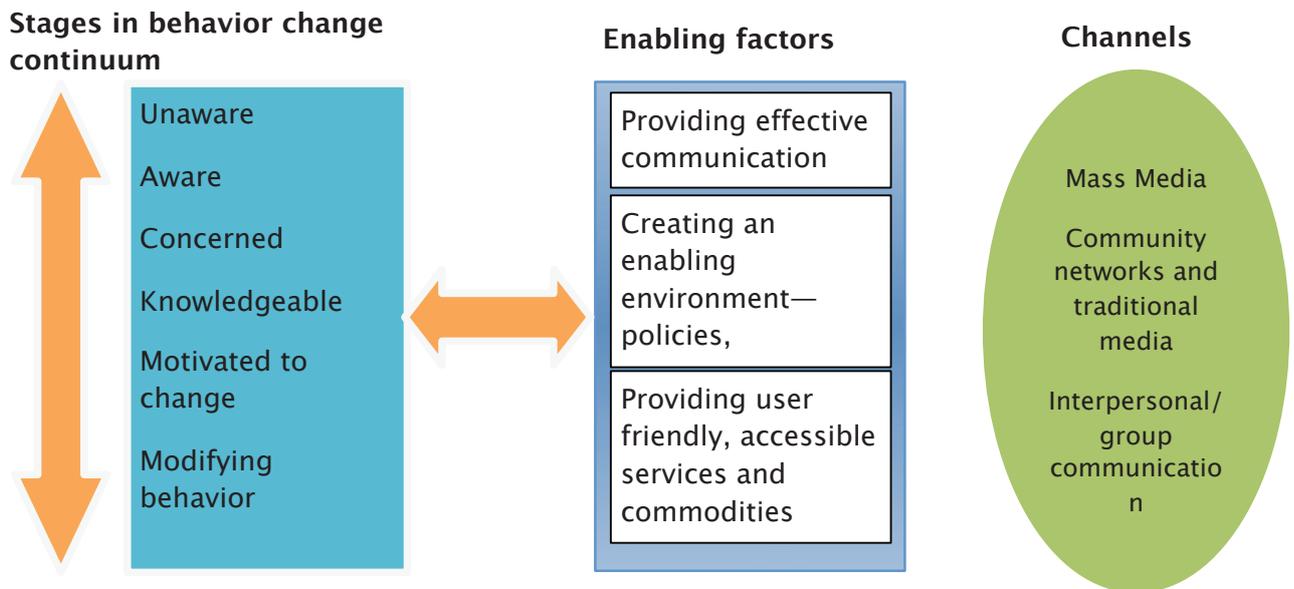
The theory is often criticized for putting too much emphasis on individual decision-making and tends to leave out other factors such as having an enabling environment or other societal norms, which may affect how a person responds to a BCC strategy's call to action.

This theory, integrated with enabling factors-- effective communication, supportive environment, and access to information and services—delivered via a combination of touchpoints, provide a comprehensive framework for behavior change communication.

The model below³ proposes that in order for people at risk to move from a state of being unaware to changing their behaviors, they must first understand the risks, must be in an environment that is supportive of positive changes in behavior, and must be provided access to information and services that will help them change. A person does not necessarily have to go through all the phases, and each person will have unique experiences. The model also acknowledges the possibility that those already practicing healthy behaviors may revert to old habits, and move from a state of behavior change to inaction.

BCC is a communication strategy that involves using a variety of touch points (that is, media and channels) to reach persons who practice unhealthy habits and risky behaviors. In health promotion, employing this strategy involves informing those most-at-risk of the consequences of risky behaviors they engage in, and encouraging them to adopt and regularly observe safer practices and healthier habits to avoid contracting preventable diseases.

³SOLVE: Integrating Health Promotion into Workplace OSH Policies Trainer's guide. ILO. Turin: 2012



BCC goes beyond the objective of influencing individual behavior. It also aims to change group or societal norms to support individual behavior change, and vice-versa, in an attempt to improve the likelihood of wider adoption of safer health practices, especially among those who are most-at-risk of contracting diseases and infections.

The scope of CHANGE

While there are many behavior-driven diseases, CHANGE only covers the following preventable infections, risk factors, and healthy practices:

1. human immunodeficiency virus (HIV) and sexually transmitted infections (STIs)
2. tuberculosis and respiratory ailments
3. cigarette smoking
4. alcohol and drug abuse
5. poor diet and nutrition
6. lack of physical activity
7. breastfeeding

CHANGE partners believe that these are the health domains where workplaces can contribute the most to workplace-based health promotion. In this campaign, CHANGE is an acronym for:

C–Cigarette Smoking
H–HIV, AIDS, and STIs
A–Alcohol and Drug Abuse
N–Nasal and Lung Ailments and Tuberculosis
G–Good Nutrition and Breastfeeding
E–Exercise

TB and HIV continue to rank as the world's top killer infections. In the Philippines, TB is the sixth leading cause of sickness and deaths, often affecting those in their prime working ages. On the other hand, while the Philippines continues to be a low HIV prevalence country, the steep rise in the number of HIV cases is enough for the Philippines to figure in the UNAIDS 2010 Global Report as one of only seven countries in the world recording more than 25 per cent increase in the number of new cases between 2000 and 2009. Majority of those newly infected fall between the ages of 20 and 39.

Cigarette smoking, alcohol and drug abuse, poor diet and nutrition, and lack of physical activity have been identified as risk factors for developing non-communicable diseases. These poor habits are blamed for six of ten leading causes of deaths among Filipinos: heart and vascular system diseases, cancer, chronic obstructive pulmonary disease, diabetes, and kidney diseases. Eliminating these poor health habits also contributes to reducing vulnerability of workers to TB by keeping their immune systems healthy. Drugs and alcohol abuse increases the likelihood of exposing workers to HIV. Use of these harmful substances affects decision-making, especially during sex or injecting drugs, and may even result to sexual violence.

The 2010 Philippines Progress Report on the Millennium Development Goals cited a significant decrease in the number of deaths among children under five. While this is a remarkable improvement, infants and children need to be continuously protected from preventable deaths, especially those that result from poor nourishment. Infants and children up to two years of age, in particular, need to be breastfed. Through the enactment of Republic Act No. 10028, or the Expanded Breastfeeding Act in the Philippines, it is hoped that the second top reason why mothers stop breastfeeding, which is the need for mothers to return to work, will be addressed.

The position that CHANGE takes and advocates is that all of these aforementioned health domains are interrelated. It means that unhealthy habits reinforce each other. For example, addiction to alcohol and drugs may increase likelihood of exposure to HIV; alcohol and drug abuse are likely to lead to sedentary lifestyle, cigarette smoking, and poor nutrition. Therefore, CHANGE takes an integrated approach to address these. Leaving out one problem may lead to an artificial, and thus temporary, solution because there is failure to address underlying psychosocial problems.

Leading a healthy lifestyle is a worker's personal choice. Yet, employers have the power to influence that decision-making process by making access to information and services available to workers. Workers spend a huge portion of their waking hours at work, making the workplace an ideal location for health promotion programs to reach a significant number of people, often those most affected by lifestyle diseases---workers in their prime working ages. Whenever a worker gets sick, whether or not due to working conditions, costs to the business are likely to follow.

The CHANGE domains, although largely determined by personal choices, are likely to result to costly expenses on the part of the enterprise anyway. Among the costs which the company is likely to incur include: health care and insurance claims, absenteeism and tardiness, staff turnover, and cost of replacement and retraining.

Conversely, having healthy employees creates opportunities for increased productivity and reduced costs. A workplace culture that promotes health among its workers improves the acquisition of best skilled talent, and, by improving employee satisfaction, it also supports your company strategy to retain them.

It is thus in your company's best interest to safeguard your workers' health and well-being.

The objective of this volume is to help you develop your own BCC Strategy for CHANGE, while already providing you with core messages and materials that you can use to jumpstart your own workplace healthy lifestyle campaign.

CHANGE core messages

CHANGE is designed to positively communicate even the most horrific reality of the health domains covered. The BCC strategy for CHANGE is not to scare workers rather, it is designed to encourage them to know more, to assess their own risky behaviors, and to act on protecting themselves from acquiring or developing so called lifestyle diseases. BCC must be based on trust, and perhaps one of the greatest motivation you can give your workers for them to embrace change involves assuring them that they will be respected and not discriminated no matter what. Another area where your enterprise can best contribute is in breaking down barriers in accessing information and services, both by making these available at the workplace and by partnering with the rest of the community.

From prevention; to treatment, care and support; to linking health and labor concerns, CHANGE aims to draw the interest of both workers and employers to take action in this healthy lifestyle campaign. This campaign's primary objective is to present a compelling case among employers and workers as to why a workplace healthy lifestyle program is a worthwhile undertaking, and why it is important for workers to improve their health, respectively. On the employers' side, this campaign hopes that management will take on the responsibility of leading the campaign. On the workers' side, this campaign aims to fulfill that right of workers to know so that they can make informed choices about their own health.

The BCC Strategy for CHANGE takes into consideration that workers make their own choices. Thus, the strategy, rather than being prescriptive, is focused on laying out options and leaves the decision-making of whether or not to avoid risky behaviors to the intended audience.

The BCC Strategy for CHANGE was developed with the following audience profile in mind:

Age: 18 to 35

Gender: male, female, and considerate of the context of men who have sex with men

Socioeconomic class: A, B and C with purchasing power

Psychosocial profile: Experiences chronic stress at work, active, mobile, adventurous, fun-loving, influence and are influenced by friends, accesses information using technology and the Internet, is also influenced by media and entertainment

For workers who already engage in risky behaviors, the BCC messages should:

- highlight that there are healthier and safer practices that can help them avoid the risks of contracting diseases and infections
- encourage them to make positive behavioral changes and let them know that it is never too late for them to do so
- explain that it is what they do and not who they are that put them at risk
- inform them of their rights most especially their right to privacy, to confidentiality, and to non-discrimination
- inform them of their right to access information and services at the workplace and elsewhere

- encourage them to avail of testing, treatment, as well as care and support services whenever necessary
- let them know that the company has a legal and ethical obligation to provide a supportive, non-discriminatory environment to promote their health and well-being

Workers who are not particularly at risk are considered secondary audiences. The communication strategy seeks to encourage them to maintain their healthy habits.

For employers, the overarching call to action is for them to lead the positive change in behavior by creating an enabling environment for the goals of CHANGE to happen, and to lead by example as well.

Other main themes of messaging for employers are:

- Employers are mandated by law to provide health services to workers
- Beyond mere compliance to law, it is the employers' ethical obligation to keep their workers productive by safeguarding their health and well-being
- Even though healthy lifestyle is subject to each worker's personal choice, a worker's health condition affects enterprise profits

Example of a Workplace BCC Strategy for CHANGE

Overall Program Goal:

Encourage the adoption of healthier habits and safer health practices.

Communication goals:

- Raise awareness on the risks associated with unhealthy lifestyle behaviors
- Encourage appreciation of the benefits that come with making healthy lifestyle choices
- Influence target audience to make positive changes to their health
- Inform target audience that they have the right to demand for workplace-based information and services that concern their health
- Promote an environment that accepts, supports, and sustains positive behaviors
- Create a workplace culture that ensures the prevention, treatment, and care and support of lifestyle diseases

Behavior change goals:

- Join a smoking cessation program for smokers
- Get tested for HIV and STIs
- Delay sexual debut, use condom, or have a mutual monogamous partner
- Minimize or eliminate alcohol consumption
- Avoid illegal drugs
- Get tested for TB and avail of direct observed treatment
- Make healthy food choices
- Express milk while at work for employed mothers with infant children
- Engage in regular physical activity

The matrix below summarizes the core messages developed for CHANGE.

Domain	Live messaging	Action for employees	Action for employers
Cigarette Smoking	Live Longer	Every pack you let go gives you more hours to do the things you love. Every stick you avoid adds precious minutes to your life. Make the habit history. Live longer.	It's not just about your people's insurance. It's about a responsibility that goes beyond the workplace. Make them choose to live longer. Lead the positive change.
HIV, AIDS, STI	Love without worries. Live without fear.	Never have to say "If Only". Practice RESPONSIBLE intimacy. Be free to love without worries. Live without fear. Know the facts. Get tested for HIV and STIs.	Inform your people how to practice RESPONSIBLE intimacy. Teach them to love without worries and live without fear. Lead the positive change.
Alcohol and Drugs	Live above the influence. Live in control.	It looks harmless but alcohol and illegal drugs can threaten your future and your life. Live above the influence. Live in control.	It looks harmless but alcohol and illegal drugs can impede your people's performance and threaten your business. Make them live above the influence and in control. Lead the positive change.
Nasal and Lung Ailments and TB	Live free from respiratory diseases.	Cough, cold, and sneezes can turn into major complications. If they persist, consult your doctor. Live free from respiratory diseases.	Cough, cold, and sneezes can be a symptom of a major health complication. Protect your people from respiratory diseases. Lead the positive change.
Good Nutrition	Live Nourished.	You are what you eat. Your performance depends on it. Eat a balanced diet to beat life's challenges. Live nourished.	Your people are what they eat. Their performance depends on it. Provide them access to healthy food choices. Help them live nourished. Lead the positive change.
Exclusive Breastfeeding	Exclusively breastfeed your baby. Live Assured.	A few minutes of privacy is all it takes. Exclusively breastfeed your baby up to six months. Live assured.	A few minutes of privacy is all it takes. Allow your employees to express breastmilk at the office. Help them live assured. Lead the positive change.
Exercise	Live Active.	Working hard should not stop you from moving. Release the tension and keep your heart pumping. Boost your energy. Live active.	Get the job done by boosting your people's energy. Release the tension and keep their heart pumping. Make them live active. Lead the positive change.

Understanding Addiction

Based on a presentation prepared by Dr. Benjamin Reyes, Assistant Secretary of the Dangerous Drugs Board, for the Health Seminar facilitated by the International Labour Organization in 2012.

Introduction

Cannabis (marijuana) is the most widely consumed drug worldwide. Between 2.9% and 4.3% of the global population aged 15-64 are estimated to be users of marijuana.

Based on a 2008 study conducted by the Dangerous Drugs Board and the Department of Interior and Local Government, an estimated 1.7 million Filipinos are drug users. While marijuana is also commonly used, the drug of choice is methamphetamine hydrochloride or shabu.

Shabu is classified as an Amphetamine-type stimulant (ATS), along with amphetamine, dexamphetamine, and ecstasy. These substances temporarily improve mental or physical functions. Use of shabu and ATS in general, cause the following side effects:

- Difficulty sleeping, loss of appetite and weight loss, dehydration and reduced resistance to infection
- Jaw clenching, headaches and muscle pain
- Mood swings, anxiety, depression, agitation, mania and panic
- Tremors, irregular heartbeat and shortness of breath
- Difficulty concentrating and remembering things
- Paranoia, aggressive and violent behavior
- Psychosis after repeated use of high doses
- Permanent damage to brain cells
- Liver damage, brain hemorrhage and sudden death from cardiovascular acute conditions

Shabu dependence also results to neglect of family, work, and other social responsibilities which often lead to the breakdown of relationships with family and friends, and difficulty in studying or working.

Understanding Drug Dependence

The term dependence implies the need to repeatedly use a specific substance in order to feel good or avoid feeling bad. Other symptoms of drug dependence include⁵:

Craving — A strong need, or compulsion

⁵ Alcohol Use and Abuse: What You Should Know (Alcohol Control Series No. 4). WHO, Regional Office for South-East Asia. 2006.

Impaired control — The inability to resist or limit intake

Physical dependence — Withdrawal symptoms, such as nausea, sweating, shakiness, and anxiety, when use is stopped

Tolerance — The need for increasing amounts to feel its effects

It is important to remember that many dangerous drugs have medical value. Abuse and dependence occurs when these drugs are not used for their medical purpose.

Addiction and the brain

Addiction is a chronic relapsing brain disease. 'Chronic' means that addiction recovery can last for long periods or even a lifetime. 'Relapsing' means that a person under treatment is likely to slide back to drug use as part of the disease recovery process. Thus, relapse should not be perceived as a treatment failure. 'Disease' means it needs to be treated.

Addiction depletes the normal level of dopamine in the brain which affects its structure and normal functioning. Dopamine gives us the ability to experience pleasure and pain.

There are two brain pathways especially important in explaining addiction: the dopamine or reward pathway, and the serotonin or control pathway. These two pathways interact with each other where one part of the brain controls or provide restraint (serotonin pathway) to a compulsive and pleasure-seeking part (dopamine pathway).

The reward pathway provides the feeling of euphoria, pleasure, compulsion and satisfaction. It pertains to all good feelings of being rewarded. In contrast, the serotonin pathway is the pathway of control, memory processing, cognition, and mood control.

The reward pathway is bolstered five times in the addicted brain, while the control exercised via the serotonin pathway is decreased. This change makes the brain crave for the substance abused for it to feel pleasure. This physiological change in the brain explains the intense compulsion to take drugs, often resulting to aberrant and irrational behaviors bordering on psychosis among persons abusing or dependent on drugs.

Addiction brings with it a host of negative consequences. For example, injecting drug users (IDUs) are more susceptible to contracting HIV because of needle sharing. Other medical problems commonly associated with this disease are hepatitis C and skin diseases. Then, there are the subsequent economic problems such as users becoming drug dealers in order to maintain their habits, or committing theft to support their habit. Persons abusing or dependent on drugs often become unable to fulfill their obligations at work, and their responsibilities especially to their families.

Addiction can be treated like any other chronic relapsing disease. It can be managed with an appropriate protocol. Outpatient periodic consultation can be shifted to intense in-patient rehabilitation if patients have difficulty recovering. Psycho-social support provided by family and friends also offer important therapeutic inputs at critical stages of recovery of individuals struggling with addiction problems.

Promoting physical activity and good nutrition in the workplace

Following are some notes based on the presentations of University of the Philippines-College of Human Kinetics Associate Professor Gilda Uy, and Dr Romulo de Villa for a Health Seminar conducted for the International Labour Organization.

Ms Uy specializes on Leisure Studies and Physical Activity in Healthy Lifestyle Promotion, including discussions on active ageing and comparative physical education.

Dr de Villa is a Molecular & Nutritional Oncologist. He is a Visiting Consultant at the Pain Management Center of St. Luke's Medical. He is also a Professor of Biochemistry & Nutrition at the Department of Biochemistry and Department of Pharmacology at the Pamantasan ng Lungsod ng Maynila-College of Medicine.

Physical inactivity and poor nutrition: contributions to the burden of chronic diseases

The World Health Organization defines physical activity as “any bodily movement produced by skeletal muscles that requires energy expenditure⁶”. Good nutrition entails having a balanced proportion of different food groups to supply the body's need for energy. What food groups and how much will be discussed in detail in succeeding sections. Combining regular physical activity and good nutrition have many beneficial effects to the body:

- Improved cardiovascular health
- Improved strength and muscular endurance
- Improved flexibility
- Greater lean body mass and less body fat
- Bone development
- Greater bodily absorption of essential vitamins and minerals
- Reduced cancer risk
- Reduced effect of acquired aging
- Improved wellness
- Other health benefits
- Resistance to fatigue
- Improved focus and productivity

Unfortunately, with technological developments, our lifestyles have also become more sedentary and

⁶ http://www.who.int/topics/physical_activity/en/ Last accessed: 4 June 2012

⁷ Ibid.

unhealthy. Work often requires sitting in front of a desktop for a whole eight hours or more. Even at home, modern appliances are fully automated and require less and less human intervention to function. Technology has also enabled the development of fast-paced lifestyles, leaving less or no time to prepare fresh, hot meals. Our on-the-go lifestyle makes us rely more and more on instant and fast foods for nourishment.

The result of widespread physical inactivity is catastrophic. Ranked as the fourth leading cause of deaths worldwide, physical inactivity is responsible for an estimated 3.2 million deaths annually⁷. WHO also cites physical inactivity as the main cause for more than 20% of breast and colon cancers, 27% of diabetes cases, and 30% of ischaemic heart diseases.

Chronic diseases identified by the WHO that are related to poor nutrition are high blood glucose, overweight and obesity, high cholesterol, low fruit and vegetable intake, and Vitamin A, Zinc, and Iron deficiency.

Six of the ten leading causes of deaths in the Philippines are non-communicable diseases (NCD) which include heart and vascular system diseases, cancer, chronic obstructive pulmonary disease (COPD), diabetes, and kidney disease. Based on the results of the 2008 National Nutrition Survey⁸, 90 percent of Filipinos had one or more of the following risk factors: physical inactivity, smoking, obesity, hypertension, diabetes, and abnormal cholesterol.

Other findings of the Survey are as follows:

- Prevalence of impaired and high fasting blood sugar increased with age and was 6% for adults in their thirties, 11% for adults in their forties, and 15% for those in their fifties;
- Prevalence of high total cholesterol averaged 7% for men and 13% for women. Prevalence increased with age up to adults in fifties where it was reported to have reached 14% percent for men and 26% for women;
- Prevalence of hypertension was 22% for women and 29% for men. Prevalence increased with age. For those in their twenties, prevalence of hypertension was 5% for women and 17% for men. This increased to 36% for men in their forties and close to 50% for men in their fifties. The increase for women was pronounced for those in their forties with a reported prevalence of 42%. More than half of women 50 years old and over had hypertension in 2008;
- Women are almost twice more likely to be obese than men. Prevalence of obesity averaged 3.7% among men and 6.6% among women. Prevalence of obesity was highest among men in the thirties and forties at 5% and among women in the forties and fifties at more than 8%;
- Less than one-fourth of adults had work related physical activity, with little variation by gender and age group.
- Mean intake of vegetables was way below the recommended vegetable intake of 90-150 grams per day. On the average, men and women only ate 75 grams and 59 grams of vegetables per day.

The road to physical fitness

We all know how vital the heart is in transporting blood and oxygen to various parts of the body. Without regular, sufficient amount of physical activity the heart muscles fail to get worked out, which leads to the development of cardiovascular diseases, obesity, pulmonary diseases and asthma, hypertension, and diabetes mellitus. While regular physical activity can help prevent or delay the onset of chronic diseases, it is

⁸ Study conducted by the Department of Science and Technology–Food and Nutrition Research Institute

also deemed to be important in promoting your safety whether at work or otherwise. More importantly, by improving your agility, balance, coordination, reaction time, power, and speed, physical activity, especially if high intensity, also improves your potential to survive disasters and cope with emergencies.

Physical activity encompasses all body movements, including time spent commuting to work or even sitting on our office desks. It also includes doing household chores, and exercising or sports which we do during leisure time. A typical worker's total physical activity can be computed as follows⁹:

$$\text{Worker's Total Physical Activity} = \text{Occupational Physical Activity} + \text{Leisure-Time Physical Activity} + \text{Commuting Physical Activity}$$

A physical activity is characterized by four components: type (i.e., exercise or non-exercise), intensity (i.e., moderate or vigorous), duration, and frequency¹⁰. The WHO recommends that adults 18 to 64 years undergo the following range of physical activity:

- at least 150 minutes of moderate-intensity aerobic physical activity in a week; or,
- at least 75 minutes of vigorous-intensity aerobic physical activity in a week; or,
- an equivalent combination of moderate- and vigorous-intensity physical activity

Exercise is a planned physical activity that is intended to improve physical fitness¹¹. While exercise is generally beneficial, it can be potentially dangerous, even life-threatening if not carefully planned.

Before starting any exercise at the workplace, assess your employees' level of fitness to know if the particular exercise promoted suits them. It is essential that you collect information on their resting heart rate (RHR) and recommended maximum heart rate. The formula for each person's ideal maximum heart rate during exercise is:

$$220 - \text{Age} = \text{maximum heart rate then,} \\ \text{Maximum heart rate} - (.7 * \text{age}) = \text{Goal heart rate}$$

Moreover, the following safety measures must be observed as well before, during, and after doing any physical activity to avoid injuries:

- Wear appropriate gears
- Check that equipment and gadgets are safe and in good condition
- Know the proper form for the exercise you want to perform before you set out to do it
- Always stretch before and after your workout
- Warm up for at least 10 minutes
- Practice regular breathing while working out
- Practice progressive workout intensity
- Avoid arching your back
- When weight training, make sure that the weights are clipped well
- Slowly decrease your intensity or speed and cool down for at least 10 minutes

⁹ Taken from the SOLVE Orientation facilitated by the Occupational Safety and Health Center of the Department of Labor and Employment, delivered in January 2012.

¹⁰ Ibid.

¹¹ Ibid.

For your workers to derive impact from exercising, it is important that you help them set their goals, plan their activities, and regularly monitor their progress. By monitoring their progress, you also get to evaluate the impact of your fitness program, and this information will be necessary when you prepare your next management presentation to request continuing or additional funding.

Promoting exercise and gym subsidy are perhaps the most common workplace-based interventions adopted by enterprises to encourage individual physical activity. While these are good practices, you may also introduce other programs like forming sports clubs, leading a group stretching activity in the middle of a busy work day or, occasionally spearheading adventure trips like trekking or kayaking. Simpler yet equally impactful changes to your workplace physical environment which you may apply include, rehabilitating your worksite stairs and walkways or repositioning common office equipment like copiers and printers at the farther side of the room to encourage, even compel, your workers to walk more often and at longer distances.

Promoting good nutrition at the workplace

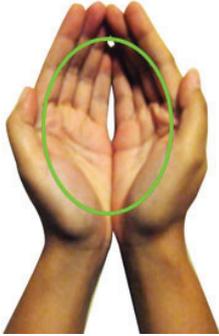
There are a number of dieting fads which often leave out at least one food group---sometimes carbohydrates, sometimes fats, or sugars. The WHO recommends that for a truly healthy eating experience, all food groups must be present in our daily diet, while only the proportions vary.

This section presents the diet and nutrition information as discussed and recommended by Dr de Villa.

For Dr de Villa, there are generally five principles of healthy eating, which are:

1. Meals should be complete. Your plate for every meal should have all the food groups which include fruits, vegetables, proteins and carbohydrates with their appropriate proportions.
2. Eating your meals should follow a proper sequence. Fruits first, followed by vegetables, then your protein food and lastly, carbohydrates.
3. Eat each food group in proper proportions. The measurement will be the palm of your hand (see below).
4. Proper timing is also important. You should only eat three meals in a day: breakfast, lunch, and dinner. If you follow the first three principles, you will not feel hungry in between meals. It should take around twenty minutes to eat a meal.
5. Be aware of healthy choices. If you follow the first four principles, metabolically you will be healthy. Your weight will be managed well. Cholesterol will not be elevated; blood pressure and sugar level will not go up.

Figure 1 Palm servings for different food groups ¹²

Vegetables	Carbohydrates	Meat	Fruits	Fat
two open hands full of vegetables	one fist size portion or rice or pasta	one palm sized portion of lean chicken or beef	one first sized portion of fruits	one thumb tip sized serving of fat or oil
				

Fruits are regulatory foods like vegetables. They contain simple sugars that can be easily digested by the body, relieving almost immediately the feeling of hunger. Taking in fruits and vegetables, which are also rich in fiber, rather than the usual Filipino eating habit of going immediately for rice, also prevents blood glucose level from spiking. Fruits and vegetables regulate the rate of absorption of sugar or the glucose that will be released from the digestion of the starch so that the blood sugar after the meal will not go up very fast.

Proteins are body building foods particularly helpful in strengthening our muscles. Proteins need carbohydrates, which are energy-giving foods. However, carbohydrates raise blood sugar or glucose higher and faster than other food groups. Carbohydrates are regulated by the fruits and vegetables you eat. Starchy carbohydrates such as grain products and potatoes mean there are more sugar in it. Some popular diets work on the principle of taking out the carbohydrates because the excess carbohydrates are often converted to fat. Very low levels of carbohydrates, however, deplete the body of energy source and it will get the energy from fat and muscles instead.

Proper dieting and weight loss must involve both exercise and good nutrition. Exercise promotes the absorption of essential vitamins and nutrients your body needs to function well and to be physically fit. On the other hand, without proper nutrition, you will not have the energy necessary to perform the moderate and rigorous intensity exercises at your ideal maximum heart rate.

The Principle of Complete Meal

Fruits, Vegetables, Proteins and Carbohydrates foods should be present in every meal. Most fast foods are protein- and carbohydrates-rich. Your workers, then, will often have ready access to proteins and carbohydrates but very little chances of obtaining the fruits and vegetables their bodies need. Some of the solutions you may consider for your workplace are:

¹² http://www.gov.mb.ca/asset_library/en/healthylivingguide/healthy_living_guide.pdf, Last Accessed: June 19, 2012.

- Talk to your concessionaire about offering daily a variety of fruits, vegetables, proteins and carbohydrates
- Advocate for your workers to pack fruits and vegetables in their lunch boxes

Always eat three meals at the same time everyday: breakfast, lunch, and dinner. Never miss any because when you skip a meal, the interval of the eating time will be longer. Your body will detect that you skipped a meal, and it will be prompted to conserve food as fat the next time you eat.

The Principle of Proper Sequence

Fruits first! Most of us, Filipinos, commonly take in our fruits after a full meal as desserts. Before you take a meal, you are hungry and your blood sugar is low. When the blood sugar is low or the body is in metabolic stress, readily available sugar from the fruit will be absorbed by the body but it will be regulated because fruits are rich in fiber.

Vegetables second! When you eat fruits and vegetables first, the tendency is to eat less of proteins and carbohydrates, because you gradually feel full. There is a general tendency to eat more of the food groups you eat first, and less of those you eat last.

It is also important to remember that while fruits and vegetables, whether eaten cooked or raw, are generally good for your diet, living foods (raw, uncooked fruits and vegetables) must be part of your regular diet. When eaten raw, you derive essential enzymes from these food groups which aid in regulating many bodily functions, detoxification, and essential in repairing, regenerating, and maintaining our cells.

Principle of Proper Amount

The proper amount per meal means one portion of fruits, one portion of vegetable, one portion of proteins and one portion of carbohydrates. Portion varies and is meant as the proportion illustrated above.

Principle of Proper timing

Meals should be five hours apart. If you eat shorter than five hours you will overeat because three meals are enough for our body's needs. If you eat in-between, the additional food intake is an excess which will be converted to fat.

Principle of Healthy Choices

1st Fruits	2nd Vegetables	3rd Proteins	4th Carbohydrates
1 portion/ meal (your fist) without peel	1 portion/ meal 80% vegetable salad (your curved wide open hand) 20% cooked vegetables (your fist hand)	1 portion/ meal (your fist) without bones	1 portion/ meal (your cupped hand)
2x	3x (salad), 2x (cooked)	2x	2x
All except mango	All	Fish (sea, scales, small) Cow (grass fed) -Meat -Full Cream Powdered milk Chicken (free range) -Meat -Boiled egg Plant Protein -Beans -Tree nuts -Legumes Healthy Cooking -Steam -Boil (nilaga, sinigang, etc.) -Use coconut milk or curry	

- Milk and egg is a good combination for breakfast
- Lunch - Fruits, garden salad, vegetable soup, bread or rice
- Dinner – Fruits, garden salad, vegetable soup, lots of beans, potato

Tips for cooking healthier meals

Use the following tips to help you prepare healthier meals:

1. Use unsaturated fats like coconut oil for cooking. Olive oil can be used as salad dressings but not as frying oil.

2. Avoid frying if you can. Sinigang, pinangat, ginataan or nilaga would be healthy methods of cooking food.
3. Your workers' fitness, diet, and your workplace

Whatever your plans are to promote fitness and good nutrition in your workplace, and however you may want to implement these, remember that in order for your initiative to be whole and sustainable, it must have clearly defined goals, linked to a workplace policy on health promotion, and people are accountable for it.

In time for the 2010 FIFA World Cup, the World Health Organization came out with the **3 Fives: Five keys to safer food; Five keys to a healthy diet; Five keys to appropriate physical activity:**^{13z}

**Five keys to safer food,
Five keys to a healthy diet,
Five keys to appropriate physical activity.**

Five Keys to safer food

1. Keep clean

- Wash your hands with soap before handling food and often during food preparation
- Wash your hands with soap after using the toilets
- Wash and sanitize all surfaces and equipment used for food preparation
- Protect kitchen areas and food from insects, pests and other animals

2. Separate raw and cooked

- Separate raw meat, poultry and seafood from other foods
- Use separate equipment and utensils such as knives and cutting boards for handling raw foods
- Store food in containers to avoid contact between raw and prepared foods

3. Cook thoroughly

- Cook food thoroughly, especially meat, poultry, eggs and seafood
- Bring foods like soups and stews to boiling to make sure that they have reached 70°C. For meat and poultry, make sure that juices are clear, not pink. Ideally, use a thermometer
- Reheat cooked food thoroughly
- Avoid overcooking when frying, grilling or baking food as this may produce toxic chemicals

4. Keep food at safe temperatures

- Do not leave cooked food at room temperature for more than 2 hours

¹³ http://www.who.int/foodsafety/consumer/3x5_SA_en.pdf Last accessed: 4 June 2012

- Refrigerate promptly all cooked and perishable food (preferably below 5°C)
- Keep cooked food piping hot (more than 60°C) prior to serving
- Do not store food too long even in the refrigerator
- Do not thaw frozen food at room temperature

5. Use safe water and raw materials

- Use safe water or treat it to make it safe
- Select fresh and wholesome foods
- Choose foods processed for safety, such as pasteurized milk
- Wash fruits and vegetables, especially if eaten raw
- Do not use food beyond its expiry date

Five Keys to a healthy diet

1. Give your baby only breast milk for the first 6 months of life

- From birth to 6 months of age your baby should receive only breast milk, day and night
- Breast feed your baby whenever the baby feels hungry

2. Eat a variety of foods

- Eat a combination of different foods: staple foods, legumes, vegetables, fruits and foods from animals

3. Eat plenty of vegetables and fruits

- Consume a wide variety of vegetables and fruits (more than 400 g per day)
- Eat raw vegetables and fruits as snacks instead of snacks that are high in sugars or fat
- When cooking vegetables and fruits, avoid overcooking as this can lead to loss of important vitamins
- Canned or dried vegetables and fruits may be used, but choose varieties without added salt or sugars

4. Eat moderate amounts of fats and oils

- Choose unsaturated vegetable oils (e.g. olive, soy, sunflower, corn) rather than animal fats or oils high in saturated fats (e.g. coconut and palm oil)
- Choose white meat (e.g. poultry) and fish that are generally low in fats rather than red meat
- Limit consumption of processed meats and luncheon meats that are high in fat and salts
- Use low- or reduced-fat milk and dairy products, where possible
- Avoid processed, baked, and fried foods that contain industrial trans fatty acids

5. Eat less salt and sugars

- Cook and prepare foods with as little salt as possible
- Avoid foods with high salt contents
- Limit the intake of soft drinks and fruit drinks sweetened with sugars
- Choose fresh fruits for snacks instead of sweet foods and confectionery (e.g. cookies and cakes)

Five Keys to appropriate physical activity

1. If you are not physically active, it's not too late to start regular physical activity and reduce sedentary activities

- Find a physical activity that is FUN
- Gradually increase your participation in physical activity
- Be active with family members - in the home and outside
- Reduce sedentary habits such as watching TV and playing computer games

2. Be physically active every day in as many ways as you can

- Walk to the local shops
- Take the stairs instead of the lift
- Get off the bus early and walk

3. Do at least 30 minutes of moderate-intensity physical activity on 5 or more days each week

- Make physical activity part of your regular routine
- Organise to meet friends for physical activity together
- Do some physical activity at lunch time with colleagues

4. If you can, enjoy some regular vigorous-intensity physical activity for extra health and fitness benefits

- Vigorous physical activity can come from sports such as football, badminton or basketball and activities such as aerobics, running and swimming
- Join a team or club to play a sport that you enjoy
- Ride a bike to work instead of taking the car

5. School-aged young people should engage in at least 60 minutes of moderate- to vigorous-intensity physical activity each day

- Encourage young people to participate in sport and physical activity for fun
- Provide young people with a safe and supportive environment for physical activity
- Expose young people to a broad range of physical activities at school and at home

Two-Day Peer Education Course on HIV and AIDS

General Objectives:

The two-day workshop will provide peer educators with a holistic framework for influencing behavioral and lifestyle change and a better understanding of their roles as health educators and change agents. This entry workshop will cover HIV and AIDS—the facts and myths of the disease and its transmission; the context within which people become vulnerable; linkages between HIV and other health problems; and preventive actions and strategies that can be advocated among peers in the workplace.

Day 1	Duration
Getting to know each other	1 hour
HIV and AIDS 101	2 hours
Wildfire	1.5 hours
Risk continuum	2 hours
Day 2	
I-changed	1 hour
Skills building: Answering questions of peer clients	2.5 hours
Present 1 A- Add knowledge: Ask-Add-Advise	1 hour
Stereotyping our peers	1.5 hours
Skills building: Case studies/role play	1.5 hours
Present 2 A- Address Concern/Decision: Assess-Affirm-Assure	1 hour
Next Steps	

DAY 1

Getting to Know Each Other

- 30 minutes – 1 hour

HIV and AIDS 101

- 2 hours

Wildfire

- 2 hours

Risk Continuum and Condom Sessions

- 2 hours

Debriefing for ToT

ask about what sessions might work in their company context – time, setting, availability of staff, et al. Ask about who might be the best to send to the ToT.

Getting to Know Each Other/Pair Introductions

(30 minutes)

Aims: At the end of this session, participants will be able to:

- Identify their co-participants through their names and other information;
- Identify how their expectations from the training can be met;
- Enumerate some of the important roles of healthy lifestyles peer educators.

Method: Paired exercises, large group discussion.

- Materials: Different colored metacards, permanent markers, paper and pens.

Methodology: Explain that before beginning the learning process together, the participants will try to discover more about each other. It is hoped that this kind of discovery through discourse would be beneficial for participants to learn more about themselves and others, and how this links to being an effective peer educator.

1. Divide the large group into pairs, have the group count-off consecutively, e.g. 1-12. If there is an odd number, the facilitator can join so s/he can be paired up with a participant.
2. Have the group count off to the halfway point then repeat with the other half, e.g. 1-6, 1-6. Request those with the same numbers to sit next to each other so that they can talk for a few minutes.
3. Give each pair a permanent marker and some metacards. Ask them to conduct a brief 10 minute interview of each other to find out 3 things, namely:
 - The name of their partner (and how they want to be called during the duration of the training), other details their partner is comfortable sharing with their group – e.g. background information on family, interests, what they do for fun/recreation, etc. – whatever they are comfortable sharing with the large group
 - something about themselves that is not work-related that they are comfortable sharing – hobbies, talents, trivia, et al
 - Their answers to this question:
What is your role as a peer educator on healthy lifestyles in your company?
4. Ask them to introduce their 'partners' to the large group using the information their partners are comfortable to share. Do a sample introduction for more clarity. Take care to provide ample time for relaxed but focused introductions, maybe around 3 minutes for both.
5. After all the introductions, thank the group for their participation and openness, and encourage them to continue to do so in later activities and future training sessions.
6. As introductions take place, support their sharing non-verbally by showing understanding –

NOTE TO FACILITATOR:

If you, as a facilitator, are paired with a participant, begin the activity with you and your partner introducing each other. This will help model/demonstrate the activity to others.

making good eye contact, nodding on occasion, and if there is more time, you may want to ask clarifying questions if you think more information about certain situations would help.

7. Summarize by identifying the striking points about the group, reinforce the variety of issues that are present (those which are similar/common and those which are quite unique), and emphasize that as a principle of participatory learning, all participants will be encouraged to share what they know and make valuable contributions during the conduct of the basic course and the follow-through activities.
8. Present the training schedule and the other training features - . Clarify what this means for their participation.
 - Introduce the idea that for the training to be successful, the group would need some norms to follow as guidelines to achieve the most learning. (house rules). Invite each pair to volunteer a few guidelines. Alternative – to save time, you may want to integrate this into the introduction.

NOTE TO FACILITATOR:

Summarize by saying how behavior change can be such a challenge because it involves many things:

- *A lot of information which can sometimes be overwhelming;*
- *Each of us may have different values and beliefs;*
- *Individual experiences in relation to family, friends, community and values are all going to affect how we feel about ourselves, and -consequently affect our behaviors (e.g. peer support, peer pressure and social influences);*
- *Our attitudes about sex, sexuality, sexual relationships and other people can be emotional at times;*
- *We need to learn a variety of skills;*
- *We need many other forms and sources of support from the community (e.g. village chief, other stakeholders);*
- *The environment in which we live – cultural and religious influences, lack of access to and poor provision of health services, lack of condoms or MSM-sensitive treatment services for sexually transmitted infections.*

AIDS 101 (Knowledge session)

Objective: To increase participants' understanding and awareness of basic HIV/AIDS information and related issues.

At the end of the session, participants will be able to:

1. identify at least 3 ways that HIV is transmitted
2. list 3 ways that HIV can be prevented
3. discuss at least 2 issues related to HIV antibody testing
4. explain at least 2 of the factors that increase the risk for HIV transmission
5. discuss at least 2 main implications of HIV and AIDS

(AIDS 101 – basic HIV and AIDS and STI review, 2 hours)

Method: STEM SENTENCE CAROUSEL OR RELAY RACE

Materials: permanent markers (broad pentel pens), masking tape, strips of colored paper, flipchart papers with headings,

Flipchart headings: (choose 6-8 from below)

1. What are some of the myths/misconceptions about HIV and AIDS?
2. The infectious load of HIV can be found in what body fluids?
3. What are the requirements for successful HIV transmission?
4. HIV is transmitted through...
5. HIV transmission can be prevented through...
6. Who are most at risk for HIV and STI?
7. A person will definitely know if s/he is has HIV through...
8. What are the implications/impact of HIV and AIDS?
9. What is the relationship between STI and HIV?
10. In your agency, what are the services available for people living with HIV?

CAROUSEL

1. Divide the large group into 6-8 smaller groups, depending on the number of flipchart headings.
2. Give each group a permanent marker and ask them to go to their assigned flipchart, according to their number.
3. Ask each group to read the headings on the flipcharts (sentence or question), and think of an answer. Have them discuss and agree on one answer. Tell them to write their answer legibly, in big handwriting. Give them 2 minutes to do this.
4. Instruct participants to move to the next flipchart on their right. Have them follow the same procedure and emphasize that they should write another answer different from the one already written. Do this until they complete all flipcharts, and all flipcharts are filled with 6 different answers.
5. Use the resulting outputs on the flipcharts to clarify information, issues and concerns about HIV and AIDS. Facilitate an interactive discussion to cover all flipcharts. Make sure that your examples are relevant to the workplace. At the end of the session, distribute relevant handouts.

ALTERNATIVE PROCESS: RELAY

1. Divide the large group into 2 smaller groups and give each group a permanent marker.
2. Ask each member of the group to carefully read the heading and instruct them to write one answer.
3. Have the next member write another answer. Do this until all the possible answers have been written. Give one minute for each heading.
4. Proceed to the next heading until all headings have been covered.
5. Use the resulting flipcharts to clarify information, issues and concerns about HIV and AIDS.

Facilitate an interactive discussion to cover all flipcharts. Make sure that your examples are relevant to the workplace. At the end of the session, distribute relevant handouts.

GENERATING INSIGHTS AND APPLICATIONS

What are some of the things that you learned that you will tell significant people in your life? Family? Friends? Colleagues? Community members? How might you tell them?

Name some of the characteristics of HIV

Lifelong/no cure

Asymptomatic

You can be infected with HIV and you can infect others

Some characteristics of AIDS include...

Common to have a collection of signs and symptoms

Incubation period used to be 5-10 years now increasing

ARV treatment slows down progression of HIV infection

Early treatment/Early ARV AS prevention

AIDS is not a death sentence anymore

You can still be productive even if you have HIV

What are the requirements for successful HIV transmission?

Two requirements must be present (infectious fluid <viral load>, portal of entry into the bloodstream)

The infectious load of HIV is found in what body fluids?

Only a few body fluids are relevant/infectious for HIV infection. Remember 4 – blood, semen, vaginal/cervical mucus, breast milk.

HIV is transmitted through...

Remember 3 – blood, unprotected penetrative sex, parent to child

HIV, like other STIs is sexually transmitted – relationship with other STIs – portal of entry + weaker immune system

It is not that easy to transmit HIV BUT it takes only one exposure

The risk for HIV infection increases with the number of exposures (VERSUS partners)

HIV transmission is prevented by...

Prevention can be creative and fun – part of a bigger response

Attitudes, skills and knowledge + enabling environment all come together in HIV prevention and behavior change

Is our company an enabling environment?

Attitude change and communication skills are key

ABCDE versus SAVE

S – Safer Practices

A – Access to treatment, care and support and other services

V – Voluntary counseling and testing

E – Empowerment, education, early detection of STI

Alphabet+ of prevention

A person will definitely know if s/he has HIV through...

HIV Anti-body Test – There is only 1 way to accurately find out your HIV status – based on window period and reliable testing from accredited clinics

RA 8504 - Voluntary versus mandatory – anonymous, confidential, with pre and post test counseling

There is value in knowing your HIV status.

Get tested. Take the test.

Challenges? Human rights issues?

Who are most at risk for HIV infection?

Anyone who practices risky behaviors

Some people are more vulnerable than others

Role of environment – stigma and discrimination

MARPs – MSM, female sex workers, IDU

VPs – migrant workers, street children

How about young professionals?

What are some of the impacts/implications of HIV and AIDS?

On the individual, family, community, workforce, constituents

What is the relationship between HIV and other STI?

Portal of entry, weaker immune system

What are the human rights issues of PLWH? Or integrate as processing for 1-4, 5, 6

Implications on duty bearers obligations to respect, protect, fulfill, promote human rights

Implications on rights holders' responsibilities to know, claim, exercise, defend their human rights

Other Content and Core Messages To Consider

HIV and AIDS 101

FACTS	Core Messages	Notes
HIV, AIDS and STI	No one is immune.	
HIV infection has no cure, it is lifelong.	No report doesn't mean no case.	
Asymptomatic	Look at STI cases as a marker.	Presenting all available options is key.
TRANSMISSION		
Myths and misconceptions	HIV is present in all areas.	
Universally recognized modes of transmission	Unprotected sex is the main mode	
It takes only one exposure	As long as you practice risky behaviors, you can be exposed.	
Number of exposures versus number of partners	It is not who you are but what you do	

PREVENTION	Why do people take risks – a range of reasons
ABCDE versus SAVE	Finding yourself in vulnerable situations
Knowledge, skills AND attitudes all come together	Vulnerable versus most-at-risk
	There many effective ways to prevent HIV transmission
Enabling environment is key	Is a combination of methods
	Means different things to different people in a variety of situations (there isn't only just one way)
	You can practice any method at any time
TESTING	
Only 1 way to accurately find out if you have HIV	Attitude before – go find them! This is counterproductive Helps set directions for developing programs Is an opportunity for prevention VCT as a good practice Is about access to treatment
Mandatory testing is not cost effective; against human rights	
Provisions of RA8504	
Voluntary, with pre/post test counseling	
TREATMENT, CARE AND SUPPORT	HIV is not a death sentence. One can still live productively. Treatment is taken for life Treatment is available for free... so far. Pediatric treatment is available (11 kids being treated in NCR)
STIGMA AND DISCRIMINATION	Negative association with living HIV and AIDS It is about reducing stigma to help people feel safe and secure to access VCT and other services (TCS) Ensuring that our healthcare services and providers are sensitive to these issues and do not reinforce stigma
SOCIO-ECONOMIC IMPACT	Loss of income, jobs, health and security Impact on your constituency

Other possible statements for individual and group activity:

- Name some of the characteristics of HIV
- Some characteristics of AIDS include...
- What is the relationship between HIV and other STI?

Other core messages:

- Take the test
- Love yourself
- Enabling environment
- Self esteem
- Reducing stigma and discrimination

Incorporate “national messages”:

- we have an HIV problem in the Philippines include description
- we have a plan and we need help to implement it
- get yourself tested – there is value in knowing your HIV status you can be infected with HIV, and you can also infect others

Wildfire (Attitudes and Feelings)

Large group role-play on what it means to be HIV positive/HIV negative

Objective

The exercise is designed to make participants experience the feelings associated with HIV infection. Their task is to express their thoughts, feelings and plans about certain situations as truthfully as they can.

The exercise will go through the different stages – exposure to HIV, thinking about HIV antibody testing, living with HIV, living with each other in a world with HIV. The amount of information to be transferred will vary with the knowledge base of the participants, but more emphasis is placed on emotional responses and attitudes. This session also helps reinforce knowledge gained already and can still address any misconceptions, false beliefs, wrong information or harmful attitudes that may emerge.

Strong emotional responses may be experienced while progressing through this exercise. It is appropriate to discuss the reactions participants are having but do not explore the reactions too deeply. The point of the exercise is to clarify issues and increase understanding.

Wildfire Quick Glance Outline (1.5 hours)

Preparation:

Based on 15 participants:

HIV antibody test results written on papers placed inside envelopes:

- HIV Positive – 15 (including repeat test results)
- HIV Negative – 15 (including repeat test results)

Relate to reality chat/Q&A – sexuality, sex, risks, real world analogies

Standard questions to remember: (asked beginning number 3 below)

- How do you feel? What are you thinking about now?
- Will you tell others? Why or why not? Who will you tell? Reasons?
- What are your plans? What will you do? How will your life be like?

Outline of the different stages of Wildfire:

EXPOSURE

- instruction – handshaking as “having sex”; different handshake meanings, tapping shoulder, handshaking 2 times
- meaning and implication of behaviors
- managing exposure – inner circle (exposed) and outer circle

TESTING

- waiting for testing
- HIV antibody test, waiting for the results
- Getting the results

LIVING WITH HIV / COEXISTENCE/ HIV- IMPLICATIONS

- Living with HIV and other issues
- Debriefing – why called Wildfire; pair sharing - back to their 1st partner , 2nd partner, 3rd partner, answer a different question each:
 - 1st partner – “scariest” part of Wildfire
 - 2nd partner – what they learned about themselves and others
 - 3rd (new) partner – what they will tell others about their experience

Narrative and procedures, modified from a UNDP document

As Wildfire is both procedurally complex and laden with sensitive personal issues, the facilitator/peer educator who will lead the exercise must review it thoroughly in advance. For a smooth flow, s/he needs to run through the narrative and procedures at least twice then review the quick-glance version. The facilitator/peer educator should also consider the following variables in preparing for the exercise;

- the variety of backgrounds and profiles of participants
- the relative level of knowledge and the types of attitudes participants have about HIV, as evidenced by previous sessions;
- the familiarity of participants with voluntary counseling and testing procedures and services;
- the degree to which an atmosphere of openness and a willingness to share feelings has

developed among the participants since the beginning of the workshop.

There will be differences in reactions between participants from a wide range of backgrounds, single and in relationships (may be married or in relationships with women and/or to men), those who have children and those who do not, those currently sexually active and those who are not, those who are in younger age groups and those who are in older age groups. The resource person should be prepared to explore these differences with the participants.

The amount of information to be transferred will vary with the knowledge base of the participants. If participants are knowledgeable about prevention, testing, etc., then more emphasis can be placed on emotional responses and attitudes. If the opposite is true, more emphasis will need to be placed on building the knowledge base and balancing this with exploring attitudes. Before you proceed to the next stage of the session, it is helpful to spend a little time addressing any misconceptions, false beliefs, wrong information or harmful attitudes that may emerge.

Strong emotional responses may be experienced while progressing through this exercise. It is appropriate to discuss the reactions participants are having but do not explore the reactions too deeply. The point of the exercise is to clarify issues and increase understanding.

Do not let the discussion wander far from what each person is feeling, thinking, deciding, intending to do. The exercise is designed to allow people to experience certain situations. Avoid too much talk about technical terms or medical issues. This will dilute the impact and relevance of the session. Always remind the group to keep the "I think", "I feel", "I will", tone especially when they say "if I were in this situation...", or "maybe I will feel...".

The person touched on the shoulder at the beginning of the exercise may feel a sense of guilt for starting the infection process. S/he must be reassured that this was only an exercise and that, for the sake of exercise, the facilitator began the chain of infection.

Ample time at the end of this exercise will be needed for debriefing. It is essential to have a break following the closure of the exercise.

The questions asked of the participants during the exercise should explore not only the participants' feelings about their own sexual behavior, but also their feelings about the impact of this on those close to them, including children, spouses and family, and on their community and professional lives.

The exercise works best when the facilitator can create a warm and supportive environment.

Steps In Conducting Wildfire

1.Explain the objectives

Briefly outline the objectives of the session to the participants, and in particular, explain that the exercise is designed to make participants experience the feelings associated with HIV infection. Their task is to express their thoughts, feelings and plans about certain situations as truthfully as they can.

Confidentiality in relation to all aspects of HIV infection is extremely important. Participants must be reminded that the need for confidentiality extends to this exercise and there must be a mutual trust within the group for people to feel that they can be open in the exercise. They must respect, as confidential, any personal information which becomes known during the exercise. Remind them of the group guidelines that were drawn up earlier.

2. Demonstrate the procedure that will be followed: symbolic handshaking

Ask the participants to put down anything they are holding and to stand in a circle facing inward.

Approach one participant and shake the person's hand. Tell him or her and the rest of the group that, for this exercise, a handshake is equivalent to having unprotected sexual intercourse. Emphasize that later, you will ask them to have sex 2 times.

While still holding the participant's hand, explain that we need some mechanism to indicate personal exposure to HIV and a light scratch on the palm of the hand during the handshake is the chosen method. Stress that a scratch on the palm indicates that the person has had unprotected penetrative intercourse with someone who did the same. It does not necessarily mean that the person is infected since the virus is not transmitted during every act of unprotected intercourse. Demonstrate the hand scratch to the person with whom you are shaking hands and display it to all the other participants.

Stop your handshake. Tell everyone that this was only a demonstration and that no one, at this stage, has been exposed to HIV in the exercise.

Ask people to shake hands gently since, possibly for some, the thought of having unprotected intercourse is difficult.

3. Select a participant to be HIV Positive (or exposed to HIV)

Tell the group that you will shortly ask them to close their eyes and that you will then walk around the circle several times during which you will touch one person on the shoulder. For the course of the exercise, the touched person has HIV. Remind this person that s/he is not to tell any other group member or reveal this status at any point in the session. However, he or she has to scratch the palm of every person's hand shaken during the exercise.

Tell the group that if any of them is scratched on the palm, that person must then scratch the palms of other people he or she shakes hands with, as long as they keep to the number times. Remind people every time they shake hands they are having unprotected sexual intercourse.

Walk around the group and lightly scratch someone on the shoulder.

4. Participants experience the invisibility of infection: participants try to identify the HIV-infected person

After touching one person, ask the participants to open their eyes and see if they can identify the person in the group who is HIV-infected. Bring out the point that one cannot tell if a person has HIV just by looking, HIV infection is asymptomatic.

Ask the group how they felt as you walked around the circle. Discuss and the point that even in a game, people are fearful of being HIV-infected and do not want to be touched.

5. Sexual networking is demonstrated: participants begin to shake hands with one another, 2 times.

Remind participants that there is one person who has HIV for the exercise. Tell them that as the group proceeds, this person will scratch the palms of all hands s/he shakes. Those scratched must scratch others, as long as they are still within the number of times limit. Stipulate the maximum number of handshakes per participant:

- 10 to 15 participants, up to 2 hand-shakes per person;
- 15 to 25 participants, up to 3 hand-shakes per person.

Ask everyone to participate.

Step out of the circle and ask the participants to begin shaking hands with whomever they wish up to the stipulated number.

6. The randomness of exposure to HIV is demonstrated: after hand-shaking stops, form participants into two groups, those whose hands were scratched and those whose hands were not scratched

When the handshaking stops, step back into the centre of the circle. Ask all those who had their palms scratched during the course of the exercise and the person who had her or his shoulder touched at the beginning to step into the middle of the circle. Ask the others to return to the outer circle seats. Seat the inner circle.

Get the group to discuss what it is like to be in either position, those on the outside and the examination of issues.

Outer circle: How do you feel? Was your behavior different from that of the people in the inner circle?

Outer circle: How did you end up in the outer circle while the others are in the inner circle?

Outer circle: How do you feel about the people in the inner circle?

Inner circle: What are you thinking and feeling now that you realize it is possible that you have HIV?

Inner circle: Would you tell anyone you may have HIV? Whom?

Inner circle: Would you tell your sexual partner or partners you may have HIV? Why or why not?

Inner circle: What support would you need at this stage? To whom will you turn? If to no-one, why not?

Outer circle: Will you continue having sex? What kind?

Inner circle: Will you continue to have sex? What kind? (especially useful question for people who said they will not tell their partners that they are possibly exposed to HIV)

Outer circle: Would you have intercourse again with a person in the inner circle? If yes, how will you proceed with that?

Remember, if necessary, to remind everyone in the inner circle that they have been exposed to the virus but it is not yet known if transmission has taken place. At some stage during the discussion, participants may ask about the possibility of an HIV antibody test. Reassure them that voluntary and confidential testing with counseling is available. Explain the importance of the window period – one exposure, one window period; a new exposure, another 3 months.

7. Knowledge of one's HIV status: voluntary and confidential testing with counseling

Offer the test to everyone, including those in the outer circle. Discuss the testing procedure, the

minimum requirements under the law (pre and post test counseling, confidentiality and anonymity, privacy) and the meaning of positive and negative results. If there is someone who does not want to take the test, ask him for what reasons he will take it (employment, new relationship, etc.). It will be for this reason that he will take the test.

If a participant still says he would not want to be tested, let him. (Just make sure you give him a test result later so you could discuss the issues and feelings around mandatory testing).

Then give each participant a result (making sure that the person with HIV gets a positive one) and request everyone not to open their envelopes but to hold them. This symbolizes the waiting time between the test and getting the results. Refer to the usual waiting period of 1 day. Ask the following questions:

- What does it feel like to be waiting for your result?
- What support would you need during this period?
- Would you tell anyone you had taken the test? Whom?
- Would you continue with unprotected sexual intercourse? Why/why not?
- Would you be able to concentrate fully at work and/or home?

8. Testing without consent

Before asking those in the inner circle to open their envelopes, give envelopes to the participant who refused to get tested. Explore with each of these persons how she or he feels about having been tested without consent.

Then ask that the envelopes be opened. Have those with a positive result stay in/move to the inner circle and those with negative results stay in/move to the outer circle.

Developing strategies to live with the news that one is not infected

Ask each person about the test result.

Discuss with each person with a negative result what impact this has had on her or him. The resource person may use questions such as:

- How does it feel to get a negative result?
- Are you going to change your behavior in order to remain uninfected?
- Do you have all the information you require about safe sexual practices?
- Where would you get further information?
- What support will you need to sustain your safe behavior?

Discuss the window period for HIV antibody testing and the need for a follow-up test, especially if people have had unprotected penetrative intercourse during the previous three months.

Ask those in the inner circle if there are participants who want to repeat their test. Give them another (positive) test result and reinforce the fact that if they observed the window period, the test result is accurate.

10. Developing strategies to live with the news that one is HIV-infected

Each person with positive results should now be encouraged to discuss his or her reactions. Ask about the first 6 questions and, if applicable, any of the remaining ones:

- What thoughts crossed your mind when you received your result?
- What is your immediate reaction to the result?
- What support do you need?
- Will you tell people your result?
- How do you think they will react?
- Will you tell your spouse/partner/sexual partners?
- Will you tell your children?
- Will you tell your work colleagues? Employer?
- What support do you need for all this?
- Do you want to have children? How will this test result affect that?

The following are recommended discussion points:

The positive aspects of knowing one's infection status should be discussed: the possibility of making changes in their lifestyles to remain healthy, the possibility of planning for one's future and that of one's children, the diagnosis and treatment of opportunistic infections. The difference between being infected and having an HIV-related illness, including AIDS, should be made clear. There should be some discussion of how to handle disclosing one's infections status and the possible consequences of disclosure. For instance, would they want to come out in media? In the community? Join education efforts?

As an affirmative end to the exercise, mobilize two separate circles – one for the inner circle and one for the outer circle. Have people in the inner circle discuss what kind of support they need at this stage. Have the outer circle form discuss what kind of support they can offer people living with HIV and their families and other affected significant others. After 10 minutes, have all of them come back and form one large circle and start the sharing. Observe if the offer for support matches the expressed needs. Affirm the efforts to provide assistance and emphasize that it is important to ask first about needs and then respond to them.

11. Developing strategies for living with the virus in our midst.

Explore with the participants some strategies for living with the virus in our midst.

Questions could include:

- Do you think we can peacefully co-exist with this virus, live with it in our midst without being infected?
- What are the ways in which we can deal with the reality of HIV infection? How can we help people living with HIV manage their situations? How can we encourage the community-at-large to be supportive of prevention, care and support efforts?
- What can we do to help lessen stigma and discrimination?
- How can you help members of your family or friends to protect themselves from this virus?

Take all the envelopes back one by one reminding the participants that this has been an exercise only and as they pass the envelope to you they also “pass back the virus”. Tell everyone that the activity is called Wildfire. Ask the group’s ideas on why it might be called such. Emphasize the quick spread and affirm the quick spread of realizations and support form all.

Then ask each participant to reflect on the exercise and initiate a series of sharings. Instruct them to go back to their 3 partners and have them share their responses to the following:

- 1st partner- The scariest part of Wildfire? (when they felt most nervous)
- 2nd partner- What did they learn about themselves and others?
- 3rd (new)partner - What will they tell others about their experience here?

Emphasize that exercise is now over. At the end, participants often feel like giving each other some kind of support: a word, a smile, a touch, a hug. Maybe a song and/or dance?

A break, preferably a meal break, must be taken after this exercise to give participants time to think about the exercise and how it affected them and to talk to others or the resource person about it. The resource person should be aware that the exercise can deeply affect participants and he or she should be sensitive to this in the following hours and days.

If needed, discuss briefly preferred language, e.g. PLHA, et al.

The following pages are suggested mock HIV antibody test results. See materials for instructions on how many to print.

HIV Negative

HIV Positive

Reference:

Joselito A. de Mesa, as adapted from a UNDP session guide

Session 2: Safer Sex Continuum (1 hour)

Objective: at the end of the session, participants will be able to:

- Identify at least 5 safer sex behaviors and what it means to reduce risks for STI/HIV.
- Identify factors that increase the likelihood of having unprotected sex

Materials: Signs labeled 'Higher Risk (Red Light)', 'Lower Risk (Yellow Light)' and 'No Risk (Green Light)'; metacards with risk behaviors written, one to a card; masking tape; risk behavior guide

REMEMBER:

Experiencing – small groups post risk placements of behaviors (where the risk for HIV infection begins)

Processing – possible changes in placements, feelings about final visual (all behaviors posted and risk level assessed)

Generalize – insights, learning points, about what increases the risks or likelihood for unprotected sex to happen

Apply – how the session will affect their sexual “repertoire”, what is most realistic for them

Methodology:

EXPERIENCING

1. Make a continuum by placing “No Risk”, “Lower Risk” and “Higher Risk” signs across the board, wall or floor/ground.
e.g. NO RISK LOWER RISK HIGHER RISK
2. Divide the groups into 4 smaller groups.
3. Distribute the cards evenly among the groups and (if needed) have tape pieces available for ready access. Ensure that each group has a range of behaviors, from no to lower to higher risk. Then explain the instructions:
 - Review the requirements for successful HIV transmission;
 - Each card contains a behavior. Based on the requirements, place each card under the heading where the level of risk for HIV infection BEGINS. And since it is a continuum, feel free to place the cards between No to Lower, Lower to Higher, or even beyond Higher;
 - Remind the group: in the event that the interaction becomes very lively and spontaneous (code for debates and disagreements), we will remind ourselves about the contract and even come up with new ones if needed.
4. Give the groups 5-10 minutes to discuss where their cards should be placed. Remind the groups that we are considering the placement of WHERE THE RISK BEGINS, NOT THE EXACT LEVEL OF RISK.
5. Tell each group to ensure that all members will get a chance to present at least one card. The placement they have decided on will be regarded as a proposed placement.

PROCESSING

1. One group at a time can place their cards on the continuum.
2. As each person places a card, have them explain why that is the placement they chose based on where the risk begins.
3. Remind everyone that as a principle of participation, they are encouraged to give their comments after the cards are presented.
4. Ask the group for feedback and provide clarifying questions if needed.
5. Assure the group that they can still suggest changes to a certain card's placement. At different points, after several cards are placed on the continuum, revisit the placements, especially if you have identified a card that needs to be moved. This way, the proposal is a result of how the cards relate to each other versus your own opinion. Also, it is usually easier to decide on placements when other cards are already presented – the cards are in better context.
6. Reinforce knowledge about other STIs. After all the cards have been presented and placements agreed upon, remind the group that up to this point, HIV was discussed. Then ask which of the behaviors might be risky for other STIs? The fact is, even some of the “NO RISK FOR HIV” activities can be risky for other STI – for instance:
 - Rubbing penises together could be risky for herpes, even if there are no evident sores;
 - Deep kissing (especially when the tongue is placed inside the mouth) can sometimes be risky for Hepatitis B.

NOTE TO FACILITATOR:

Your role is to ensure that issues surface and are discussed in an open, interactive atmosphere, in the least threatening way possible. Take care to provide ample and “equal” time to those who want to share. Anticipate that there will be a lot of discussion, even debates about the cards. Often, people could relate to the behaviors being discussed and found themselves being very engaged, as if their own behavior was being talked about.

This is the point of the exercise: to have participants talk about behaviors and APPLY how they happen in real life (which may be theirs and others'), but in the least threatening and confronting manner. There are no names in the cards. No personal details that might link a participant to any of the cards. It is what they bring to the discussion that makes it more meaningful, practical and realistic.

At some point, some participants might associate a behavior or situation already posted with other cards, or sometimes with an “obvious next act”. This is acceptable, even encouraged. But do remind the whole group that as discussions are welcomed, the process will always go back to only what the card says, not to what people think might/will happen afterwards. Hopefully, this kind of interaction becomes more of a norm from this point on, as more issues will be tackled in the other sessions.

GENERALIZING

Ask for feedback and feelings – how might this affect our behavior with others? What might be most realistic for many MSM?

APPLYING

Ask for insights. What did they learn about the variety of safer sex options? What kind of risky situations would you need to watch out for? Avoid?

Gear the sharing towards identifying:

1. Factors that increase the risks for STI/HIV;
2. That some behaviors, on their own merits, have less risk in comparison to other behaviors, or a combination of thereof;
3. Many behaviors, even in combination with others, are still pleasurable but is risk-free for STI/HIV;
4. That RESOLVE or COMMITMENT or a CONSCIOUS DECISION to change behaviors is the first step towards changing behaviors.

NOTE TO FACILITATOR:

“High Risk”/“Red Light” behaviors involve the exchange of blood, semen, breast milk, or vaginal secretions and pose a definite risk of transmitting HIV.

“Low Risk”/“Yellow Light” behaviors involve a barrier such as a condom, but they are activities during which there is some potential exchange of body fluids. This might create some danger of transmitting HIV.

“No Risk”/“Green Light” behaviors involve no exchange of blood, semen, or vaginal secretions and thus pose no risk of transmitting HIV.

Some cards refer to risk factors that could increase the likelihood of unprotected behavior, therefore increased risk for STI/HIV, among other things. It is ideal that these cards are later classified separately. If participants would like to include these under the risk continuum, affirm this decision and make sure to process them in relation to other cards.

BEHAVIOR/SITUATION CARDS for Safer Sex Continuum

Risk factors:

- Unable to negotiate condom use;
- Unable to talk about safer sex;
- Excessive alcohol consumption;
- Using prohibited drugs;
- Being depressed, feeling alone;
- Does not have condoms and lubricants ready;
- Thinks he is not at risk.

Reference:

adapted from a session conducted by Konstance McCaffree PhD

“No Risk” cards:

- Mutual masturbation;
- Solo masturbation;
- Fingering;
- Showering together;
- Erotic massage;
- Watching erotic films;

- Phone sex;
- Sexy role-playing;
- Kissing on the lips;
- Kissing and licking all over the body;
- Caressing;
- Using sex toys without sharing;
- Body rubbing.

“Lower Risk” cards:

- Anal sex with a condom;
- Oral sex with a condom;

“Higher Risk” cards:

- Anal sex without a condom;
- Oral sex without a condom;
- Anal sex with multiple partners without using a condom.

Moving cards:

- Having sex with someone you love;
- Having sex with young people;
- Injecting and sharing drugs;
- Having sex with foreigners;
- Never had sex;
- Paying for sex;
- Currently abstaining but had sex before

EXPLORE THESE PROFILES:

- Having quickie sex
- Is stressed out
- Is depressed
- Has sex for money or other forms of exchange

The following sessions on the next few pages serve as options. But do seriously consider including a condom demo and negotiation session.

Condom and Lubricant Demonstration (45 minutes)

Objective: at the end of the session, participants will be able to:

- Demonstrate ease in using condoms and lubricants correctly
- feel more confident and comfortable in using condoms and lubricants

Materials/Preparation:

Condoms, lubricants, penis models or penis-shaped objects (vegetables, fruits, wooden ornaments, etc.)

REMEMBER:

Experiencing – basis 5 senses; condom demo and return demo of pairs

Processing – how they felt during the demonstration

Generalize – what they learned about condoms skills and comfort

Apply – how they will use the knowledge and experience gained with partners

Methodology:

EXPERIENCING

Divide the group into pairs and have them sit beside each other. Distribute 6 condoms, 2 sachets of lubricant and 1 penis model (or penis-shaped fruit/vegetable) to each pair. Facilitate an interactive discussion about condoms and lubricants. Begin by asking about the 5 main human senses. Let participants discover more about condoms while you go through each sense and present relevant information and insight.

1. Sight – what do you see in the packet, condom?; sealed packaging, brand, latex label, expiry date and/or manufacturing date
2. Touch – what does the packet feel like?; teeth around the edges for tearing, smooth package, condom texture, feeling of latex on skin (this almost always counteracts the notion “there is no feeling/less feeling when using condoms for sex);
3. Smell – what does the condom smell like? describe the odor;
4. Taste – what does the condom taste like? Describe the taste;
5. Hearing – what do you hear when you strike the intact condom packet on your palm with the intact packet? What sound do you hear when the condom is stretched then released? (this reinforces the strength of latex)

Add relevant information as needed: storage, expiry date/manufacturing date, recommended water-based lubricants, and other core messages (use condoms and lubricants from start to finish, with anyone - anytime).

RETURN DEMONSTRATION

1. Ask someone to demonstrate how to use condom. While the volunteer is doing the demo, observe carefully and take note of what steps need to be repeated and clarified, if any. Thank the volunteer and proceed with your own demonstration, emphasizing key steps and reminders.
2. Ask each pair to take turns practicing putting a condom on.
3. If someone is aware and is willing, request him to demonstrate how to put on a condom using the mouth. Remind the group that this is especially helpful with difficult, resistant partners.

The following are strongly recommended exercises/demonstrations that help reinforce the effectiveness of condoms.

Many times people have a vague concept of just how flexible a condom is, just how much it can really accommodate. Most often, the following demonstrations are very useful in reinforcing specific core messages on the condom's reliability.

CONDOM FIST/FISTFUL OF CONDOMS

Immediately after your own condom demonstration, talk for a while about other issues. Especially highlight issues regarding what kind of sexual organs, in terms of size and girth, the condom can really accommodate. While talking, begin putting the condom into your fist, being careful to slip in one finger at a time. Do this in a rather quick fashion, just in time when you finish the topic about penile size. Then hold up your condom covered fist and ask, that at least for the condoms available in our area, this would prove that ONE SIZE FITS "ALL"?

CONDOM BARRIER

One of the most contentious issues about condom as an effective barrier to HIV and sperm, is whether it really prevents HIV and sperm from passing through. The fact is in terms of size, the molecules of hydrogen and oxygen (the elements which make up water) are much, much smaller than viruses, bacteria and sperm. Prepare this in advance – a condom filled with water, the fuller, the better. Emphasize that during sex, the role of proper lubrication is the key. "Spilling" the semen is avoided when ejaculation is done away from the vagina, anus or mouth.

BE AMAZED WITH WATER-BASED

Often, people forget the key role of proper lubrication in effective condom use. And even when people remember to use lubricants, they are the improper ones. Take this opportunity to review which lubricants are suitable to be used with condoms. Afterwards, make a condom balloon, as big as you can. Then apply about a teaspoonful of baby oil in your palm and fingertips (or any of the oil-based lubricants being used with condoms, as shared by participants). Rub your oiled palm and fingertips on the condom balloon until it bursts. Make an analogy of what just happened and what could happen during sexual intercourse.

Condom Line-up (30 minutes)

Learning Objective

At the end of the session, participants must be able to outline procedures of correct and consistent condom and lubricant use.

Materials

Two sets of meta-cards labeled with the procedure of using condoms, namely:

- I am convinced to use condoms
- Talk about safer sex
- Talk about using condoms
- Check the date of expiry
- Open the packet carefully

- Find the correct unrolling side
- For increased sensation, add a little lube on the tip of the penis
- Pinch the tip of the condom to remove air
- Roll down to the base of penis
- Add water-based lubricant
- Penetrative sex... and...
- Check once in a while if the condom is still on
- Ejaculation
- Holding the base of the penis, withdraw while still erect
- Unroll the condom carefully
- Tie up the condom and dispose properly
- Relaxation
- Relaxation
- Loss of erection
- Loss of erection

Reference:

Joselito A. de Mesa, as adapted from sessions conducted by DKT International, makers of Trust quality condoms

Procedure

Step 1. Divide the group into two. Shuffle each set of meta-cards so that they are not in order, and then give each group a set.

Step 2. Ask each group to discuss what they think is the proper procedure in using condoms and put the cards in the right order.

Step 3. When they are done, ask them if they are satisfied with the order or if they wish to make adjustments. Give them time to make adjustments.

Step 4. Once the groups are finished, go over their work to discuss each step and for possible “corrections” – logical procedures. More than “corrections”, this activity is about modifications based on realistic situations (condom use is not just about procedures...). This is also about providing more opportunities to discuss some of the realities when using condoms. Emphasize the talking and negotiating part in the beginning. Also highlight that loss of erection and relaxation can happen anywhere during the line-up.

OPTIONS FOR FOLLOW-THROUGH

Safer Sex Alphabet (1 hour)

Objective: at the end of the session, participants will be able to:

- identify safer sex messages which can be used in different situations
- feel more confident in using the messages in their own situations

Materials/Preparation:

of small groups –

OPTION 1: 4 groups if difficult letters are included;

OPTION 2: 3 groups if difficult letters are to be brainstormed separately by the large group 4 flipchart papers, each with alphabet letters outlined vertically, the first 3 flipcharts with the easier letters and the fourth flipchart with the more difficult ones;

- permanent markers, masking tape

Prepared safer sex messages for ALL letters; to be offered when there are letters with no messages

REMEMBER:

Experiencing – message brainstorm using alphabet; prepare skit

Processing – group identifies most useful messages

Generalize – insights, learning points, what they know now compared to before, any change in confidence level

Apply – how they will use the messages in future situations

Methodology:

EXPERIENCING

Emphasize from the previous session that preventing STI and HIV transmission is not only about ABC. There are a lot of other important messages about safer sex we can think of based on the Myanmar alphabet.

FACILITATOR'S NOTE:

Based on the number of small groups you decided on, proceed with the appropriate instructions:

OPTION 1

1. Divide the group into 4 smaller groups and give each group a number of alphabet letters outlined vertically on a piece of flipchart paper.
2. Review what safer sex means and emphasize that the messages we would like to develop include condom use (both in anal AND oral sex), non-penetrative sex, masturbation or self-sex. Instruct each group to think of safer sex messages that begin with the letters assigned to them.
3. Encourage the group while brainstorming about the messages, to also think about things they want to say to different kinds of partners in different kinds of situations.
4. When you notice that participants have difficulty filling in the other letters, if announce that in a while, you will ask them to switch flipcharts, and that they should finish the message they are writing, if any. After 2 minutes (or after they have finished completing their last message), ask them to pass their flipchart to the next group to the right. They are then to continue filling

out the other letters in their “new” flipchart. This process is repeated until all groups have gone through all the flipcharts. If participants are very engaged, encourage the development of multiple messages per letter, both for the easy letters and especially for the more difficult ones.

PROCEED TO #6

OPTION 2

1. Divide the group into 3 smaller groups and give each group a number of alphabet letters outlined vertically on a piece of flipchart paper.
2. Review what safer sex means and emphasize that the messages we would like to develop include condom use (both in anal AND oral sex), non-penetrative sex, masturbation or self-sex. Instruct each group to think of safer sex messages that begin with the letters assigned to them.
3. Encourage the group while brainstorming about the messages, to also think about things they want to say to different kinds of partners in different kinds of situations.
4. When you notice that participants have difficulty filling in the other letters, if announce that in a while, you will ask them to switch flipcharts, and that they should finish the message they are writing, if any. After 2 minutes (or after they have finished completing their last message), ask them to pass their flipchart to the next group to the right. They are then to continue filling out the other letters in their “new” flipchart. This process is repeated until all groups have gone through all the flipcharts. If participants are very engaged, encourage the development of multiple messages per letter.
5. Once all the small groups are done, present the flipchart with the more difficult letters for the large group to brainstorm together. Prepare the previously identified messages and offer it as an option when needed, or when the large group has difficulty coming up with one. When the groups have “finished”, or have exhausted their thoughts, ask each group to post the flipchart so everyone could see the result of their combined efforts. Ask for comments and feedback.
6. Have everyone go back to their small groups, take a closer look at the messages and prepare a short skit of couples/partners in a difficult sexual situation. The situation could be one that has been very common in the discussions so far. The situation has to include the particular meeting place, cruising area, or sex venue, with a particular partner/s. They are to involve all the members of the group.
7. For example, sex worker and client, a couple wanting to take the HIV antibody test, a couple in a relationship trying to explore safer sex without condoms, 2 men exploring safe sex with condoms, et al
8. Instruct the groups to incorporate most, or if possible all of the safer sex messages in the flipcharts assigned to them. Give them 20 minutes to rehearse the skit.

PROCESSING AND GENERALIZING

After each presentation, encourage the other groups to share their thoughts about the following questions: which of the messages were the easiest to say? Which were not as easy? How could we modify some of the messages for easier usage?

- which of the messages can be very effective which message/messages can be used in different

situations with different partners?

APPLYING

- How might this session help us in dealing with challenging situations in the future? What kind of help do we need from others? From friends? What kind of support can we offer others?

I – CHANGED! (Sharing - Personal Change Events) 1.5 hours

Materials – metacards, pens, presentation materials

Objectives: At the end of the session, participants will be able to:

1. identify the stages of behavior change
2. identify the components for promoting healthy lifestyles
3. identify relevant peer educator roles
4. interact and be more comfortable with co-participants

PROCEDURE:

Have the participants do this activity individually first.

1. Instruct each of them to think of a personal change event in their lives. Clarify that this may mean a change of behavior – they used to smoke now they don't, they used to drink alcohol too much and now it has lessened; introduce these stem sentences for them to complete as prompt – “before, I used to.... Now I...”. Give each participant 10 minutes to do this.
2. Divide the group into two smaller clusters. Have each person share with the small group their personal change event. From this exchange, have each group identify the common stages of behavior change that they went through Ask each pair to share their answers about the following: What did they do to make a change? What kind of information did they need? What kind of support was important for them to get while they were trying to change? What kind of emotions did feel while changing? What did they feel about the resulting change? Give each cluster 10 minutes to do this.
3. Encourage the pairs to exchange with others what they are comfortable sharing on what they talked about with their partners. Use their sharing to transition into the presentation of the behavior change cycle (see page.....).
4. After the presentation, have the pairs find another pair to make four people (quad). Have them identify the common features of their journeys toward change by answering the following – what did they need before they decided to change? What were some of their difficulties while they were in the process of change? What were some of the supportive

DAY 2

I-CHANGED

- 1 hour

Skills Building: Answering Questions Clients Ask (Triads)

- 2.5 hrs.

Present 1A – Add Knowledge: ASK-ADD-ADVISE

- 30 mins

Stereotyping Our Peers

- 1.5 hours

Skills Building: Case Studies/ Role Play; Dyads

- 1.5 hours

Present 2A – Address Concern/ Decision: ASSESS-AFFIRM-ASSURE

- 30 mins

Next Steps: Link to other health domains; Day 3

- 30 minutes

mechanisms that they needed? Were they able to sustain the change? How? Give each quad 15 minutes to do this.

5. Encourage the quads to share their insights. Use their sharing to transition to the presentation on behavior change requirements and health promotion components.
6. Ask the plenary for insights. What did they learn from the session? Anything that they learned about or discovered for the first time? Anything that was striking for them? How might this session help them as peer educators?

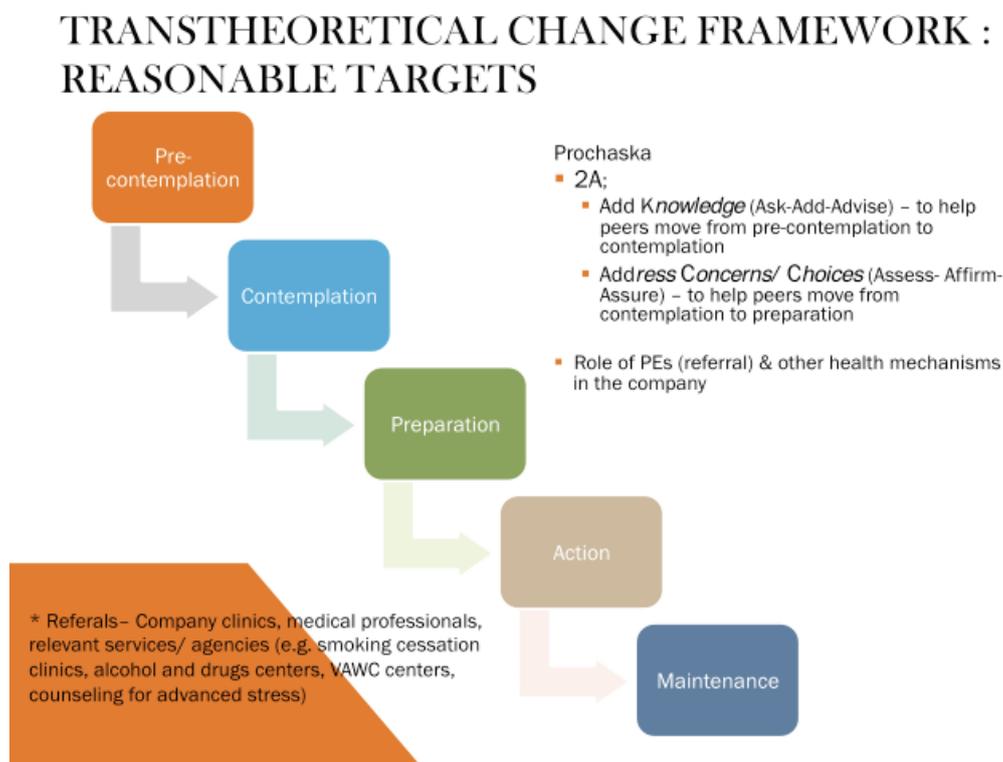
PROCESSING AND GENERALIZING

Behavior change theories¹⁴ began to be built into the design of health promotion programs, particularly in communicating the ill effects of risky behaviors and in persuading key affected groups to practice healthy habits. The premise of health promotion is that diseases can be prevented if only people will stop practicing risky behaviors. Still, factors that cause people to change their behavior are under debate. Nevertheless, the popular consensus is that communicating for behavior change does not merely involve a one-time message blast but is a dynamic, continuous process of communication and feedback.

Perhaps the most utilized theory of behavior change is that of Prochaska's Stages of Change Theory¹⁵, which explains how a person moves from pre-contemplation phase to practicing and maintaining desired behavior.

This model describes five stages of human behavioral change:

1. Pre-contemplation, where people are unaware of the problem have no intention to change;



.....
14 <http://www.fhi360.org/nr/rdonlyres/ei26vbslpsidmahxc332vwo3g233xsqw22er3vofqvrjvubwyzclvqjcbdgexyzl3msu4mn6xv5j/bccsummaryfourmajortheories.pdf> Last accessed: 31 May 2012

15 Prochaska J.O. and DiClemente C.C. (1982). Trans-theoretical therapy – toward a more integrative model of change. *Psychotherapy: Theory, Research and Practice* 19(3):276–288

2. Contemplation, where people recognize the need for change and are considering change;
3. Preparation, where they intend to change and plan for change; and
4. Action, where they initiate change and put new behaviors into practice; and
5. Maintenance, where they sustain new behaviors and address relapses to earlier stages in the change process.

Movement from each stage to the next is determined by different cognitive processes and levels of emotional readiness. For example, to move from pre-contemplation to contemplation, awareness of the behavior's consequences and availability of a support system must be raised.

The Stages of Change Theory was used to develop the Behavior Change Communication (BCC) strategy for CHANGE, but most especially applied to the peer education training program prescribed in this initiative. Peer education is a vital component of any BCC program for health promotion because lifestyle and habits are often dictated by peer pressure, and target audience have been found to turn to peers for information and support.

APPLYING

This theory sets reasonable targets that peer educators may aim for, which involves moving people from a pre-contemplation stage of healthy lifestyle change through a knowledge and awareness phase, to contemplation stage where persons at risk begin to recognize the need for change. It is hoped that, at some future time, the consistent presence of support and availability of peer educators in the workplace may contribute significantly to facilitate movement of peer clients to higher stages and eventually to actual positive changes in behaviour.

DAY 2

As participants come in, encourage them to write on their journals their thoughts and insights from what they learned the previous day. Offer this as an option, not a requirement. Then welcome back everyone and do a quick participatory recap. Ask the group to mention the activities from the previous day then invite volunteers to share what they learned. They may choose to read from their journals or be spontaneous.

Introduce the idea that the knowledge they gained and the insights they learned would be most beneficial if put to good use and shared with others. Refer back to the roles of peer educators and add that it is important to always keep updated with relevant information, continue examining attitudes, and keep practicing skills.

In this light, introduce the proposed 2A peer education framework and explain the 2 levels.

Refer back to the behavior change model and focus on unaware to aware and aware to prepare as reasonable targets. Emphasize that as peer educators, their main task is to assist their colleagues to move from unawareness to preparedness. For HIV and AIDS, this may mean helping their peers make decisions about:

- taking the HIV antibody test – for them and their partner/s, significant others, loved ones, friends
- safer sex – negotiating with partners, getting comfortable with condom use, practicing talking about and using condoms and other safer sexual behaviors
- referrals for STI diagnosis and treatment, ARV treatment, and other related concerns

Answering Questions Clients Ask

1. Divide the plenary into triads. You may have 4 to 5 groups. Assign each triad a random number – 1,2,3,4,5.
2. Tell the triads to brainstorm on the questions on HIV and AIDS that they anticipate to be asked by their colleagues. These could be questions about information, referrals, feelings, attitudes and skills. Questions could also start with who, what, when, where, why, et al.
3. Instruct each triad to write each question on one metacard – one question, one metacard. They can write as many questions as they can. Have them label their questions according to their triad number.
4. Have each triad face each other in a triangle. Collect all the questions from all triads while keeping them in separate sets. Redistribute the set of questions - give the questions from triad 1 to triad 2, questions from triad 2 to triad 3, and so on, until all triads have a different set of questions.
5. In each triad, assign these roles:
 - **Colleague** – the one with the set of questions, and will ask the question on top
 - **peer educator** – must do his/her best to answer the question
 - **observer** – makes notes on what was effective and what might be done differently and offers these observations at the end of each round
6. Clarify and reinforce the roles then give the set of questions to person #1. Once the question is asked and answered, have person #1 pass the set of questions to #2 and instruct the triads to change roles – #2 becomes the colleague (and will ask the next question), #3 becomes the peer educator and #1 becomes the observer.
7. Have the triads go through all the questions and instruct them to discuss their observations. Have them wait for other triads to finish.
8. After everyone is done, have each triad pass their set of questions to the next triad. Repeat procedure #6.
9. After all the triads have gone through all the sets of questions, have them gather in a plenary and discuss collectively - which questions were the most difficult to answer? Which were the easiest to respond to? What might be good tips and techniques in answering questions?
 - What is the best way to introduce the topic – passive? Active?
 - What kind of information is relevant for our peers to consider behavior change?
 - Introduce and reinforce Add Knowledge: ASK-ADD-ADVICE
 - Another round if needed
 - Skill sheet?
 - Emphasize that the next round of skills building activities will focus on preparing peers for change

MEAL

Stereotyping Our Peers –

confronting attitudes and different profiles in the workplace; implications

HIV Prevention work is not just about understanding risk and vulnerability but also looking at the different

most at risk and vulnerable populations and the situations they are in. It is also about our personal and professional attitudes towards other people and how this may affect healthy interaction.

This may be a challenge to deal with, possibly because we lack the exposure/experience, and often it is also because of how we learned from and taught by our families, friends, people in school, work, media, and the community-at-large. As a result, we have commonly held perceptions (stereotypes) of who they are and what they are like, and these are usually very negative, demeaning and hurtful. As peer educators, we are faced with a challenge to examine and confront these stereotypes and arrive at insights that will, hopefully, make us better peer educators, and ultimately, our company a better, more affirming workplace.

This session will assist us in confronting these stereotypes and identify ways of supporting our peers and looking at different most at risk and vulnerable populations positively.

Impact of Stereotyping (2 hours)

Aim:

To help participants learn more about the individuals who they might have different interactions with;

To assist participants in challenging their own commonly held stereotypes, which may impact negatively on how they relate with other people, particularly Most At Risk Populations (MARPs) and Vulnerable Populations (VPs)

Materials: Scenarios/profiles on flipchart posted around the room: **each flipchart is a workstation**

Select 4-6 from the examples below. Especially select profiles which you think are the most stigmatized/ stereotyped, both within and outside the community.

- You are MSM/transgender;
- You are a person living with HIV
- You are a smoker;
- You have sex for money or other forms of exchange
- you use drugs
- You abuse alcohol/drink til you drop/drink too much alcohol
- you have TB
- you experienced violence at work or at home
- you are super stressed
- you are depressed
- prepare a few others?

3 labels per profile (which will be placed on participant's backs; each profile is written on strips of paper for use in procedure #3).

REMEMBER:

EXPERIENCING – workstations in 2-parts – 1) most difficult to be then most difficult to educate; 2) writing then shouting negative stereotypes

PROCESSING – how it felt while shouting, being shouted at

GENERALIZING – insights, learning points, what they learned about themselves and others

APPLYING – sharing about what they want others to know about them, how they could encourage other journalists to write sensitively about MSM sexuality

Make sure that before you begin this activity to define what stereotypes are (usually negative images of people and even when “positive”, they are always limiting; for instance, all gay men are creative, all MSM love unprotected anal sex).

Remind the group that we are working with stereotypes and that some people in the group may in fact be the people we are stereotyping. Remind the group that stereotypes often make people feel bad, but that we also need to recognize our stereotypes. So for those participants who belong to a group being stereotyped, they should recognize that this activity hopefully will help others appreciate individuals and not stereotypes.

Methodology:

Experiencing

1. Ask the participants to stand in front of the profile which would be the most difficult for them to actually be (in reality). It is possible that everyone will group at one or two. Once they have chosen, ask individuals at each situation to talk about their feelings and reasons with each other. As a facilitator, talk to participants who might be alone under a profile. Encourage volunteers to share these discussions with the large group. Synthesize the relevant points. Emphasize stigma and the feeling of not wanting to be like someone because of the anticipated negative reactions and consequences.
2. Then have the participants stand at the station/profile which would be the most difficult for them to educate. Have them talk to each other about the feelings and the reasons from each situation, involving as many participants as possible. Anticipate that participants may stay under the same profile or move to another. Ask volunteers to express reasons for staying or moving. Acknowledge reasons for discomfort and say that you will look at ways of managing that towards the end of the session.
3. If there are 15 participants and 5 or more profiles, ensure that there are at least 3 labels for each profile. Randomly or purposively, put one of the labels on the back of each participant. Do the following example if you want to make it more purposeful – put the label “you are an MSM/TG” on someone who has very negative opinions about that kind of person. The participant should not know what her/his label is, so remind everyone not to look at the labels of the people beside them.
4. Ask the group, one profile at a time, to brainstorm the stereotypes/negative adjectives they think (other) people have of each of the profiles. Give examples if necessary. Write these on the flipchart as they say them. Do these to other profiles until all profiles have at least 10 stereotypes written on them.
5. Allow participants to “discover” what their own label is, and ask them to remove the labels

NOTE TO FACILITATOR:

if there are profiles without participants, ask what this might mean: is this an “easy” profile to be? Summarize the responses.

from their backs and stick the labels on their chest.

6. One by one, ask those with labels to go under the corresponding profiles.
7. When two (or more) people are in front of a profile, ask the rest of the group to read aloud the stereotypes/negative adjectives one by one. Expect that some participants may shout and even be physical. Do the same for all profiles.

Processing

8. Bring the participants back to the large group to discuss the following:
 - How does it feel to be stereotyped this way? How did you react when people were shouting negative things at you?
 - In reality, what ways do people express this kind of negative behavior?
 - Verbal/emotional violence like name-calling, blaming, finger-pointing;
 - Non-verbal/physical violence like ignoring, purposely showing an unpleasant face, physically hurting someone, sometimes even rape;
 - In the family? In school? In the community? In media? IN THE WORKPLACE?
 - Direct or indirect discrimination – not hiring/not promoting/firing someone because they are MSM or HIV positive; denying certain “kinds” of people to receive or even have the access to health, non-health services;
 - What IF you worked in your company, and fit into one of the profiles/descriptions:
 - How would you want your peers to act/behave towards you? What do you expect from the management? Your supervisors?
 - what would you fear if you were approached by a peer educator about HIV and AIDS? How could peer educators help you with your concerns about HIV and AIDS? How do you expect them to behave? What skills do you expect them to have?
 - How would you want to be received?

Generalizing and applying

9. As a symbolic gesture, collect all the labels into one stack and pass it around by saying, “pretend these labels are ourselves, demonstrate how you would express your support by entrusting them to each other”, carefully passing the stack, representing the lives of their peers, from one hand to another.
10. In the large group, ask what they learned about themselves, and about others. What did they learn about how to treat others who are dealing with health challenges like HIV? They feel uncomfortable with? How might this exercise affect how they relate with other people in their company?

Synthesis (If there is time)

Insights, expressions of support/contributions

1. What are three things that you know now that you didn’t know before about HIV and AIDS? Being HIV positive?
2. Identify 3 ways that life is different for people living with HIV
3. Brainstorm on how you can help create a supportive environment in your company – teams, (e.g. safer spaces) in the workplace.

4. What are some of the next steps that may help you become a better, more enlightened peer educator? Suggested activities? Continuing education? Follow-through activities?
 - Skills Building/Case Studies or Answering Questions Clients Ask 2 or Dyads

Case studies could be based on anticipated scenarios:

1. taking the HIV antibody test – for them and their partner/s, significant others, loved ones, friends
2. safer sex – negotiating with partners, getting comfortable with condom use, practicing talking about and using condoms and other safer sexual behaviors
3. referrals for STI diagnosis and treatment, ARV treatment, and other related concerns
4. other scenarios

Case Studies/Role Play

1. Divide the plenary based on the number of scenarios.
2. Have each small group prepare a 5-minute role play involving all members. The role play must reflect a real-life situation of a colleague approaching a peer educator for help in preparing to make a change. These changes are based on the scenarios above.
3. Have them brainstorm on a scenario, assign roles and rehearse their presentation for 20 minutes.
4. Have the first group present their role-play and then process the insights.
5. Present 2A Address Concern/Decision: ASSESS-AFFIRM-ASSURE and relate the relevant insights.
6. Have the next group present, process the insights then relate to the 2A. Do the same for the succeeding groups.

Dyads and quads

1. Prepare scenarios.
2. Divide the plenary into pairs.
3. Ask each pair to assign roles – colleague and peer educator.
4. Ask all the peer educators to go out of the room so they can't be seen and heard. Instruct them to do their best to assist their colleagues in preparing to make a change.
5. Ask all the colleagues to stay in the room and get together. Instruct them to role play as peers who are preparing to make a change. Assign them specific roles based on the scenarios above (on page....).
6. Ask the pairs to get back together and proceed with their roles. Give them 10 minutes to do this. Instruct them to remember their insights for sharing after another round.
7. Have the pairs reverse roles. Repeat step#4-6.
8. Invite all pairs to stay together and gather in a circle. Invite volunteers to begin the sharing of insights by discussing the first scenario, then the second scenario.
9. Take note of the learning points and make sure to integrate them with your presentation of the next 2A level – Address concern/decision – ASSESS-AFFIRM-ASSURE.
10. Present the next 2A level: Address concern/decision – ASSESS-AFFIRM-ASSURE.

Other aspects for discussion:

- What is the best way to introduce the topic – Passive? Active?
- If you were to be approached by a peer educator, how would you want them to behave? What kind of skills do you want them to have?
- You want to change but you can either be open or you can clam up – how would you like the peer educator to approach you – with an opening for change?
- Fears, discomfort, turn offs about peer educators?
- Skill sheet? Next steps?

References:

1A and 2A - Add knowledge, Address Concern for Change - Joselito A. de Mesa, adapted from a DoH manual on smoking

SKILLS BUILDING - Joselito A. de Mesa, as adapted from a session conducted by Konstance McCaffree PhD (answering questions peers ask - triads activity)

STEREOTYPING - adapted from 2 sessions conducted by Konstance McCaffree, PhD

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