Asia-Pacific Social Science Review (2016) 16(1): 146-155

RESEARCH BRIEF

Peer Education Counseling Services for HIV, Health Promotion and Gender Equality: Designing a Job from Strategic Information on MSM, TGW, and PWID

Roberto E. Javier Jr.
De La Salle University, Manila, Philippines
roberto.javier@dlsu.edu.ph

Recent researches in HIV risk reduction included not only about its promotion and prevention but also on treatment and management. In this paper, the most relevant researches on the topic, including models on health promotion, were reviewed to draw ideas and insights for strengthening the standards of peer education (PE) programs for AIDS prevention in the Philippines, particularly its counseling services component. The themes, here used as headings, were culled from similarly shared thoughts (needs, problems, concerns, issues, and solutions) and from differently expressed arguments about standardization of procedures to ensure high quality of health service delivery to intended recipients such as counseling services. The running theme in all assessment studies revisited here is about the mechanisms and measures needed to address the advancing AIDS problem in the country which is associated with low standards for this health sector specifically that of the emerging key populations, that is, males having sex with males (MSM), transgender women (TGW), and people who inject drugs (PWID). The recurring theme though is the high potential for human resource development in the health service from the community particularly among MSM, TGW, and PWID peers who can be equipped with better tools and advanced level of education on STI-HIV promotion and prevention, particularly on providing counseling services to clients.

The surveys of Wells et al. (2012) and Reid (2013) were sponsored by the World Health Organization–Western Pacific Region while the assessments of Casey, Dano, and Merilles (2014) and Saniel et al. (2010) were commissioned by the Department of Health (Republic of the Philippines). The studies discussed in the Scientific Meeting of the AIDS Society of the Philippines (ASP) were focused on understanding the HIV problem as this relate to MSM and TGW. The researches of Ofreneo, Gerochi, Guiang, and Osea (2015) and Ditangco (2015) were funded by Philippine government organizations, Philippine National AIDS Council (PNAC) for the former and Philippine Council for Health Research and Development (PCHRD) for the latter. The study of Norella, Ignacio, and Cortes (2015) had a grant from the Global Fund. The study of Agbulos (2015) was covered in a scholarship program from De La Salle University with funds from the Ford Foundation.

Findings From a Hard-to-Find Key Population - MSM

The Wells et al. (2012) survey presented facts about MSM, a hard-to-find key population. It noted that MSM are contributing the most number of new HIV cases. Of the 96% of newly identified cases of HIV infection in males, 87% of whom were MSM. Ditangco's (2015) ongoing cohort study of MSM reported the same observation of consistently high incidence of HIV cases in this population. Wells et al. (2012) noted that these men do not have natural or existing link to health education, health services, and HIV Counseling and Testing (HCT). In profiling the MSM as at-risk population, the young ones who belong to this group are prominent. The median age is 23 years old, their first male-to-male sex was at age 16, having four male partners per year, about 6 in 10 favor males exclusively, and only about 4 in 10 use condom at last male sex. These men meet their male partners in bars and clubs, workplaces, and streets. They get information about HIV mostly from friends. MSM who are young, those with more disposable income, and also those who have high income have lower access to HIV services; they socialize in large groups and that only about 2 in 100 have ever had an HIV test as almost 1 in 2 does not know a place to get HCT.

Wells et al. (2012) suggested that to curb the growth of AIDS, the three factors that trigger the development of the epidemics have to be attended with urgency. The determinants are behavioral, structural, and biomedical. They noted that since sexual contact has consistently been the most common mode of HIV transmission, accounting for 9 in 10 cases of AIDS and that only about 4 in 10 of MSM used condom at last anal sex with another male, there is a need to foster safer sex practices passionately, particularly among those who engaged in frequent, unprotected sex with multiple partners. Moreover, the study suggested that MSM who are HIV positive have to be more adherent to Anti-Retroviral Therapy (ART) and more cautious of their sexual behavior. Wells et al. (2012) study reported that heterosexuals with HIV who adhered to ART have reduced the transmission of the virus by 96% suggesting that if MSM would also commit to the same drug therapy AIDS could be controlled in this group. Wells et al. also argued for the "treatment as prevention strategy" that early detection of HIV leads to healthier living since taking HCT will lead to ART, thus there are more chances of survival as subsequent unsafe behaviors are radically reduced. With regards the structural factor, Wells et al. made salient the stigma associated with MSM sexual identity, behavior, and practices. MSM are on the margins of society. In this regard, peer educators who are MSM can bridge the gap between their needs for health services and the society.

The Wells et al. (2012) study noted that many MSM do fear HIV testing. Those who are infected with HIV still do not access HCT as they do not know their HIV status. They have no access to treatment services even if these are available since stigma stands in the way. Thus, they are not reported to the registry keeping them hidden in the population. The solution offered by the study team is to reach MSM through their peers for HCT and, if HIV positive, to adhere to ART. However, there is scarcity of PE workers as health promoters, service facilities matched for MSM, and funds to sustain the activities of the program. To address the need for PE, NGOs (non-government organizations) can be tapped for PE counselors who are MSM, large companies can pay MSM PE counselors (in call centers and BPOs – business process outsourcing), and avail effective tools used by NGOs for MSM PE. The more inviting facilities are preferred by able to pay MSM. These facilities foster confidentiality, high quality services (ex. MMC – Makati Medical Center, Icon-ASP), and offer specialized services (to cushion stigma e.g. Malate Clinic of RITM – Research Institute for Tropical Medicine). Among the indigents and minor MSM, government health insurance can cover the cost for HCT. Local government units (LGUs) have to help in HCT by sustaining existing activities of social hygiene clinic (SHC) that can be tweaked into MSM-friendly facility (Sundown Clinic, QC). MSM's nervousness and awkwardness about disclosing sexual identity and history can be minimized in clinics that are meant for them. If, however, HCT has to be done in companies, it was suggested that results should be kept out of human resource databases.

Noteworthy to reiterate is the characterization of MSM in relation to HIV risk reduction which Wells et al. (2012) identified as barriers to HCT among the target clients. These include MSM's poor health-seeking behavior, lack of awareness of facilities providing HCT, perception that SHC are for sex workers, perception that they will be stigmatized in SHC, perception of lack of confidentiality in clinics, and perception of HIV as being both a cause of further discrimination and a death sentence. Added to these barriers to HCT are the cost of testing and the process of test that the MSM are wary about.

Some Solutions From a Study of a Subpopulation

Agbulos' (2015) case study reported a subculture of MSM who engage in sex and illicit drugs. He noted that a critical number of MSM who use drugs for sex were HIV positive. He reported that use of condom during sex was almost nil if not, irrelevant. Reid's (2013) mission report for the WHO on setting up essential services for another subpopulation, the PWID also presented some solutions to concerns that such group posed specifically on endorsing PE counselors engagement in reaching out to persons injecting drugs. Also, in this report are found health needs of PWID-self identified MSM. It is interesting to note that there is an overlapping of issues, as persons do not belong strictly to just one subpopulation. The report reiterated that the increase in HIV infection is due to sharing of contaminated needles and syringes among the PWID and unprotected sex among the MSM. It highlighted again that the highest risk behavior is in receptive anal or vaginal sexual intercourse and that the highly effective response to reduce the likelihood of HIV transmission, which is condom use, is passively promoted in PE counseling service.

In the mission report, Reid (2013) rolled out the problems faced by PE counselors and their solutions. This include fear of police arrest, health and safety, occupational hazard (such as not given vaccine for HBV – hepatitis B virus), lack of social workers in the field to provide assistance, the Church leaders' misconceptions on HIV that include wrong notions on condom use and needle use and no demonstration on how properly condom should be used. Saniel et al. (2010) reiterated the problems raised by Reid (2013) on the issue of security and the need for protection of peer educators working for HCT promotion. They noted the need to provide PE counselors with proper identification, insurance coverage (accident or life), and police's tolerance on their operations to reach out to the PWID subpopulation.

Moreover, the TGW, like the MSM and PWID, share similar stigma and discrimination as they have behaviors believed to be bad and having a gender identity atypical in society. This observation was reported both in the Ofreneo et al.'s (2015) study on self-acceptance issues of HIV positive persons and Norella et al.'s (2015) study on stigma and discrimination experienced in health care settings of MSM and TGW. Such factor contributes to low health-seeking behavior of MSM and TGW. Also, such behaviors as noted, "overlap" in different subpopulations, that is, there are PWID and TGW who are MSM and/or are sex workers; also that there is an association between drug use and sexual activity as reported in Agbulos' (2015) study. There are those who sell sex to buy drugs. Given this context, the need for PE counselor may be subpopulation-specific and/or can be provided training to comprehend such a complexity of individual behavior in the target population. Reid (2013) outlined in his report that some solutions to the problem, starting with a standardized PE program to include traits and characteristics, intensive training, relevant curriculum content, and sound ethical principles. Saniel et al.'s (2010) study supported such solution to start from the selection of PE counselors from among those who have had some formal schooling, those selected are trained on a standardized curriculum, and if they pass the qualifying examination have to sign a contract.

PE Counselors as Champions of HIV Promotion and Prevention

Casey et al.'s ((2014) research peered into peer education counselors' participation in the

STI-HIV programs and strategies for MSM, TGW, and PWID in the Philippines. Specifically, the study looked into the scope, quality, degree of integration, comprehensiveness, coordination of intervention, and different service-provision modalities of STI-HIV programs and strategies for the identified subpopulations. Their research also appraised the content of IEC (information, education, communication), multimedia, and online information provided about STI-HIV, HCT, HIV treatment and care and STI (sexually transmitted infection) screening and care services. They showcased some health sector models to benchmark from, in seeking high quality service standards for STI-HIV program.

The research group reported that there is inadequacy in the competency of health-service personnel particularly the PE counselors and the insufficiency of messages and materials both in terms of the veracity of the content and the volume to meet the demands of specific subpopulations that are most vulnerable to STI-HIV. The shortcomings of PE counselors are attributable mostly to lack of structures and systems to govern such group of health promoters. They noted that there is no articulation of PE strategic plan in the 5th AMTP (AIDS Medium-Term Plan 2011-2016). There is no appointed national technical focal point to guide program activities. There is a limited number of PE counselors to squarely address the sexual and reproductive health needs of emerging subpopulations, for example, TGW most at risk to STI-HIV including those persons with disability. When demoralized about not reaching target number for HCT, they noted that such leads to leaving voluntary service as PE. There is no quality performance indicator other than the number of targets reached. There is also role uncertainty and confusion among the peer education counselors. There is dire need for supervision and monitoring of their activities, as this responsibility is not even clear at the national level. PE counselors seemed to be handpicked for the work since there is no standard criteria for choosing among the more capable and competent could be engaged in counseling and educating their peers. Agreements for commitment to minimum service and for confidentiality are not required. Young PE counselors do not match their older peers' sexual health concerns and that there are no PE counselors for older MSM.

Casey et al. (2014) noted that the PE counselors' performance in the delivery of STI-HIV education and counseling services as received by their peers needs quality improvement. They noted the PE counselors' limited range of knowledge and skills to do the job, that is, from doing data generation and utilization to making presentation, discussion of STI-HIV messages, and demonstration on the use of prophylactics in order to influence behavior change among their target clients. PE counselors are unable to provide persuasive and convincing answers to queries about behaviors that posed higher risk such as having discomfort with condom during sex (e.g. reduced sensitivity) or unable to negotiate its use with partner (i.e. power relation). PE counselors who were on street-based education were observed to have too little time to talk to the client in a discrete, sufficiently detailed conversation about realistic risk and risk reduction. Likewise, the materials that they have at their disposal to aid them in doing their tasks have to be leveled up to acceptable standards to ensure effectiveness. Analyses of the contents of IEC, multimedia, and online messages indicate insufficient and inadequate information, which are most relevant for MSM, TGW, PWID, and the in-betweens in these groups. The materials were found to be so heavy with text but too light on the essentials such as treatment literacy, benefits of safer sex, and hepatitis vaccination. The images in the materials on STI-HIV prevention were also of heterosexuals, as such there were no explicit messages on STI-HIV risks and risk reduction strategies for those persons who engage in same-sex sexual behavior such as oral sex, rimming, fisting, group sex encounters, and bondage sex acts.

In the report, Casey et al. (2014) also thoroughly reviewed the legal, professional, and ethical aspects of PE counselors' facility and field operations particularly those pertaining to the conduct of counseling and testing, facilitating learning, and quasi teaching. It was observed that most of them missed the meaning of shared confidentiality with regards to the release of results of HIV test as referred to in Paragraph 5 Article 2 Section 32 of Philippine AIDS Prevention and Control Act of 1998. They noted

that medical service providers are bound by law to govern the access of medical record and ensure that the patient or client understands its content. They reported that copies of test results were not readily accessible, which they retorted could unnecessarily delay clients' entry to treatment and care. The report also suggested that while there is an RA8504 that protects patients' rights, there is none for the PE counselors who provide a vital link to HCT for these patients, not even at the grassroots level. Casey et al. retorted that there is no protection from police interference when the PE counselors work in the field and that they are not identified as working legitimately for a government agency. They are not also skilled to manage threats to their personal safety when working in the field. As regards the professional and ethical aspects of the work, Casey et al. reported lack of standard operating procedure (SOP) for counseling and venipuncture for outreach and mobile HCT. They noted that the counseling training for PE is inconsistent, non-standardized, and that volunteers were engaged in counseling even if they do not have the skills for the job. Unbecoming were also reported such as clients were allowed to self-complete counseling forms, dating or having relationship with clients albeit isolated were such cases, and that some do still have unsafe sexual behaviors.

Putting up a Platform for PE Counseling Services

Interestingly, the findings in the studies reviewed point to putting up a platform to advance the PE program, particularly its counseling services. The aim is the promotion and prevention of STI-HIV as pioneered by peers themselves on the road to a shared responsibility in managing the health of MSM, TGW, and PWID. The evidences from the studies suggest that a quality standard has to be developed for PE program operations to ensure its efficiency and effectiveness. Such standard can start from harmonizing the views on what is the nature of PE counseling services and why and how it is associated with all other STI-HIV health-related activities. The studies all pointed to the role PE counselor play in the efforts of both government and civil society organizations in addressing the AIDS epidemic. However, PE counselors' engagement in such effort seemed simplistic since the specifics of their work are not identified and clearly defined. Casey et al. (2014) for instance noted that PE counselors are a valuable resource in social hygiene clinics not only as STI-HIV prevention promoters but also as assistants to nurses and medical technologists in attending to clients' and their needs. A PE counselor also attends to varied needs of clients for health services from a diverse subpopulation such that there are overlapping issues and health concerns (ex. a MSM sells sex to buy drugs thus is also a PWID who is cohabiting with an unsuspecting woman of child-bearing age). Many PE counselors continue to do their job despite the very low remuneration they receive as reported in the studies of Wells et al. (2012) (Php1,000/mo. for PE and Php10,000 for PE supervisor) and Casey et al. (2014) (inconsistent incentive pay). In Reid's (2013) report, he suggested some remuneration for PE counselors as they work for a program that aims to modify risk behavior. Saniel et al. (2010) suggested too that LGUs could ensure the sustainability of PE program through the leadership of their local chief executives. LGUs with local AIDS council (LAC), they noted, can be revitalized to put up a PE program.

The concerns that surfaced from the studies and which the peer education counselors were pressed pertain to commitment, competence, work conditions, and compensation, all of which are components of a defined job. The apparent vagueness of the work they do in the provision of health services is due to the fact that there is no job design for a PE counselor. Also, undefined are the different tasks they actually have to do and how well they have to do them to accomplish the specific goals set by the employing organization/s. As there seems to be no delineation as well on which tasks are for whom to do, there is role confusion. The levels of authority of PE counselors are not fully described albeit a hierarchy, that is, PE counselor, SIO (site implementation officer), and supervisor. Corollary to this is the absence of PE counselor classification as to the levels of expertise, namely, trainee or novice, trainer or master, and administrator/manager (supervisor or site-implementation officer).

Thus, performance is far from expectations, as outcomes of tasks done are not defined very clearly. Cases of observations in the Casey et al. (2014) study suggested that peer education counselors (perhaps the rookies) and site implementation officers all do share similar skill inadequacies. The PE counselors had wrong beliefs about the efficacy of HIV treatment and effectiveness of condom. Young MSM who are HIV positive whom PE counselors thought cannot be treated are then left behind. The PE counselors were unable to offer adequate answers to client inquiries on the advantages of condom use for people living with HIV (PLHIV) (cited in the study is that sexual dysfunction is common in HIV which contribute to poor adherence to condom use). They lack knowledge about the impact of using anabolic steroids and sexual stimulants among the MSM (especially among those on ART or anti-retroviral therapy) and they are unable to assess if clients are injecting steroids.

Casey et al. (2014) observed that PE counselors have very limited knowledge about deadly diseases that may be caused by risky sexual behaviors. PE counselors have limited knowledge of STI as they are unable to discuss emphatically the need for routine screening (testing), to argue that condom is not totally effective for STI prevention, to focus on the need for screening with or without the symptoms of the disease, to talk convincingly on the need for vaccination (as cited in the study, they provide very limited information on hepatitis and that HBV is preventable a disease). They also have limited knowledge on STI specific health-issues affecting MSM, for example, the need for anorectal examination and the risks of taping, tucking, strapping genitals, hair removal, and sharing syringes to inject hormones. They are also unable to deal with peers who are thinking of having or have second thoughts about having sex reassignment.

Added to the list of what they lack has to do with the value of patient data that they generate during the interaction with the client. Their skill in recording, reporting, and using data to draw up a discussion for HCT and STI-HIV prevention needs improvement. However, as reported in the Casey et al. (2014) study, not only the PE counselors but also the other health personnel needs training on data handling, that is, collection, processing, and reporting. They noted that there is no data governance program, no policy and procedural manual for recording and reporting, and no standardization in record keeping. The researchers retorted too that data and information processing is protracted. They noted that treatment hubs and social hygiene clinics are the primary source of data about STI-HIV such that information management is a training that is needed for all its personnel, especially among its frontline health workers.

Setting the Standards in Counseling Services in STI-HIV Prevention, Health Promotion

The researches reviewed did not only present the problems in the PE program but also forwarded the solutions they deemed necessary to strengthen its structures and systems for operations. The PE counselors have to be effective in their work of supporting the services provided to their peers whose practices pose concerns to their personal health as well as to those in the larger population. To make PE counselors as effective aids of health service delivery, the researchers recommended major reforms in the peer education program.

Reid (2013) presented the training needs of PE counselors for PWID. These pertain to the essentials of peer education program to include a working schedule, roles and responsibilities, attributes of an effective counselor, and the topics for training program. They must maintain regular contact with peers, provide services at hours more convenient to peers, works on a flexible schedule, and be given some remuneration. The PE counselor should be tasked to distribute commodities (condoms, needles); ensure there is sufficient stock; provides education regarding relevant health issues (TB, STI, and HIV) and safer sexual practices; promotes behavior change by demonstrating how to use condom correctly; encourages peers to attend health services for the prevention, diagnosis, and treatment of TB and STI-HIV; supports those undergoing STI-HIV testing; escort peers who attends health services and if required has to assist with follow-up; actively fosters relationships with peers in the designated area; and

scans for new entrants. An effective counselor has commitment to HIV prevention, exhibits concern, has knowledge of the area; and ideally belongs to a large network of peers, is trusted by an at-risk-individual, is of similar age and background as his peers, has potential leadership qualities, has sufficient control over his own life, and possesses strong communication skills. Such attributes are salient among peers that identification and recruitment of new counselors has to be undertaken by PE counselors themselves. The topics for PE training program includes the principles and concepts of peer education, the roles and responsibilities of PE counselors, delivery of commodities, communication skills, maintaining daily logbook, diseases and infections (TB, STI, HIV, HBV, and HCV – hepatitis C virus), and sexual practices. Their training must be more practical and participatory in nature, for example, group exercises, brainstorming of ideas, role-playing, and reflections on work practices. Such training has the following requisites: structured outline of topics is used, support materials are provided, and closer supervision is given.

Wells et al. (2012) recommended that PE counselors of MSM must themselves be MSM in order to reach such subpopulation of males. They have to come from the youth group as the median age of MSM is 23 years old and that 3% of Philippine male population in 2011 is MSM. The MSM PE counselor is a strong link to such group of clients for HCT. Wells et al. (2012) suggested that PE counselors should have HCT targets to be met each month. As models of peers, they must take the test too for HIV. They have to be employed by social hygiene clinics using the LGU funds (from Local AIDS Council), as this is more sustainable and cost-effective. Casey et al. (2014) reiterated such recommendation, that for an LGU (local government unit) to hire MSM PE counselor (i.e. an LGU level provision, a job order or a plantilla item). They also recommended that a memorandum of agreement or understanding based on mutual needs for a volunteer PE counselor had to be signed prior to his engagement. They proposed that PE training must cover topics about safer injecting practices, the impact of drugs and alcohol on PLHIV, and HIV in closed settings such as the prison. They added that PE counselors must have training on STI, that is, its importance in HIV prevention, assessment for specific population, and quality of screening for MSM. Such training on STI must make salient that self-treatment is wrong, it results from sexual activity, there may be no signs and symptoms of infection, treatment must be completed, and that infection and co-infection is common. The training must also emphasize that if a person has STI, she/he gets or passes HIV easier, it complicates HIV treatment, and passes to mother-to-child (bring birth defects). In short, they suggested that PE counselors must move beyond the HIV basics to studying significant STI.

Conclusion

A rundown on strategic information and suggestions from the studies all point to a rich resource for strengthening the peer education program. All the studies are keen on suggesting a SOP for PE particularly on counseling services. Inputs for the development of such SOP can be drawn from the findings of the studies. Such can start with hiring an adjunct to the medical personnel to do just a PE counseling service job. A PE counselor is a member of a team of health-service delivery workforce, that is, physicians, nurses, midwives, medical technologists, barangay health worker, social workers, psychologists, and guidance counselors. It is necessary to determine what a PE counselor job is and who fits and matches this kind of work. It is important to determine the measures for PE counselors' work outputs and performance for purposes of promotion, remuneration (compensation and benefits or incentives), and recognition. Selection and screening of this kind of personnel necessitate a standard of qualities, qualifications, and competence for a job called PE counselor. Sets of training have to be provided in all levels of PE counseling work, from a starter to a specialist, subordinate to supervisor, from the on-the-job training of a PE counselor to continuing education and from basic to advanced level of training. The job analysis, its description, and the design of PE counseling work as well as the training and skills required of it make up the essentials for this kind of health promotion work.

Sources of standards for PE counselor include Reid's (2013) itemized suggestions on the training needs and trainee qualities, which is short of a table of specifications for the conduct of job analysis needed. Wells et al.'s (2012) demographic data of MSM population and detailed description of their sexual behavior in relation to HIV risk as well as the barriers to HCT are important inputs to doing a PE job design. Casey et al.'s (2014) data from observations of PE counselors' actual engagement and evaluations of tools and techniques they used are prime considerations for producing high quality teaching-learning materials for peer education and modules for training and development of PE counselors. The studies reviewed suggested that a PE program can be designed and developed much like a training program. As a training program, it is aimed at developing the abilities and skills of marginalized persons (having different beliefs and behaviors like behaving as MSM). Tapping them as PE counselors, they become a resource to their community. When empowered they would in turn enable their peers to acquire better life skills and more adaptive behaviors. As a training program, it is an on-going process of learning because the PE counselors have to undergo a continuing updating and upgrading of the tools and techniques they use for health promotion while on-the-job. Also, as they eventually will come to full circle in the program that is in two to three years they would have completed the training and are expected to exit from it. A certification of completion of the training program should be provided. This document would attest to the abilities and skills the PE counselors have acquired over the 2-3 years of training while being engaged in the health promotion efforts. This paper is a proof that the PE counselor has a set of skills honed in the program that can be transferred in other tasks or related jobs that would require them.

Inductees to the PE training program have to possess minimum qualifications other than being a peer of a given community. Since the PE counselor job is akin to that of a mentor or a coach, having very similar qualities have to be included in the checklist in the screening and selection. At least three essentials are demonstrable: (1) is able to converse well or communicate, (2) able to give instructions or facilitate the learning of something new, and (3) is capable of doing a demonstration or showing how something is done. The next three attributes are intrinsic: (1) has a sense of volunteerism, (2) commitment, and (3) the right intention. All six qualities are measurable; the first three through actual activities or exercises while the last three through a kind of job interview. Screening of potential PE counselors can be done by outgoing or older PE counselors initially by identifying the desirable qualities for the task from among their former clients. Induction to the PE training program has to be done by a PE selection team. Since the PE counselor will become a member of the health team, such selection team must be formed in a given locale where the services will be delivered. The selection team can be composed of, either a physician or a nurse, an LGU-LAC official or representative, a barangay health worker or a social worker, and a peer trainer. Decision tools for the selection of PE counselors have to be developed to standardize the procedure.

Suggestions for Strengthening the PE Program

The researches reviewed indicated that the PE program for HIV-AIDS prevention and health promotion in the Philippines could be strengthened further by instituting some reforms in its operations and procedures. The IFRCRCS Standards for HIV Peer Education Programmes (2009) can be used as reference for producing a strengthened Philippine PE training program standards. There are 11 components that make the IFRCRCS standards: (1) PLHIV and key populations' meaningful involvement, (2) gender equality, (3) advocacy, (4) needs assessment, (5) strategic planning, (6) recruitment and retention, (7) training, (8) program implementation of activities, (9) supervision and support, (10) management and governance, and (11) monitoring and evaluation. This document drew on valid methods of constructing evidence such as interviews, observations, reviews, ratings, and reports as means of verification. These verification methods are bases for observing and keeping the standards and even changing them to

meet the requirements for effective and efficient delivery of programs. All these 11 standards are also observed in Philippine PE program as studies done on the subject have shown. To reiterate, the needed major changes in the structure of Philippine PE program have to be done not only to make it at par with international standards but more importantly to ensure the sustainability, effectiveness, and efficiency of engagement in the HIV-AIDS intervention strategies in the local context.

Philippine PE program for HIV-AIDS can be developed too in consonance with the HESIAD framework for health promotion. The discussion that follows on the HESIAD framework and health promotion are drawn from Hubley and Copeman (2013) who derived the three dimensions HE-SI-AD from the WHO Ottawa Charter's 5 dimensions of health promotion, otherwise the source is cited. WHO defines health promotion as the process of enabling people to increase control over, and to improve, health. The 5 dimensions of health promotion action from the Ottawa Charter include building healthy public policy, creating supportive environment, strengthening community action, developing personal skills, and reorienting health services. These dimensions are regrouped to form the HESIAD framework. The dimensions (1) developing personal skills and (2) strengthening community action are about health education while the dimension, (3) reorienting health services pertain to service improvement. The dimensions, (4) building healthy public policy and (5) creating supportive environment pertain to advocacy. Interestingly, in the Ottawa Charter the participation of the community is reaffirmed and empowerment in health promotion is introduced. Thus, at the core of the HESIAD, health education, service improvement and advocacy framework is community participation in health promotion. The PE counselors are from a community where they identify themselves since they share similar characteristics, thus, they have the same experiences, lifestyle, and sentiments about their health situation. Thus, PE counselors could provide for a more effective health education, promote services, and conduct activities aimed at changing policy in the community. Enabling them through training with the capabilities and capacities to work with their peers is a practical health promotion strategy as they belong to that tightly knit network that otherwise is exclusive and inaccessible to outsiders. The beneficiaries of health are not only the peers but also the PE counselors who would consistently profess in their lifestyle the necessary modifications in their behaviors that are adherent to healthy practices. Also, in the development of the PE program, the community is involved in identifying problems and solutions, in analyzing their situation and in the planning and implementation of the said program. In effect, the PE counselors and their community are empowered since they, all "share information and control over decisions and are involved in the design, implementation and control of efforts toward goals defined by group consensus" (Laverack, 2013, p.18).

References

Agbulos, K. R. (2015). *ChemSex: The episodic influence of drug use on sexual behavior among men who have sex with men in Metro Manila*. Paper presented in the Scientific Meeting of the AIDS Society of the Philippines held on October 23, 2015 at Quezon City, Philippines.

Casey, K., Dano, E., & Merilles, O. E. A., Jr. (2014). *Evaluation of the HIV and STI programs and strategies for males having sex with males, transgender and people who inject drugs in the Philippines*. Manila: National AIDS STI Prevention and Control Program (NASPCP), Department of Health, Republic of the Philippines.

Ditangco, R. (2015). *Incidence of HIV in a cohort of men who have sex with men in Metro Manila*. Paper presented in the Scientific Meeting of the AIDS Society of the Philippines held on October 23, 2015 at Quezon City, Philippines.

Hubley, J., & Copeman, J. (2013). *Practical health promotion* (2nd ed.). Cambridge, UK: Polity Press.

Laverak, G. (2013). Health activism: Foundations and strategies. London, UK: Sage Publications Ltd.

Norella, L. B. P., Ignacio, M. C. V., & Cortes, R. P. (2015). *The SADS-HCS 2015 in Indonesia, Malaysia, the Philippines and Timor Leste – The ISEAN Hivos stigma and discrimination study in health care settings*. Paper presented in the Scientific Meeting of the AIDS Society of the Philippines held on October 23, 2015 at Quezon City, Philippines.

Ofreneo, M. A. P., Gerochi, R. R. D., Guiang, R. S., & Osea, J. S. P. (2015). Understanding the needs of people living with HIV in the Philippines. Paper presented in the Scientific Meeting of the AIDS Society of the Philippines held on October 23, 2015 at Quezon City, Philippines.

Philippine AIDS Prevention and Control Act of 1998, Republic Act 8504 (1998).

Reid, G. (2013). *Setting up essential services for people who inject drugs and monitoring the impact on HIV in Cebu*. Manila : World Health Organization – Regional Office for the Western Pacific.

Saniel, O. P., de los Reyes, S., Guevarra, J., Amit, J. M., Jimenez, S. J., Medina, V., . . . Obsequio, S. (2010). *Assessment of peer education approaches for sex workers and people who inject drugs (PWID) as an intervention strategy for STI, HIV and AIDS prevention*. Manila : University of the Philippines Manila College of Public Health and Department of Health.

Standards for HIV peer education programmes. (2009). Geneva: International Federation of Red Cross and Red Crescent Societies.

Wells, W., Nadoll, G., Belimac, G., Samonte, G. M., Calibjo-Prado, H., & Salva, M. (2012). *Health sector models to increase access to HIV counseling and testing (HCT) among males who have sex with males in the Philippines*. Manila: World Health Organization – Western Pacific Region.