PATA PEER SUPPORT PROGRAMME HANDBOOK

“Improved access to and quality of treatment and care for HIV+ infants, children and adolescents”

The handbook is a guide for health providers working with PATA peer supporters
Table of Contents

Acronyms .................................................................................................................................................. 3

1. Introduction ........................................................................................................................................... 4

2. Organisation background ................................................................................................................... 5

3. Overview of the Peer Support Programme ......................................................................................... 7

4. Benefits of the Peer Support Programme ........................................................................................... 8

   4.1. Objectives: ...................................................................................................................................... 8

       4.1.1. Improving treatment outcomes and adherence ...................................................................... 8

       4.1.2. Integrating YPLHIV into the healthcare system as CHW and ensuring health provider sensitisation ....... 9

       4.1.3. Task-shifting and sharing, lessening the burden on health providers so that they may have more time to focus on improving quality of care ......................................................................................... 10

       4.1.4. Expanding the number and type of psychosocial service offered by clinics to ensure a holistic model of child and youth sensitive treatment and care .......................................................................................... 10

5. Requirements for a successful Peer Support Programme ..................................................................... 11

   5.1. Adolescents Friendly Health Services (AFHS) ............................................................................. 11

       5.1.1. Different types of adolescent-friendly health facilities ................................................................. 11

       5.1.2. Characteristics of adolescent friendly services .......................................................................... 12

       5.1.3. Minimum services that should be available at the health facility for addressing health needs for adolescents .................................................................................................................................. 13

       5.1.4. Steps to establish or strengthen adolescent friendly health services ....................................... 13

       5.1.5. Psychosocial support .................................................................................................................. 13

       5.1.6. Support groups .......................................................................................................................... 14

   5.2. Integrating SRHR and HIV ........................................................................................................... 15

       5.2.1. Suggested youth friendly integrated HIV and SRHR services .................................................. 16

       5.2.2. Minimum standard for integrated SRHR/HIV services .......................................................... 16

       5.2.3. Quality of service provision ..................................................................................................... 16

   5.3. Meaningful engagement of adolescents and YPLHIV ................................................................. 16

       5.3.1. Peer supporters and AYPLHIV leadership .............................................................................. 17

       5.4. Clinic-community collaboration within peer led models .......................................................... 17

       5.4.1. Evidence of effectiveness of community-based HIV interventions for young people ............... 18

6. Expected outcomes ............................................................................................................................... 18
7. Important Notes for Planning .................................................................................................................. 19
   7.1. Peer Supporter Basic Conditions of Service .................................................................................. 19
   7.2. Peer Supporter Recruitment ......................................................................................................... 22
   7.3. Contract ......................................................................................................................................... 23
   7.4. Performance Appraisals ............................................................................................................... 23
   7.5. Peer Supporters Orientation ...................................................................................................... 23
   7.6. Peer Supporters Code of Conduct ............................................................................................... 24
   7.6.1. Scope of role ........................................................................................................................... 24
   7.6.2. Core ethical values and standards required of Peer Supporters .............................................. 24
   7.7. Peer Supporters Supervisor’s Code of Conduct .......................................................................... 25
8. Financial Management .......................................................................................................................... 27
9. Training .................................................................................................................................................. 27
10. Policies .................................................................................................................................................. 27
   10.1. Introduction to Anti-Corruption / Bribery and Child Safety Policies ........................................ 27
   10.2. Policy Guidelines ....................................................................................................................... 28
   10.3. Pledge of Commitment for Peer Supporters ............................................................................ 29
Appendix 1: Reporting Deadlines .......................................................................................................... 30
Appendix 2: Project Activities ................................................................................................................ 30
Appendix 3: Project Budget ................................................................................................................... 30
Appendix 4: Template for Receipt of Funds .......................................................................................... 30
Appendix 5: Template for Banking Details ............................................................................................ 30
### Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AFHS</td>
<td>Adolescent Friendly Health Services</td>
</tr>
<tr>
<td>ALHIV</td>
<td>Adolescents Living with HIV</td>
</tr>
<tr>
<td>AYPLHIV</td>
<td>Adolescents and Young People Living with HIV</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>AY+</td>
<td>African Young Positives</td>
</tr>
<tr>
<td>AYPLHIV</td>
<td>Adolescents and Young People Living with HIV</td>
</tr>
<tr>
<td>ART</td>
<td>Antiretroviral Therapy</td>
</tr>
<tr>
<td>CBO</td>
<td>Community Based Organisation</td>
</tr>
<tr>
<td>CHW</td>
<td>Community Health Worker</td>
</tr>
<tr>
<td>CoP</td>
<td>Community of Practice</td>
</tr>
<tr>
<td>C3</td>
<td>Clinic Community Collaboration</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>IATT</td>
<td>Inter-Agency Task Team</td>
</tr>
<tr>
<td>LTFU</td>
<td>Lost to Follow-Up</td>
</tr>
<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
</tr>
<tr>
<td>MoU</td>
<td>Memorandum of Understanding</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-governmental Organisation</td>
</tr>
<tr>
<td>PATA</td>
<td>Paediatric Adolescents Treatment Africa</td>
</tr>
<tr>
<td>PLHIV</td>
<td>People Living with HIV</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention from Mother-To-Child Transmission</td>
</tr>
<tr>
<td>PS</td>
<td>Peer supporter/s</td>
</tr>
<tr>
<td>PSS</td>
<td>Peer supporter supervisor</td>
</tr>
<tr>
<td>P2Z</td>
<td>Peers to Zero</td>
</tr>
<tr>
<td>REACH</td>
<td>Re-Engaging Adolescents and Children living with HIV</td>
</tr>
<tr>
<td>RIATT-ESA</td>
<td>Regional Inter-Agency Task Team – East and Southern Africa</td>
</tr>
<tr>
<td>SRH</td>
<td>Sexual and Reproductive Health</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>YAP</td>
<td>Youth Advisory Panel</td>
</tr>
<tr>
<td>YPLHIV</td>
<td>Young People Living with HIV</td>
</tr>
</tbody>
</table>
1. Introduction

This handbook provides an overview of the Peer Support Programme to improving access to, and quality of, antiretroviral treatment for HIV positive infants, children and adolescents within PATA’s action network of health providers within sub-Saharan Africa. The handbook is an important tool in assisting peer support supervisors, in setting minimum standards and building greater uniformity across the programme.

The purpose of the handbook is to:

- Provide an overview of the Peer Support Programme;
- Provide guidance to health providers working with peer supporters on how to recruit, train, supervise and mentor Peer Supporters;
- Promote the integration and recognition of peer supporters as valued members within existing clinic treatment teams;
- Provide guidance to clinic management on key considerations in integrating adolescent-friendly health service (AFHS) approaches to improve health outcomes among adolescents and YPLHIV;
- Provide an overview of what a meaningful engagement of adolescents and young people living with HIV should look like in a health facility setting;
- Provide direction as to how a health facility can integrate sexual and reproductive health and rights (SRHR) in a comprehensive and sustainable manner; and
- Elaborate the value that young people living with HIV (YPLHIV) can bring into the healthcare system for strengthened clinic and community collaboration.

The handbook promotes the integration of peer support into health services and urges all participating health facilities to actively pursue ways in which peer supporters can be provided with the necessary training, skills and opportunities to advance their careers and be incorporated into the clinic. This is needed for long-term sustainability within and beyond their role as peer supporters.

Information and materials in the handbook have been incorporated from an earlier edition which supported the previous PATA and One to One Children’s Fund Expert Patient Programme. Questions concerning information given in this Handbook should be addressed to PATA Programme Managers. Feedback and suggestions are welcomed.
2. Organisation background

PATA’s mission is to mobilise and strengthen a network of frontline health providers to improve paediatric and adolescent HIV prevention, treatment, care and support in sub-Saharan Africa. PATA works through four activity streams: PATA Forums, PATA Incubation Projects and Programmes, PATA Practice-Based Evidence and Advocacy and PATA Connect. Each of these activity streams works towards three common outcomes:

1. Improved quality of paediatric and adolescent treatment, care and support at health facility level
2. Increased peer-to-peer exchange between health providers across countries and regions
3. Positive change in policies, programmes and practices at national and global levels

Through PATA Forums, PATA provides paediatric and adolescent HIV technical input and capacity-building to operationalise change on the frontline of service delivery. Annual PATA Continental Summits convene healthcare providers from all PATA focus countries for cross-fertilisation and peer-to-peer exchange across the continent. PATA Local Forums bring together health providers from local districts to develop strategies and solutions and form ‘communities of practice’ in local areas.

Through PATA Incubation Projects and Programmes and PATA Practice-Based Evidence & Advocacy, PATA utilises a unified monitoring and evaluation (M&E) system to synergise monitoring and analysis across all PATA activities to identify, document and advocate for promising practice implementation models in line with the global targets.

PATA Connect is a portfolio of web-based strategies and collaborative learning platforms on which PATA draws to maintain connection among its network of health providers, highlight promising practices, provide technical input and build capacity, promote shared learning and facilitate peer support and exchange.

PATA aims to build the capacity of its direct beneficiary group (frontline health providers) to equip them to improve the lives of its indirect beneficiary group (children and adolescents living with HIV). PATA believes that health providers are an effective entry point to and channel for improving paediatric and adolescent HIV outcomes.

PATA has established a network of health provider teams that collectively care for more than 220,000 children and adolescents living with HIV. PATA creates a powerful platform to deliver multi-country capacity-building programmes directly to the frontline.

PATA’s programmes span districts in nine countries across Southern, East and West/Central Africa. PATA is thus able to draw on and leverage its existing partnerships and networks in country to benefit outcomes.
PATA’s partnerships with policy-makers and policy-influencers drive policy change at national and global levels. These include memberships and active participation in groups such as the IATT, IATT Child Survival Working Group, IATT Community Engagement Working Group, WHO Operational Guideline Development Group, ATC and RIATT-ESA.

PATA works collaboratively with NGOs and community organisations across the continent. PATA’s Clinic-CBO Collaboration (C3) Programme has set up and supports 36 health facility-CBO partnerships across districts in nine countries. These partnerships work together to mobilise demand for services, sensitize communities, undertake active outreach provide care and support and create enabling service environments. Learning across this 3-year initiative has built PATA’s capacity to meaningfully facilitate community engagement.

PATA is guided by the principles of the Positive Health and Dignity Framework, with PLHIV, and YPLHIV at the centre of its work. All PATA programmes and activities are developed and assessed through consultations with YPLHIV through its new Youth Advisory Panel (YAP). From 2016, the YAP is a central part of the organisation’s governance structure, with this group of YPLHIV elected at the 2016 Youth Summit centrally involved in decision-making, programme review and programme development. The chairperson of the YAP has just been formalised onto the PATA board in 2017.

PATA’s partnership with AY+ within the Peers to Zero (P2Z) consortium brings together health providers and YPLHIV, creating a unique platform for advocacy and service delivery change. Unifying these two stakeholder groups as consortium members in P2Z creates a combined and integrated response, promoting YPLHIV participation within the health service response whilst also increasing access to and improving quality of adolescent-centred HIV treatment and care.

PATA forums and summits provide dedicated space and opportunity to engage and consult with health providers and YPLHIV. These collaborative meetings consist of dialogues, peer workshops, interactive sessions, and skills-building and centrally involve YPLHIV in planning and leading the programme.

Finally, PATA implements ongoing engagement and correspondence with of its YPLHIV peer supporters through a WhatsApp community of practice (CoP). The CoP is highly active. Key topics such as adherence, onward disclosure and transition are discussed. Each of these activity areas are forms of engaging YPLHIV to inform and shape PATA’s programme design, implementation and evaluation.
3. Overview of the Peer Support Programme

HIV-positive children in sub-Saharan Africa have poor access to quality paediatric HIV care, with a severe shortage of health care workers being one of the healthcare system’s major barriers. Currently overburdened health teams are unable to offer the psychosocial support and child-friendly services that are needed to provide holistic, integrated and comprehensive care to children living with HIV disease.

In 2015, 45% of children eligible for treatment in accordance with WHO guidelines received HIV treatment versus 49% of treatment-eligible adults. Although practical and logistical difficulties had accounted for this inequity in earlier years, these current inequities stem from failure to link children born to HIV-positive mother into care, the use of innovative methods to ensure affordable early infant diagnosis and ensuring the availability and effective use of affordable antiretroviral formulations for children. Due, in part, to the success of previous paediatric HIV treatment efforts, an increasing number of young people are now also living beyond young childhood into adolescence. This success brings with it new challenges, including immunological complications, suboptimal antiretroviral therapy (ART) and formulations, and difficulties encountered in the transition from caregiver dependence to a growing independence. HIV-related deaths among adolescents were estimated to have increased since 2000, making HIV the second leading cause of mortality among this age group worldwide. 86% of 2015 global adolescent HIV-related deaths are estimated to have occurred in Africa with one out of every six deaths being AIDS related.

There are many service delivery challenges and gaps for child or adolescent specific populations. Infected children and youth have unique needs and require a targeted approach which considers their stage of life and the concomitant challenges that disclosure and transitioning inevitably brings. Appropriate access of healthcare is often limited by inadequate understanding and insufficient sensitisation of health providers of all levels to the different clinical and psychosocial needs of children and adolescents.

There is existing evidence that suggests that peer-to-peer engagement is important and provides an effective mechanism for psychosocial support and improved levels of treatment adherence and health service engagement. HIV positive youth who have left school can play an effective role as trainers, counsellors and adherence supporters for their HIV-positive peers, caregivers and health providers whilst also undertake additional task sharing activities within the clinic. HIV-positive youth provide a positive role model to younger children as they have walked a similar journey, can relate to the experiences of children and have greater appreciation for their concerns and fears. Young HIV-positive Peer Supporters would have

---

1 UNAIDS Global Report 2011
2 Sohn and Hazra, 2013
first-hand knowledge and experience of the challenges faced in accessing health as well as the barriers and concerns at clinic level, and could play an effective link for both adolescents and peers, as well as for younger children and their caregivers accessing the clinic.

High prevalence rates and the lack of access to affordable health services and treatment significantly impact the human rights of children and adolescents, severely compromising the region’s ability to attain political stability and social development for future generations. It is essential that there is a focus on implementing innovative best practices to ensure that quality care is delivered in a sustainable and holistic manner to children and adolescents living with HIV/AIDS. Young PLHIV have often cared for ill family members, may be caregivers of HIV exposed children and are a vulnerable population due to various challenges such as stigma and discrimination, poverty and limited employment or career prospects. The voice of YPLHIV is seldom heard within a healthcare context.

A peer-to-peer support model provides learning and new evidence in working with HIV-positive youth as a cadre of young community health providers attached to a clinic. These YPLHIV are provided skills and opportunities to further their training and improve their livelihood and ability to care for their own health and wellbeing. Young peer supporters can also be catalysts for effective engagement between younger patients and the clinic, providing child and youth focused projects that improve the overall quality of services for HIV-positive children and youth.

### 4. Benefits of the Peer Support Programme

The Peer Supporter Programme will shift toward providing an opportunity to harness the expertise of YPLHIV. Peer supporters are youth aged 18-23 years and will be recruited into a one year cycle, which will continue into a second year if funding permits. The programme targets children and adolescents 0-25 years of age and will provide task shifting and sharing roles within the clinic to access and improve the quality of HIV prevention, treatment, and care and support services. The programme takes place in key priority countries where PATA is currently implementing or partnering in adolescent-focused programmes.

#### 4.1. Objectives:

**4.1.1. Improving treatment outcomes and adherence**

This is achieved through the following:
• Improvements in early diagnosis, timely treatment and treatment adherence through individual follow-up, counselling and support for pregnant youth and children living with HIV: a peer supporter can apply their unique insight of living with HIV and taking ART to help support others facing similar challenges. Home visits and community outreach work play a key role in reaching peers, children and families living in remote areas, and who are reluctant to face the stigma of a clinic visit.

• Reducing waiting time and improving access to treatment through the provision of increased staff resources at clinics. The provision of additional staff resources in the form of peer supporters will ultimately help to ensure that more people can be seen and treated at clinics.

• Offering a wider range of support options to children, adolescents and their families. This includes activities that make clinic visits less traumatic, such as support groups for children and adolescents, creating child-friendly spaces, offering play and simple ECD activities at the clinics and teen support clubs.

• Busy healthcare professionals often do not have the time to follow up on patients who have defaulted from care. Peer supporters visit defaulters in their homes and provide them with support so that they are retained in care.

• Youth peer supporters are visible members in their communities and act as role models to other PLHIV, specifically to peers and younger children living with HIV.

4.1.2. Integrating YPLHIV into the healthcare system as CHW and ensuring health provider sensitisation

• Peer supporters are considered valued members of healthcare teams and participate in weekly staff meetings and team activities. This provides the opportunity for the voice of YPLHIV to be heard in a clinical context. To ensure the necessary support for peer supporters in carrying out their duties, they are closely supervised and mentored by a designated staff member who ensures that they have a detailed job description, are trained for specific tasks (and understand the boundaries of their role), time is set aside for regular mentorship and their performance is appraised on a quarterly basis. Peer supporter supervisors receive support from PATA and are guided in their role by PATA’s Peer Support Programme Handbook.

• Peer supporters’ work may contribute to sensitising health providers to the needs of children and adolescents.
Opportunities for young peer supporters to meet, share experiences, network and mobilise as an important stakeholder group.

4.1.3. Task-shifting and sharing, lessening the burden on health providers so that they may have more time to focus on improving quality of care

Many tasks necessary for the smooth functioning of a busy clinic are performed by health providers that could otherwise be performed by people with less skill and training. For example, it is necessary to make sure that clinic folders are transported to the pharmacy for pill counts and dispensing medication. Peer supporters are trained to perform specific tasks that can free up the time of health provider for more technical tasks, thus ensuring that clinics operate more efficiently. Each clinic participating in the programme identifies specific roles and tasks within their clinic which can be fulfilled by peer supporters.

4.1.4. Expanding the number and type of psychosocial service offered by clinics to ensure a holistic model of child and youth sensitive treatment and care

From the time freed up through task-shifting, doctors, nurses, counsellors and pharmacists have greater capacity to provide psychosocial support to patients, leading to an expanded repertoire of psychosocial support services.

Youth peer supporters are directly involved in running support groups for children and adolescents living with HIV, and can offer a variety of peer to peer activities such as support groups, teen clubs and mentorship.

Peer supporters’ work may contribute to improving access to SRH services for young people with a focus on young teen mothers.

4.1.5. Improving the quality of life for YPLHIV

Through the Peer Supporter Programme, previously unemployed young school leaving PLHIV have learnt new skills and earned a monthly stipend. Young peer supporters also have improved job prospects as their work experience assists them in being eligible for other positions and potential integration into the health departments. Training will assist the young peer supporters with future career growth and will be an additional focus of the programme.
5. Requirements for a successful Peer Support Programme

The implementation of a Peer Support Programme can only be successful if the health facility provides an environment that is friendly to children and adolescents and that offers a range of information and services tailored to improve health outcomes for this population group. This Handbook suggests a number of these services and requirements.

5.1. Adolescents Friendly Health Services

Adolescent friendly health services (AFHS) is an approach that brings together quality and high standard services that adolescents demand. A health service that is adolescent-friendly provides a comfortable and appropriate setting for ALHIV, meets their needs and retains young clientele for follow up and repeat visits.

AFHS should be offered to all adolescents in all settings irrespective of their HIV status. They should be accessible, acceptable, appropriate, effective and equitable. AFHS are provided by health providers who are sensitive to the needs of young clients. In providing AFHS, health providers should encourage autonomy and demonstrate respectful, non-judgmental attitudes and maintain privacy and confidentiality.

The rationale for having AFHS is that adolescence is a period of transition to adulthood that requires special attention to support a successful transition. During this transition phase, adolescents may face fears, concerns and lack understanding about their own needs and their behaviour often includes experimentation and risk-taking, making them more vulnerable. While on the other hand, adolescents tend to be healthy and do not perceive health to be an issue needing special attention. AFHS should therefore be designed to provide specialised care tailored to the needs of adolescents and appropriately supporting them through this phase.

5.1.1. Different types of adolescent-friendly health facilities

A facility may take different approaches in providing adolescent friendly services:

a. Having a designated day for seeing adolescents living with HIV:
   Adolescent HIV clinic run as a specific day within the general HIV clinic setup on which only ALHIV are offered care and treatment. In this scenario, the clinic operates within the same infrastructure as the adult clinic.

b. Having a designated Adolescent HIV clinic:
   Separate or stand-alone clinic setup for only ALHIV, operating outside the adult clinic infrastructure. A health facility may choose to use whichever model is feasible.
5.1.2. Characteristics of adolescent friendly services

Special attention needs to be paid to certain aspects of a facility to make sure all the necessary structures are in place to support provision of AFHS:

a. Technical performance
   - Health providers trained and sensitised to work with adolescents
   - Staff are trained to respect adolescents and their needs
   - Staffs acknowledge the central importance of privacy and confidentiality in dealing with adolescents

b. Effectiveness /Efficiency of service delivery
   - Enough time allowed for health provider and adolescent patients interaction
   - Special times when adolescents and young people can receive services
   - Wide range of services available in one setting — “one-stop shopping”

c. Access to services
   - Clinic managers make sure there is extra time allowed for health provider to discuss adolescents’ special issues.
   - Convenient hours and location
   - Informal and flexible: Drop-in patients welcomed
   - Publicity, marketing materials that inform and reassure youth
   - Referrals to clinics available

d. Interpersonal relations
   - Friendly to both male and female patients
   - Youth involvement in programme design and monitoring
   - Continuity of services

e. Safe, affordable or no fees for services

f. Physical infrastructure and comfort
   - Adequate space and privacy
   - Comfortable, youth-friendly surroundings
   - Overcrowding is avoided and short waiting times

g. Choice of services
   - Set up to provide chronic disease management, including multiple appointments and medications
   - Youth support groups and peer supporters available
   - Youth-friendly educational print material and audio visual (if possible) to take away
   - Appointment systems in place and tracking systems for clients who miss appointments
5.1.3. Minimum services that should be available at the health facility for addressing health needs for adolescents

- Information and counselling on health especially growth and development
- Information on reproductive health issues
- Recreation facilities
- Life skills education
- Information on body hygiene and environmental hygiene
- Counselling and management on sexual abuse
- Counselling on mental health
- Counselling on alcohol and substance abuse
- Pregnancy testing
- Nutritional services
- Referral and follow up
- Sexual and Reproductive Health Services (SRHS) e.g. antenatal care, safe deliveries, post-natal care, STI prevention, screening, and treatment; family planning method and post abortion care

5.1.4. Steps to establish or strengthen adolescent friendly health services

- Hold a meeting with the health facility management
- Conduct a needs assessment to appreciate the current state
- Determine the number of adolescents in care
- Hold meeting with supervisor and colleagues
- Reorganise the clinic
- Improve the waiting area
- Health talks by providers and peers
- Teach adolescent some skills—how to make crafts, draw and paint art pieces
- Include recreation space or room
- Counselling and consultation rooms that ensure privacy and confidentiality
- Avoid unnecessary referrals
- Develop a plan to involve the adolescents in their care
- Identify opportunities for integration of adolescent care services in other services
- Orient the community and adolescent to create demand for services
- Putting up notices in public places
- Liaise with community health workers to spread the news and refer clients for services
- Work with community leaders to reach the community

5.1.5. Psychosocial support

HIV infection affects all dimensions of a person’s life: physical, psychological, social and spiritual. HIV-positive adolescents face various challenges including disclosure, adherence, cognitive delays and clinical conditions. Even when access to treatment and adherence support is in place, complex social issues such as

---


stigma, psychological distress and fear, family conflict and caregiver challenges contribute negatively to the health of HIV-positive adolescents. Other factors, including discrimination by health providers, disempowering sexual and reproductive health legislation, inaccurate perceptions of HIV-related risk, and poor adherence and loss to follow-up, contribute to poor outcomes in this population.

Psychosocial support and counselling can help ALHIV cope more effectively with each stage of the infection and enhance their quality of life. Psychosocial support addresses the ongoing psychological and social problems of HIV infected ALHIV, their families and caregivers. For both individuals and their families, psychosocial support can assist people in making informed decisions, coping better with stress, illness and dealing more effectively with discrimination. It improves the quality of their lives, and prevents further transmission of HIV infection.

Psychosocial support services are traditionally provided by mental health professionals, such as psychologists, social workers, counsellors, specialised nurses, etc. These professionals might also refer patients or their families to other sources if they identify other needs. Considering the need of task shifting in a complex and busy health facility settings, peer supporters are being trained as lay health worker to provide psychosocial support. Nevertheless, peer supporters have no formal professional or paraprofessional certificated or degreeed and can only be able to provide peer to peer psychosocial support that may include the following services:

- One on one basic counselling
- Facilitate peer support group interactions
- Adherence counselling, HIV health education and treatment literacy
- Peer support activities (for example: camps, teen club, adolescent friendly corners, sports, art, drama etc.)
- Caregiver and family engagement (for example: home visit)
- Referral for professional mental health support

5.1.6. Support groups

Psychosocial support has been a key service component in improving AFHS within a health facility. Support groups are increasingly becoming a recommended platform through which psychosocial support should be

---

provided. However, overburdened mental health providers are often unable to be fully involved in support groups to offer psychosocial support and discuss adolescent-friendly services that are needed for ALHIV. Therefore, mental health providers are required to provide much needed capacity to peer supporters so they are adequately equipped to implement support group activities and provide psychosocial support within these support groups.

Considering the diversity of needs, psychosocial support within these support groups can be provided per differentiated needs, for example:

- Gender and age
- Perinatal vs horizontal infection
- Length of time since diagnosis
- Teen mothers etc.

The use of creative methodologies, such as sports, arts and drama within these support groups are encouraged; as well as responsive support services, such as one-on-one counselling, home visits, accompaniment to HIV services, health talk, lost-to-follow-up, outreach and other peer activities to build treatment literacy, encourage peer support and treatment adherence. ALHIV and peer supporters should be empowered to conduct support groups activities with the guidance of health care providers. Support group activities may include the following:

- Peer to peer interaction
- Play and recreational activities
- Educational activities
- Mini resource centres for adolescents and young people
- Drama, dance and storytelling (puppets)
- Youth and sports clubs

5.2. Integrating SRHR and HIV

There is a strong but complex relationship between HIV, SRH&R and gender. The presence of sexually transmitted infections (STIs) increases the risk of HIV transmission. Sexual reproductive ill health and HIV transmission share root causes such as poverty, limited access to SRH information, gender inequalities and stereotypes, harmful traditional/cultural practices and social marginalisation. Prevention of HIV and SRH ill health targets can be more effectively and efficiently met when quality and equitable HIV and SRH services are delivered in an integrated comprehensive and sustainable manner.

Integration refers to different kinds of SRH and HIV interventions and services that can be joined together to enhance outcomes (for example referrals). It is based on the need to offer comprehensive services.
5.2.1. Suggested youth friendly integrated HIV and SRHR services

- HIV testing, counselling and treatment
- STI testing, counselling and management
- Pregnancy testing and abortion related services.
- Contraception counselling and provision (family planning services)
- Maternal health services and PMTCT
- Counselling services:
  - Sexual abuse counselling
  - Relationship counselling
  - Counselling and psychosocial support relating to individual issues that undermine sexual health and wellbeing
  - Referral services (including outside of the health sector such as legal, nutritional and social services)

5.2.2. Minimum standard for integrated SRHR/HIV services

All service delivery points/outlets can either provide or refer clients to other youth friendly providers to access the minimum package of youth friendly services including both SRHR and HIV related services. Health facilities should ensure that they offer comprehensive, integrated HIV and SRH services. If the health facility is unable to provide these services in one place, AYPLHIV must be referred to receive these services elsewhere.

5.2.3. Quality of service provision

- Service providers must be committed to rights based service provision that integrates SRHR and HIV services
- Young people living with HIV should be engaged in client satisfaction surveys and feedback mechanisms
- Service providers should also support young people living with HIV to provide services to their peers and help to monitor treatment outcomes

5.3. Meaningful engagement of adolescents and YPLHIV

Evidence suggests that peer-led interventions have the potential to create context specific services that support ART adherence, retention in care, viral suppression and psychosocial support for A&YPLHIV. Peers often serve as a primary source for information about HIV and sex and hence are influential in decisions made by peers about sex.

More recently, the principles of peer engagement are increasingly being applied to support adolescents and young people living with HIV (AYPLHIV). Such interventions draw on the knowledge and lived expertise of AYPLHIV to plan, deliver and monitor HIV services.

Adolescents and young people should therefore be involved in the design, implementation and evaluation of services. This recommendation is emerging as a key component of adolescent and youth friendly service
strategies. Issues affecting adolescents and young people cannot be properly addressed if they are excluded from these processes.

Health providers may engage AYPLHIV in service design by allowing them to provide inputs around key consideration for a comprehensive adolescent-friendly service that speaks to the need of adolescents. This can be done through focus group discussions run by and for AYPLHIV where they discuss key topics, share examples on different challenges they faced in the past and how they dealt with etc. Health providers may also collect AYLHIV’s input in service design through interviews, questionnaires and suggestion boxes.

In addition to this, health providers may engage AYPLHIV in service monitoring by involving them in case management and staff meetings or through health facility dialogues between health providers and peer supporters/AYLHIV. AYLHIV may also be engaged in post service delivery surveys.

5.3.1. Peer supporters and AYPLHIV leadership

AYPLHIV can raise service level issues at national, regional and global levels. However, AYPLHIV are generally not well represented at these levels, and are often excluded from leadership positions to present their unique needs and interests. There are instances where global PLHIV networks have expanded to include AYPLHIV. However, they operate at an individual membership level, and offer limited support and capacity building to emerging country and regional networks of AYPLHIV.

It is essential that AYPLHIV and peer supporters are capacitated with leadership and advocacy skills, as well as are offered opportunities of being linked to existing national networks, so that they can become future leaders in AYPLHIV national network. In this way, they can undertake human rights advocacy and influence policy, whilst promoting enabled health facility environments. This will create effective mechanisms and platforms to raise service level issues at facility, district, national and global levels whilst linking and guiding new leadership into national YPLHIV structures to influence country programmes.

5.4. Clinic-community collaboration within peer led models

Community involvement is considered an important element of most health and development programmes and community participation can inform programme design when community members are involved from the beginning to extend the reach and scope of interventions. Experience with programmes in many sectors has shown that community involvement can impact behaviour change to improve people’s health, wellbeing, knowledge and attitudes not only at the individual level, but also at the community level. Community-level shifts in attitudes and social norms create a more supportive environment that enables individual to adopt and maintain new behaviour. Community involvement can also create the sense of ownership necessary to sustain behaviour change.
The involvement of the larger community is considered critical to the success of the Peer Support Programme. Incorporating community participation into peer led models may help in the following:

- Determine how the Peer Support Programme can be defined and standardised while remaining flexible and responsive to the people and communities it serves through:
  - Person-centred approach – taking full advantage of peer supporter’s ability to meet individuals where they are and to reflect their needs, strengths, lives, and aspirations.
  - Population-focused approach – organised, implemented, and sustained to meet the needs of all those for whom they are designed, e.g. HIV+ pregnant teens.
  - Comprehensive – flexible in the modes and content of peer support interventions to meet varied needs and circumstances of intended communities.

5.4.1. Evidence of effectiveness of community-based HIV interventions for young people

Community-based programmes have been proven to be successful in catalysing change by helping communities reflect on traditions, norms and values that jeopardise their AYLPHIV health and survival. Community involvement has been demonstrated to also play an important role in HIV prevention, treatment, care and support interventions for young people through:

- Providing access to young people in the community through adult gatekeepers
- Creating a supportive community environment that enables individual behaviour change and mitigating the impact of HIV-related stigma and discrimination on young people
- Facilitating changes in gender norms that affect young people’s risk of HIV infection
- Increasing community awareness of available HIV services, generating youth demand for such services and increasing access to and use of services through referral systems and support

Any community mobilisation of young people to use HIV prevention and treatment services should support young people in the adoption of preventive behaviours and increase young people’s status in the community so they can assume leadership roles in spreading HIV information and education in their communities.

6. Expected outcomes

- Improved clinic capacity and functionality
- Increased number of infants, children and adolescents initiated on ART
- Expanded range of services and number of youth friendly services
- Increased case finding and community engagement
- Improved adherence and retention rates for PMTCT, infants, children and adolescents
- Improved access to training, mentoring, supervision for peer supporters
Increased number of peer supporters accessing life skills, knowledge and future livelihood and career prospects

- Improved networking and collaboration amongst peer supporters
- Best-practice peer support model documented

### 7. Important Notes for Planning

#### 7.1. Peer Supporter Basic Conditions of Service

It is important to recognise that **peer supporters are not employees**; they are **volunteers** who receive a small stipend for helping within the clinic. Peer supporters cannot be expected to work full time hours as they are not afforded the same legal employment protections. Peer supporters need time to their personal commitments such as taking care of themselves and their children/ families, pursuing income generating activities and/or attend to studies. PATA provides each clinic on the programme with a monthly grant to offer stipends (NOT salaries) to peer supporters who help in their clinic. This will be specified in the MoU and may comprise amounts related to:

- Stipend amount for each peer supporter
- Management, supervision and administration fee
- Activity costs related to support groups, safe spaces, networking and or community outreach

The primary motivation for peer supporters comes from **feeling valued within the clinic** and knowing that they are able to make a difference in the lives of other YPLHIV. Peer supporters are positive role models and provide valuable support for their peers and become a key liaison between younger patients, their families and health providers, whilst also being a constant advocate for YLHIV within the clinic setting. The successful outcomes of the Peer Support Programme depend on how well peer supporters are supported and empowered.

---

**NOTE:** Peer Supporters are extremely vulnerable to exploitation because they work in the same clinic which is responsible for their treatment and wellbeing. In addition, because they work with people who share similar struggles as themselves, they are more likely to over identify and are prone to experience psychological stress. For this reason, it is vital that each peer supporter is directly supervised by someone with whom they can openly communicate and who will act as an advocate and mentor to them. **Supervisors must have time and empathy to undertake the task of supervising peer supporters.**

To help clinic management to support and empower Peer Supporters, the following basic conditions of service need to be considered and are recommended as a minimum condition of service:
a. **Number of Peer Supporters per clinic:** Each sponsored clinic is required to recruit the number of peer supporters agreed in the project MoU. Clinics will need to demonstrate that their allocated grant is used to financially support these peer supporters.

b. **Peer Supporters hours of work:** As stated above, peer supporters are not full time employees and receive a small stipend for helping within the clinic. Peer supporters should not be required to work more than 80 hours per month (approx. 4 hours per weekday). Clinics are advised to research their local labour laws and regulations in their respective countries to ensure that peer supporters are not exploited or treated unfairly. A record of peer supporter stipend payments must be maintained in addition to invoices/receipts and any other payments made on the programme. All receipts need to be kept and may be requested by PATA for the duration of the programme.

c. **Peer Supporters minimum stipend:** PATA will ensure that all clinics accepted onto the programme provide each Peer Supporter a minimum stipend of $65 (US) per month. Please note that there is no guarantee that this programme will continue after the contracted time in the MOU. It is therefore important that both the clinic and the peer supporters themselves explore additional and alternate funding options for sustainability.

d. **Peer Supporters must know what is expected of them:**

They must:

- Know to whom they should report when they come to work
- Have a thorough understanding of the work they are expected to do
- Know what hours they are expected to work (as stated above, a maximum 80 hours per month)
- Know how much money they will receive for their contribution (as stated above, each Peer Supporters should receive $65 (US) per month).
- Know that any additional costs they incur (e.g. transport and telephone) will be refunded and what procedure must be followed and what budget is available
- Know what to do if they have a grievance. In the unlikely event of conflict arising between the peer supporter and supervisor they must understand the grievance procedure and know to whom they should go
- Know what leave they are entitled, if any (i.e. annual and sick leave)
- Know who to contact if they are sick or unable to report for duty
- Sign a contract with the Clinic which clearly states the above points
- Be paid monthly and must sign for their stipend EACH time they receive it
- Be reassured that their work as a peer supporters in no way changes their rights as a patient
- Be warned of the potential risk to themselves, of working with people who have tuberculosis and other infectious conditions
- Be instructed about expected behaviour and the code of conduct (see below)
- Be supplied with any equipment and or tools they need to do their tasks
- Be aware and informed on all clinic or programme specific policies

e. Peer supporters **job description and consideration of tasks:** Clinics must determine peer supporters’ tasks based on the needs of the clinic, but it is imperative that supervisors also align their peer supporters’ activities and tasks to the overall aims and outcomes of the programme. Peer supporters may work anywhere within the clinic or community where there is a need to task-shift and improve the provision of treatment and care to younger children (0-9) and adolescents (10 – 19) infected and or affected by HIV. Peer supporters in PATA affiliated clinics can do one or several of the following tasks:

- **Infant and children (Early Childhood Development) tasks:** Create child friendly spaces and promote playgroups in the clinic. Engage in activities such as storytelling, and the provision of art, crafts, games and puzzles to stimulate cognitive development in young children.
- **Psychosocial tasks:** Peer support groups, organise adolescent/teen clubs and camps. Organise variety of educational and psychosocial support activities utilising creative methodologies, such as drama, art, crafts, sports and dance where possible; promote linkage to life skills training, skill building and related community and or school support services
- **Counselling tasks:** act as a peer counsellor, support group leader and treatment buddy. Provide HIV counselling and testing (HCT), disclosure and adherence counselling and monitoring, treatment literacy as well as information and support in accessing SRH services.
- **Educational tasks:** share information and conduct training sessions on nutrition, adherence, infant feeding, disclosure and other relevant topics
- **Outreach/community work:** visit client’s homes to conduct educational talks, follow up on lost to follow-up (LTFU) cases, case finding – encourage infants, children and adolescents to receive HIV counselling and testing (HCT). Disseminate programme materials and resources and actively participate in community sensitisation efforts.
- **In-clinic tasks:** are defined by each clinic’s needs, and is programme specific. In addition to tasks already mentioned, in-clinic tasks can include the supervision of play areas and adolescent friendly spaces, receiving patients for clinic visits, assisting with clinic bookings and undertaking nonprofessional tasks such as: recording height, weight, acting as an interpreter, provide
assistance in the pharmacy with data entry, filing and other administrative tasks, as well as assisting with escorting patients to different services that they may be referred to or transitioned to.

- **Networking:** peer supporters are encouraged to engage in local networks of YPLHIV and support community initiatives that support mobilising, organising and training of YPLHIV.
- **Training:** attend trainings and skills building opportunities as specified and/or in consultation with the clinic supervisor and/or PATA
- **M&E:** maintain paper or electronic based information as the programme or clinic specifies

### 7.2. Peer Supporter Recruitment

Peer supporters are usually selected by the clinic staff member who is responsible for their supervision. Peer supporters should possess some or all of the following qualities:

- Demonstrated commitment and passion in helping peers
- HIV positive and known at the clinic for at least a year. ART registered (consistently on ART for the last 12 months)
- If female, should not be pregnant at the time of recruitment and not nursing a child below 1.5 years
- Have fully disclosed their status and willing to talk about their HIV status to others
- Aged 18-24 years
- Willing to talk about their HIV status to others for purposes of peer support
- Enthusiasm and a record of participation in clinic activities
- Out of school, readily available
- A member of at least one of the clinic support groups
- Self-motivated and reliable
- Ability to communicate effectively in oral and written mediums
- Respects others and behaves in a manner that reflects appreciation for dignity and diversity
- Displays empathy and sensitivity
- Shows consistency in words and actions
- Leadership qualities with active participation in YPLHIV networking activities
- Emotional maturity
- Basic level of education – ideally a school leaver (able to read, write and count)
- Preferably can speak, write and read English and French we
- Fluent in national and local language
- Ability to be a good role model to peers

The peer supporters must understand that:

1. Working as a peer supporter means their HIV status will become known to a wider group.
2. Working as a peer supporter means they will be exposed to people with tuberculosis (TB) and other communicable diseases.
3. Working as a peer supporter means that information on other patients must be confidential (see code of conduct).
7.3. Contract

Each peer supporter must sign a contract in line with all the local labour laws and regulations of their country, which clearly outlines the following:

- Full names and date of birth of the peer supporter
- Clear job description (tasks and responsibilities)
- Clearly defined volunteer hours
- Specifies stipend and how this will be paid
- Specifies whether sick leave and annual leave is applicable
- Highlights levels of authority within the clinic (e.g. who they report to)
- Grievance procedure/Disciplinary procedure

7.4. Performance Appraisals

Peer supporters need to have their performance appraised every six months and ongoing monthly monitoring is strongly advised. Ongoing appraisal of their performance should be a continuous process. In order to conduct a successful performance appraisal, the following are necessary:

- Clear definition and agreement on the performance that is required
- Positive feedback when things go well, to reinforce performance
- Immediate critical feedback on poor performance, to put things back on track
- Agreement on steps that will improve performance in the longer term

The most important part of performance management is effective communication. It is vital that feedback on specific incidents of poor performance be addressed immediately and not kept until the formal performance appraisal.

7.5. Peer Supporters Orientation

The following aspects must be included in an orientation which must take place during the first two weeks, regardless of the work they do. Other training should be individualised according to the specific experience, prior learning and tasks each peer supporter is responsible for.

- All aspects listed under the heading Basic Conditions (section A above) must be explained
- Personal safety in the workplace (e.g. hand washing, gloves, etc.) as well as safety while in the community (encountering inappropriate behaviour, violence, etc.) discussed
- Basic infection control in the clinic
- Orientation to the clinic layout and an explanation of clinic hierarchy
- Code of conduct for peer supporter (see section below)
- Explanation of all policies that may impact, for example a Child and Vulnerable Adult Safeguarding protection and Anti-Bribery and Corruption policy
- Effective communication and listening skills
- Record-keeping
• Enthusiasm and willingness to work
• Positive attitude
• Being honest about their own limitations and not trying to take on work which is beyond their skills and training
• Reporting accidents, acts and omissions to the supervisor or appropriate person in clinic

7.6. Peer Supporters Code of Conduct

A code of conduct provides guidance to peer supporters in their conduct within the clinic and community they serve.

7.6.1. Scope of role

A peer supporter is a lay health worker who assists with less technical tasks in the clinic and performs patient level engagement and can also undertake community outreach. Peer Supporters report directly to a Peer Supporter Supervisor.

7.6.2. Core ethical values and standards required of Peer Supporters

a. **Respect for persons**: peer supporters should respect patients as persons, and acknowledge their intrinsic worth, dignity, and sense of value.

b. **Best interests or well-being**: peer supporters should not harm or act against the best interests of patients, even when the interests of the latter conflict with their own self-interest.

c. **Human rights**: peer supporters should recognise the human rights of all individuals.

d. **Autonomy**: peer supporters should honour the right of patients to self-determination or to make their own informed choices, and to live their lives by their own beliefs, values and preferences.

e. **Integrity**: peer supporters should incorporate these core ethical values and standards as the foundation of their professional conduct.

f. **Truthfulness**: peer supporters should regard the truth and truthfulness as the basis of trust in their professional relationships with patients and their supervisors.

g. **Confidentiality**: peer supporters should treat personal or private information as confidential in professional relationships with patients - unless overriding reasons confer a moral or legal right to disclosure e.g. issues of abuse

h. **Compassion**: peer supporters should be sensitive to, and empathise with, the individual and social needs of their patients and seek to create mechanisms for providing comfort and support where appropriate and possible.

i. **Tolerance**: peer supporters should respect the rights of people to have different ethical beliefs as these may arise from deeply held personal, religious or cultural convictions.
j. **Boundaries:** peer supporters should understand the limitation of their role and understand that they are not registered medical professionals.

k. As a Peer Supporter attached to a facility it is important that the Peer Supporter does not engage in any form of sexual relationship/s with patients and does not accept money or gifts from patients.

l. **Punctuality:** peer supporters should be punctual and reliable in their duties. In the event that the peer supporter is unable attend work, they must contact the peer supporter supervisor.

m. **Self-care:** peer supporters should make sure to take care of their well-being and make sure to inform the Peer Supporter Supervisor if they do not feel well.

n. **Role model:** Peer supporters are expected to act as role models to the patients they take care of and in their community.

o. **Anti-bribery/ corruption:** Peer supporters should be made aware of and observe anti-bribery and corruption measures.

Supervisors are expected to conduct at least 30 - 60 minutes scheduled face-to-face meetings per week with peer supporters and at least 4-5 hours of interaction-time per month.

The health facility must select a peer supporter supervisor who will supervise peer supporters including recording their activities and managing the human resource requirements of the peer supporters, which include recording the days and hours worked by the peer supporters. The peer supporter supervisor will be responsible for submitting the quarterly financial reports and narrative progress. Please refer to MOU for all reporting requirements. Supervisors must be readily contactable by PATA on a monthly basis, either telephonically or by email. Supervisors must be willing to attend an annual PATA or PATA partner training event, when available.

### 7.7. Peer Supporters Supervisor’s Code of Conduct

In the capacity of **Peer Supporters Supervisors**, they must:

i. Show RESPECT towards **Peer Supporters** by:

   - Treating **Peer Supporters** as courteously as they would like to be treated
   - Being civil, welcoming to differences, and **protective of the privacy of peer supporters**
   - Maintaining confidentiality with all aspects related to peer supporters’ health status

ii. Working cooperatively, giving appropriate credit to the contributions peer supporters. Be FAIR by:

   - Handling similar matters consistently, with fairness and due process
   - Utilising equitable and non-discriminatory management practices
iii. Have COMPASSION towards peer supporters while performing their duties by:

- Understanding that their actions at work can impact the lives of peer supporters’
- Being aware of and responsive to individual needs and feelings

iv. Demonstrate TRUSTWORTHINESS by:

- Saying what they mean and doing what they say, modelling clear, honest and full communications and disclosure
- Employing good judgment and displaying ethical behaviour in decision making, never inducing or compelling peer supporters to take part in unethical, improper or illegal conduct
- Avoiding conflicts of interest, ensuring that outside interests, affiliations, or activities do not influence, or appear to influence decision-making, research activities or job performance

v. Take RESPONSIBILITY for their actions and behaviour by:

- Being readily contactable by PATA, either by cell phone, phone and/or email
- Working directly with the peer supporter
- Evaluating the peer supporter’s performance at least twice a year
- Acting as the peer supporter’s mentor and advocate
- Making time to mentor peer supporters and assist with debriefing
- Pursuing excellence and continuous improvement

vi. Take RESPONSIBILITY for the role as a supervisor. Be clear and explain to peer supporters:

- To whom they should report
- Their roles and responsibilities within the clinic and in the community they serve
- Their working hours per day/ per week/ per month
- The monthly stipend amount they will receive and the frequency as agreed per the MoU
- If costs incurred will be refunded (e.g. transport/mobile phone credit)
- The steps to take if they have a grievance and in the unlikely event of conflict arising between the Peer Supporter and Peer Supporter Supervisor
- If they are allowed leave and for how long (i.e. annual and sick leave)
- Who to contact if they are sick or unable to report for duty
- The contract they will sign
- They must sign for their stipend each time they receive it
- That their work as Peer Supporter in no way changes their rights as a patient
- The potential risk to themselves, of working with people who have tuberculosis and other infectious conditions/communicable diseases
- Their expected behaviour and their code of conduct
- That they will be supplied with any equipment they need to do their work
- All supervisors must consent to adhere by the Peer Supporter Supervisor Code of Conduct above before commencing their duties.
8. Financial Management

- Funds for the Peer Support Programme will not be paid into a bank account held by an individual. Funds can be paid directly to a clinic and or a corresponding or partnering NGO.
- Identify a person who will be responsible for financial reporting to PATA.
- As stated in the MOU, clinics/partnering NGO are required to acknowledge receipt of all funds transferred into the provided account within two (2) weeks of funds received and to submit finance and narrative reports using templates provided by PATA following the MoU requirements. Clinics are expected to pay each peer supporter as per their contractual obligation and on a weekly or monthly basis.
- Records of stipends paid and proof thereof (signed receipts by peer supporters), as well as receipts and proof of payments for all project expenditure must be available at all times and may be requested.

9. Training

Training is integral to improving the capacity of peer supporters and PATA seeks to actively promote skills development amongst YPLHIV.

- PATA understands that practical onsite training will be provided by clinic staff and the peer supporter supervisor. Participating clinics will make every effort to engage peer supporters in available training opportunities.
- In addition to the quarterly tranche payment, a small grant may be reserved to support the Peer Supporter Programme training. Training must be provided by an external accredited service provider who is locally recognised.
- A PATA Community Health Worker e-Toolkit will also be provided to complement training. This toolkit can be used as an aid in peer supporters’ supervision sessions as well as independently by peer supporters and community health workers.

10. Policies

10.1. Introduction to Anti-Corruption / Bribery and Child Safety Policies

PATA has a ‘zero tolerance approach’ to bribery and corruption involving project funds and staff. PATA is also committed to promote good practice for the safety and protection of children. In so doing the welfare of the child and young people remains paramount. Children and young people should be protected from
receiving less favourable treatment on the grounds of gender, disability, HIV/AIDS status, race, age, sexual orientation, creed, colour, nationality and ethnic or national origin.

Project partners are expected to;

- Take all reasonable steps to protect children and young people from harm, discrimination and degrading treatment and to respect their rights, wishes and feelings;
- Report all suspicions and allegations of poor practice or abuse;
- Ensure that children are aware of their rights to be safe from abuse;
- Ensure that employees, volunteers and peer supporters working on the project are recruited on the basis of being suitably responsible in working with children and young people;
- Ensure parents/carers complete a Photographic Release Form for any child under the age of 18, before taking photographs or video footage;
- Make every effort to ensure that confidentiality is maintained for all concerned. Information should be handled and disseminated on a need-to-know basis only.

In the event that project partners, staff or peer supporters working on the project are found to be involved in any form of corruption, bribery or non-compliant to child safety and protection protocols, PATA will act firmly and resolutely in reporting the matter to the relevant authorities and terminating its existing MOU.

10.2. Policy Guidelines

This section outlines the responsibility of peer supporter supervision towards the programme implementation.

<table>
<thead>
<tr>
<th>What peer supporter supervisor MUST do</th>
<th>What peer supporter supervisor MUST NOT do</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Report any suspicion or allegation of bribery or corruption within the project to PATA</td>
<td>• Give a bribe or accept a bribe designed to influence an individual in the performance of his/her duty</td>
</tr>
<tr>
<td>• Remember that a bribe may not always involve money</td>
<td>• Accept any form of bribe, included where sexual favour is involved, or gift in cash or kind, or there are any kick-backs or reciprocal arrangements</td>
</tr>
<tr>
<td>• Take all reasonable steps to protect children and young people from abuse, harm and discrimination and respect their rights, wishes and feelings</td>
<td>• Abuse, harm or discriminate again a child or young persons, including; taking a child or young person to your home where they will be alone with you, engaging in rough, physical or sexually provocative games; allowing or engaging in inappropriate touching of any form, or making any form of sexually suggestion or comment</td>
</tr>
<tr>
<td>• Treat all young people and children equally and always put their welfare first</td>
<td>• Ignore or fail to report a disclosure of alleged abuse by a child or young person</td>
</tr>
<tr>
<td>• Report any suspicion or allegation of abuse of a child or young person to the relevant authority in your facility</td>
<td></td>
</tr>
</tbody>
</table>
10.3. Pledge of Commitment for Peer Supporters

I, ................................................................................................. declare that in my role as a peer supporter/peer supporter supervisor, I am committed to upholding the following principles:

- I will do my utmost to ensure that the work that I do improves access to treatment and care for HIV positive children, adolescents and their families
- I will perform my role in the clinic, and in the community I support, to the best of my ability and to a high standard
- I will listen to and respect the feelings and wishes of all the patients I support and maintain the strictest confidentiality at all times
- I will support and respect the needs of my colleagues
- I believe that the welfare of children and young people is of paramount importance
- I believe that the welfare of vulnerable adults is also of vital importance
- I will immediately report any concerns I have about abuse or neglect to my supervisor
- I will maintain a professional relationship with patients and clients at all times
- I will not accept money or expensive gifts from patients or clients
- I will report any concerns I have about corruption and bribery to my supervisor

Signed: _________________________

Date: _________________________
Appendix 1: Reporting Deadlines

Appendix 2: Project Activities

Appendix 3: Project Budget

Appendix 4: Template for Receipt of Funds

Appendix 5: Template for Banking Details