

PARTNERING FOR CHANGE

Chronic Care in Humanitarian Crises

Peer support handbook

Planning, implementing and
evaluating peer support with people
living with noncommunicable
diseases in humanitarian settings



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Lebanon

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Contributors

Lars Bruun Larsen (Danish Red Cross), Jytte Roswall (Danish Red Cross), Megan Barlow (Danish Red Cross), Rima Kighsro Naimi (Danish Red Cross), Sylvia Khamati Anekha – Logendo (Danish Red Cross), Carla Njeim (Lebanese Red Cross), Hezron Mukhonji Nambiro (Kenya Red Cross), Sigiriya Aebischer Perone (International Committee of the Red Cross), Pablo Perel (London School of Hygiene & Tropical Medicine), Éimhín Ansbro (London School of Hygiene & Tropical Medicine), Hanna Phelan (Médecins Sans Frontières Sweden

Innovation Unit), Philippa Boule (Médecins Sans Frontières), Mike Woodman (United Nations High Commissioner for Refugees), Apoorva Gomber (Brigham and Women's Hospital, NCDI Poverty Network), Stella Njagi (International Rescue Committee), Mahmoud Tharwat (International Federation of Red Cross and Red Crescent Societies), Ea Suzanne Akasha (International Federation of Red Cross and Red Crescent Societies Reference Centre for Psychosocial Support), Tine Mette Gammeltoft (University of Copenhagen), Đặng Thị Ngọc Anh (Thai Binh University of Medicine and Pharmacy), Sara Fasoli (NCD Alliance), Ibtihal Fadhil (Eastern Mediterranean NCD Alliance), Gina Ferrari (Brigham and Women's Hospital, NCDI Poverty Network), Zipporah Ali (Primary Care International), Kiran Jobanputra (World Health Organization), Jasmine Kalha (Centre for Mental Health Law & Policy, Indian Law Society), Favila Escobio (HelpAge International), Diana Hiscock (HelpAge International), Marion Staunton (HelpAge International), Poppy Walton (HelpAge International), Amal Ireifij (Royal Health Awareness Society), Megan Sheridan (Direct Relief) and Mohammed Seyam (University College London).

Conception

Lars Bruun Larsen, Jytte Roswall, Sigiriya

Aebischer Perone, Benjamin Schmid, Éimhín Ansbro, and Pablo Perel

Author

Benjamin Schmid (London School of Hygiene & Tropical Medicine)

Design

Last Mile (Copenhagen, Denmark)

Publication

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This handbook is dedicated with special appreciation to the millions of people affected by humanitarian crises now and in the future. They are at the centre of why this handbook was created, and the authors and contributors sincerely hope that they will benefit most from it.

ACRONYMS

HIV/AIDS	Human immunodeficiency viruses/ acquired immunodeficiency syndrome
IDF	International Diabetes Federation
IFRC	International Federation of Red Cross and Red Crescent Societies
IRC	International Rescue Committee
M&E	Monitoring and evaluation
MHPSS	Mental health and psychosocial support
NCDs	Noncommunicable diseases
PLWNCDs	People living with noncommunicable diseases
ToC	Theory of change
P4C	Partnering for Change
WHO	World Health Organization



GLOSSARY

Continuity of care

Continuity of care is the provision of coordinated care and services, over time and across levels and disciplines, which is coherent with the patient’s health needs and personal circumstances.^{1(p10)}

Continuum of care

Continuum of care refers to a person’s uninterrupted access to comprehensive services and interventions that address that person’s health needs and well-being, from the moment a health condition is identified until the person recovers a functional state consistent with the context.²

Facilitator

Facilitator is used to describe any person leading peer support sessions, including peer leaders and non-peer facilitators (e.g., social workers).

Humanitarian setting

A humanitarian setting is one in which

an event or series of events has resulted in a critical threat to the health, safety, security or wellbeing of a community or other large group of people. The coping capacity of the affected community is overwhelmed and external assistance is required.³ This handbook’s use of blanket terms, such as humanitarian setting and noncommunicable disease, reflects its generic nature. The authors acknowledge their limitations in capturing the full nuances of people and places, and hope that they serve as a reminder of the need to adapt.

Model of care

The overarching design for the provision of a particular type of health care service.⁴ (p49) Ansbro et al.⁵ propose a conceptual framework of a model of NCD care in humanitarian settings.

Noncommunicable diseases (NCDs)

[NCDs], also known as chronic conditions, tend to be of long duration and are

the result of a combination of genetic, physiological, environmental and behavioural factors.⁶ This handbook uses examples primarily in line with the global “5x5 NCD agenda”, but remains equally relevant for all NCDs.⁷ While mental health and neurological disorders are one of the five key NCD groups in the global agenda, this handbook highlights them in certain sections to emphasise the need for integrating physical and mental health.

Peer leader / Participant

Peer support is often – but not necessarily – led by a peer. To distinguish their roles from those taking part, this handbook uses the following terms:

- Peer leader = a person living with NCDs leading peer support sessions.
- Participant = a person living with NCDs taking part in the sessions.

Implementers can choose any synonym preferable in the project’s setting.

USER'S GUIDE

This handbook serves as a practical guide for how to plan, implement and evaluate peer support with people living with noncommunicable diseases (PLWNCDs) in humanitarian settings.

WHO ARE THE INTENDED USERS?

Humanitarian health and project planning professionals working at regional, national or sub-national level. The focus of the handbook is NCDs, yet it can be equally relevant for other areas (e.g., communicable diseases and maternal, newborn and child health) and contexts (e.g., more stable settings).

WHAT CAN THIS HANDBOOK HELP WITH?

- Enabling humanitarian actors to decide on whether to use a peer support approach.
- Guiding the design of an intervention and its adaptation to the local context.
- Selecting and training acceptable facilitators and defining criteria for participation.
- Preparing the implementation logistics and anticipating potential challenges.
- Establishing the foundation for creating a detailed day-to-day manual and tools, a facilitator training guide and a monitoring and evaluation (M&E) plan (these are not covered in detail).

HOW TO USE THIS HANDBOOK

- If you are new to the concepts of peer support, explore the section on [concepts of peer support](#).
- Follow the step-by-step guide to planning ([Phase I](#)), implementing ([Phase II](#)) and evaluating ([Phase III](#)) peer support interventions OR choose to review specific sections or skip steps based on existing experiences and needs.
- Review the [Annex](#) for helpful tools and operational case studies.

For simplicity, the steps are shown as linear, while in practice they are interconnected and iterative ([Figure 1](#)). This handbook has been developed as a generic guide. It gives projects the flexibility to adapt peer support to a specific context. This adaptation is crucial; it could be the determining factor in having an impact or not. The handbook supports this process with practical tools marked by cross-cutting visual cues. Links to complementary resources have been added where possible. [Annex A](#) details the handbook's development.

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This handbook is an evolving and open-access publication. Scan the QR code for the latest version.



Lebanon

Phase overview

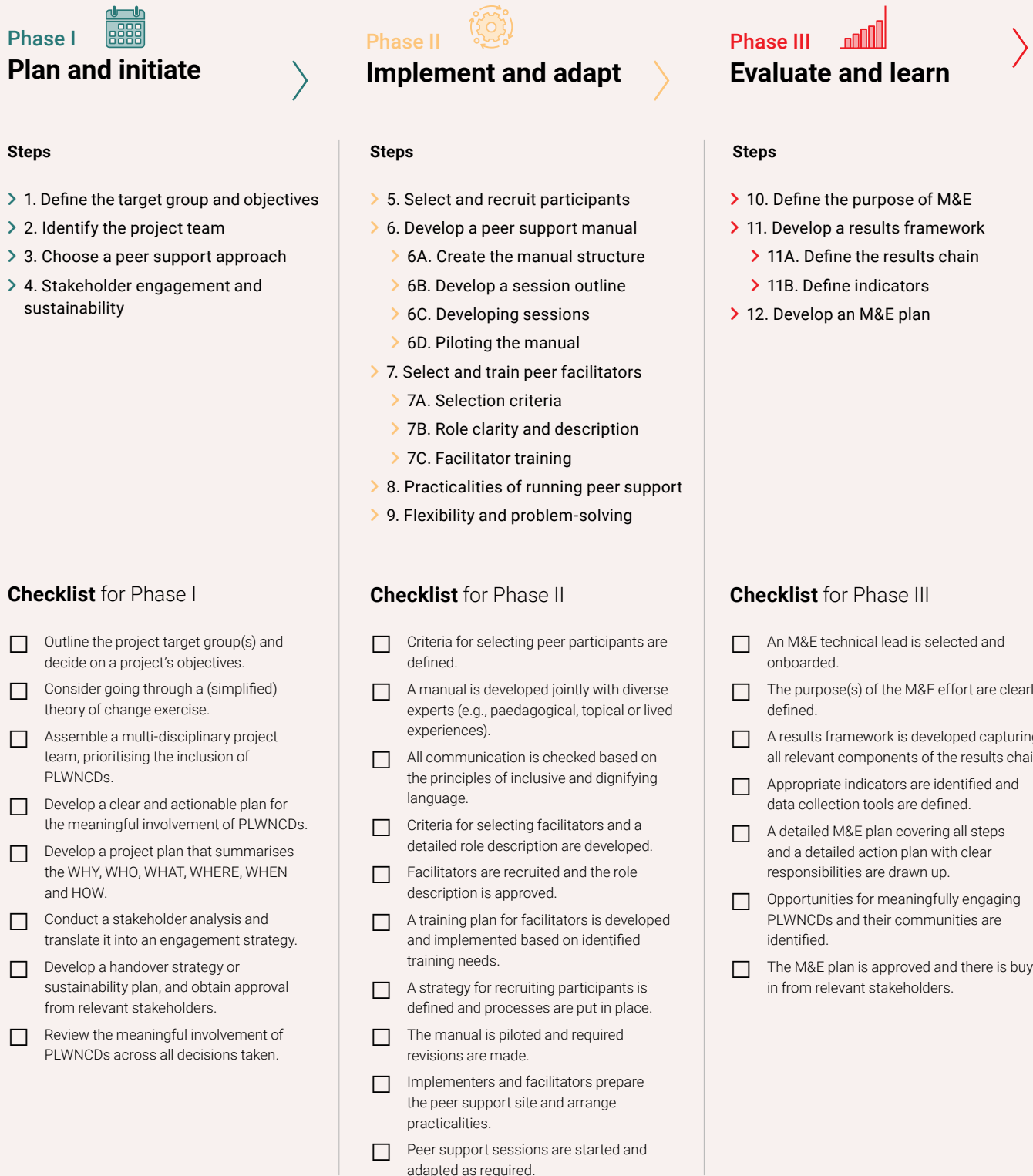


Figure 1: Handbook core phases, steps and checklists

Tools



Reflection questions

Considerations that help guide the process and refine the peer support intervention



Practice tips

Useful tips that help implement the handbook's content into practice



Checklists

Lists of objectives for each phase



Exercises

Practical exercises to inform the development of the peer support intervention



Case studies

Examples of how peer support has been applied in various settings, including Lebanon, India, Vietnam and Kenya



Further reading

Links to useful resources

CONCEPTS OF PEER SUPPORT

Peer support is a compelling concept. For many people, the idea of peer support simply makes sense. In part because it is easy to think of personal experiences or examples from our social networks of how powerful it is when someone finally gets it. Despite its intuitive nature, it can be surprisingly difficult to put a finger on what exactly peer support is and how it differs from other types of support.

WHAT IS PEER SUPPORT?

To understand peer support, it is useful to think about who a peer is. The word may, for example, bring to mind work colleagues with a similar seniority, classmates or people of a similar age. What defines peers is them "being equal" in some way. This can be based on virtually any experience and/or characteristic. Through

their similarities, peer relationships can form horizontally and at eye level. These features distinguish peer relationships from most others in the healthcare system, which are typically defined by hierarchy (doctor/expert versus patient/beneficiary) based on a gap in technical knowledge. In this handbook, we use a definition of peer support in the healthcare context:

"the provision of emotional, appraisal and informational assistance by a created social network member who possesses experiential knowledge of a specific behaviour or stressor and similar characteristics as the target population"^{8(p329)}

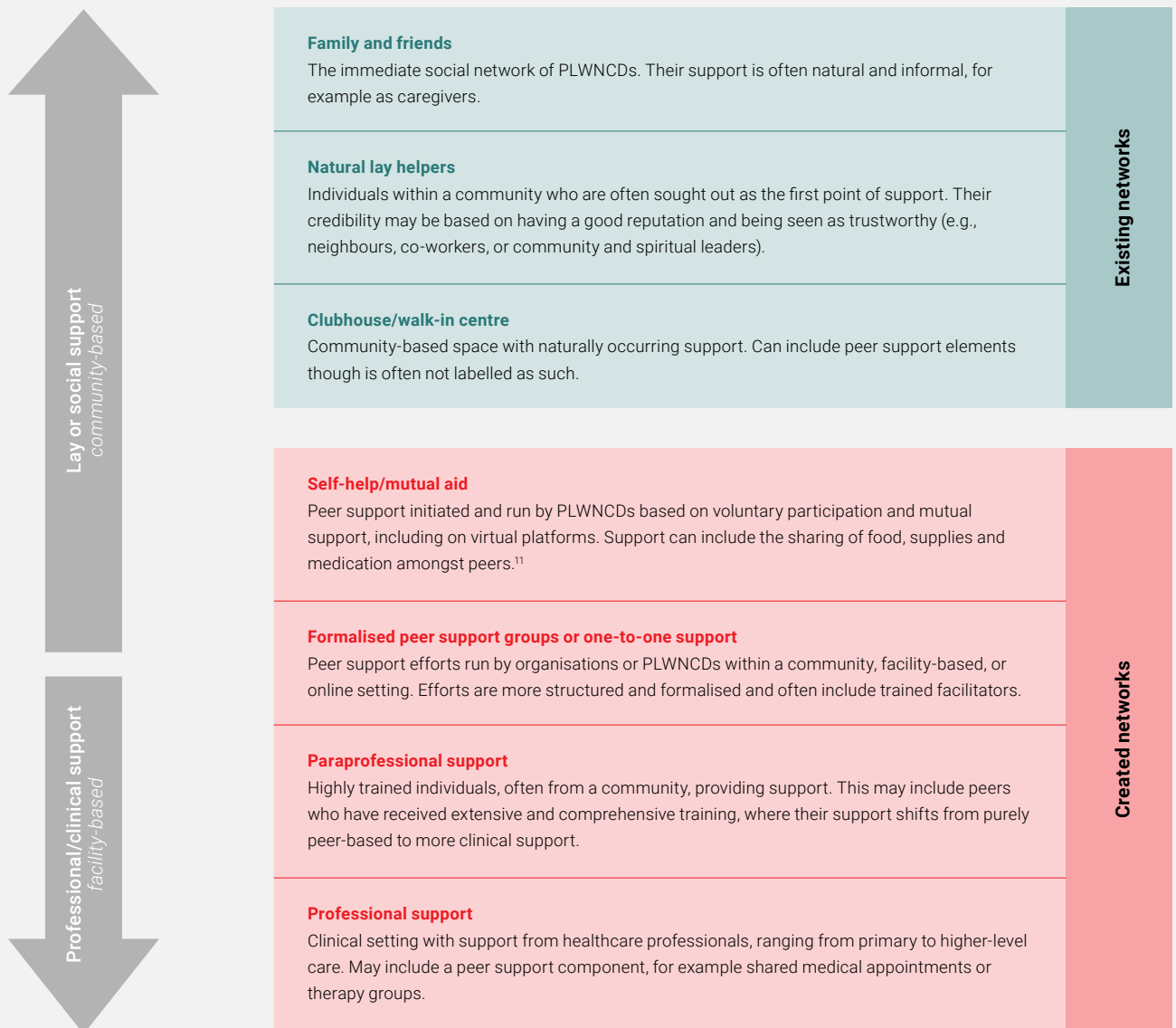


Kenya

Experiential knowledge is typically understood as shared experiences of living with a condition, such as an NCD, or specific stressors associated with it (e.g., stigma).⁹ What is covered by similar characteristics is context-dependent. It can include social and economic status, culture, social identity or shared experiences of a humanitarian crisis.^{9,10} Thinking of these similarities and how they may overlap can feel fairly abstract. For now, it is enough to remember these core features of peer support, as their influence on practical decisions gets more attention in [Phase II](#).

Comparing peer support to other types of support may provide more clarity ([Figure 2](#) and [Box A](#)). It shows that these differentiations are not black-and-white, and highlights their many nuances and overlaps. For example, is a nurse with lived experiences with an NCD providing professional or peer support during a consultation? Peer support is itself anchored at the intersection between community- and facility-based efforts ([Figure 2](#)) and can help bridge the two spheres.

Figure 2. Types of supportive relationships (adapted from¹² and⁸)



BOX A

Synonyms and concepts related to peer support^{11,13,14}

Synonyms

Peer educators, peer facilitators, (mutual) support groups, patient groups, mutual aid, peer mentors, peer experts.

Community health workers

Community health workers are members of a community who provide basic healthcare services and act as a bridge between people and the formal healthcare system. They are also known as health promoters, health educators, community health volunteers or outreach workers. Importantly, they are from the same geographical area or culture as the people they support. This may also be the case for peer supporters; the two concepts are not mutually exclusive. In general, the key characteristic of peers is their lived experience with a certain condition.

Layperson support

A layperson is someone without specific vocational training. They would be on the opposite side of the scale from a highly specialised healthcare professional. Most peers would be considered laypersons in the context of healthcare. The handbook’s wording prefers “peer” as it emphasises their unique position of having lived experiences, rather than the lack of professional training. In the context of mental health interventions, the term lay counsellor is sometimes used.

Task-shifting/-sharing

The task-shifting/-sharing concept is often part of discussions on healthcare delivery, including in humanitarian settings. It builds on the idea that some tasks can be done partially (sharing) or fully (shifting) by a less specialised provider or layperson. It spans much wider than peer support and can include all types of clinical and non-clinical service, usually with the aim of efficient resource use. Peer support

does not squarely fit under this umbrella, as it brings many additional contributions to the table beyond taking over existing tasks.

Shared medical appointments

Shared medical appointments are “clinical encounters where a group of patients receive patient education and counselling, physical examination and clinical support.”¹⁵ These group appointments have large overlaps with peer support approaches. They typically build – to varying degrees – on bringing people with similar challenges together and go beyond a solely biomedical view of disease. They may also address multiple concerns, for example by employing psychoeducation approaches.

Medication adherence clubs

Medication adherence clubs are groups of people living with a certain condition, such as HIV or NCDs. They aim to simplify the medicine collection process and to provide health education opportunities. While like peer groups, they do not necessarily consider criteria of similarity and shared experiences. Their purpose and use are often narrower unless designed with peer support components in mind.

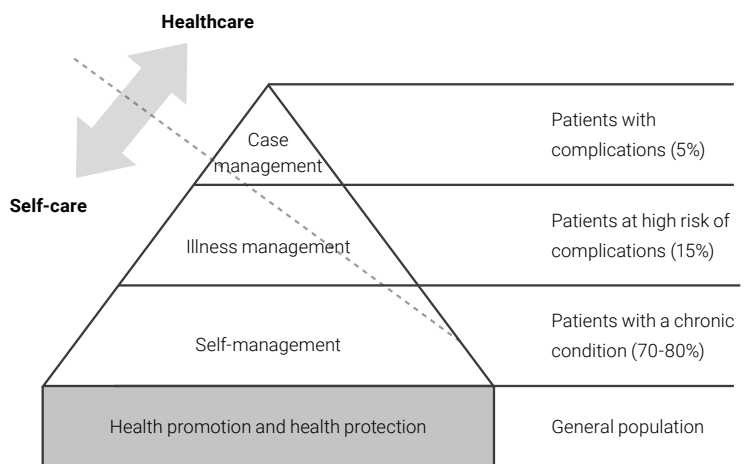
Therapy and self-help groups

Both concepts are well established within the mental health space. They – as peer support – bring together people with common problems. Group therapy is typically led by a trained mental health professional and often focuses on specific recovery aims. In contrast, self-help groups are more informal, unstructured non-hierarchical, and often initiated by people or communities themselves. They share core concepts with peer support, such as mutual support and empowerment.

THE VALUE OF PEER SUPPORT

One of the core values of peer support is its holistic and person-centred view of NCDs.¹⁶ It supports people in their full experience of living with NCDs, beyond their diagnoses and symptoms. Peer support focuses on the 99% of care that is shouldered by PLWNCDs and takes place as self-care in their personal, work and social spaces (Figure 3).¹⁷ Peer supporters are uniquely placed to understand people’s self-care journey. They can strengthen people’s self-management skills – often developed over time – or support the initiating and sustaining of behavioural change, which is incredibly challenging even in well-resourced settings.¹⁶

Figure 3. Health systems perspective on the relationship between self and professional care (adapted from,¹⁸ CC BY-NC 3.0 IGO DEED licence)



The potential of peer support is best captured by how widely it has been used. Examples range from NCDs to end-of-life care, HIV/AIDS and other communicable diseases, maternal, newborn and child health, including breastfeeding practices, mental health and psychosocial support (MHPSS) and refugees-support-refugees efforts. In high-income countries, peer support is accepted as an important companion of facility-based NCD care. Equally, many humanitarian actors are amongst its advocates.^{19–23} Despite this recognition, investment in self-care efforts, experiences with scale-up and integration of peer support concepts into clinical guidelines are often lacking.

BOX B

The potential benefits of peer support are extensive:^{24–30}

- Improves physical and mental health outcomes throughout all care phases
- Improves psychological outcomes (e.g., self-efficacy, hope)
- Reduces social isolation and loneliness
- Improves people's quality of life
- Enhances people's self-care skills and promotes behaviour change for healthy lifestyle choices
- Strengthens people's linkage and engagement with care providers
- Reduces the burden on facility-based staff and hospitalisation rates
- Provides a cost-effective NCD model of care component
- Connects people with lived experiences and strengthens advocacy and mutual aid networks
- Advocates for and advances the transition towards people-centred care

This list shows the variety of changes that peer support can bring about, with some variability in the strength of evidence.¹⁶ Yet its primary strength lies in its ability to go beyond a single purpose, and interventions rarely need to be limited to one specific NCD or condition. In contrast, peer support may also – if implemented poorly – lead to unintended adverse effects for peer leaders and participants (e.g., overburdening, compassion fatigue, diminished feelings of self-efficacy, reinforcement of unfavourable behaviours).⁹ It can equally risk replicating existing disparities in healthcare access or, if actively planned for, be uniquely impactful in reaching marginalised and under-served populations.³¹

For humanitarian actors, the core value of peer support may be its relatively simple implementation (e.g., no advanced technologies required) and its anchoring at community level, which aligns with many actors' primary-care-centric model of NCD care.⁵ Peer support has proven to be remarkably resilient during periods of volatility and service disruptions, and can actively help people

cope.³² These characteristics make it an effective tool in the wider humanitarian NCD toolbox. However, it should not be thought of as a stand-alone intervention, nor be used as a substitute for facility-based care. It is at its strongest when complementing facility-based routine care and patient education efforts.

HOW DOES PEER SUPPORT WORK?

While the evidence of the potential of peer support is growing, much less is known about how it works. Dozens of potential approaches make it difficult to predict which components create the impact a project is (or is not) seeing. This is especially true for humanitarian and fragile settings, emergencies and conflict-affected populations given the scarcity of evidence specific to these settings.

Fundamentally, peer support works due to how peers' unique features (i.e., experiential knowledge, similar characteristics) shape the type of support they can provide.³³ This is an important observation. Peer support is not only about bringing peers together; it depends equally on whether there is space for them to build relationships and interact as peers. For example, even shared medication adherence clubs or group therapies can be designed for genuine peer interactions. Beyond the importance of these core features, there is little agreement on how peer support works. Given the evolving evidence base, any theory of how peer support works should be considered a work-in-progress that requires contextual adaptation. Research into peer support provides insights into probable mechanisms of how peer interactions can lead to achieving its potential benefits:^{15,34–38}

- **Trusting relationships:** Trust is key to creating an open and safe environment where peers feel accepted and comfortable sharing. Without trust, positive peer interactions are impossible. It may be a primary mechanism that acts as an enabler for all others.
- **Social connections:** PLWNCDs can feel isolated from their network and experience (self-)stigma. Social integration – an outcome in its own right – can facilitate other positive changes (e.g., self-care, quality of life). New social connections and the opportunity to leave the house can foster people's motivation, address feelings of loneliness, and allow for mutual accountability.
- **Positive outlook and identity development:** Peers may stimulate a range of positive psychological processes, which are equally a relevant outcome and a key mechanism. For example, by nurturing a sense of hope or agency, self-efficacy, finding meaning and inspiration, addressing stigma or coping with challenges. These build on complex peer interactions, including validating each other's experiences, mutual encouragement, finding joy, observing someone's positive self-identity or evoking helpful social comparisons.
- **Shaping knowledge and perceptions:** Peer support can provide a new network for accessing accurate and relevant information about NCDs and healthy living. It also offers a space to address potential misconceptions. The reach of this information – and

peer support in general – can extend beyond the participants and shape the views of peers’ networks. In addition, improved knowledge levels can contribute positively to people’s self-care practices.

- **Practical and emotional assistance for self-care:** Peer supporters can help a person navigate their self-care journey and figure out what works for them in a non-judgemental and empathetic manner. Peers’ words often carry more weight than those of personal networks or healthcare professionals. Their legitimacy is grounded in their experiential understanding of the complexities of living with NCDs. Observational peer learning can also play an important role.
- **Linkage to care:** Peers can act as a bridge to other facility- or community-based care services. They may be able to discuss care options, remove barriers to engagement or help navigate the system. The trust invested in peers may be extended to other service providers.
- **Being there and together:** While identifying key mechanisms can be helpful, it is important to remember that peer support is fundamentally human. People’s relationships and interactions can take many forms and shapes. Implementers should remember to give space for people to simply be there and connect with each other.

These mechanisms show that peer support acts by facilitating positive change as well as buffering negative impacts.⁹ They also capture the depth of peer interactions beyond simple listening and sharing.³⁹ There are a number of social and behavioural theories and techniques that may explain their effectiveness (e.g., social identity theory, social comparison theory, social cognitive theory, self-determination theory, behavioural change techniques).¹⁶ Anchored in the core mechanisms, peer support interactions and relationships are guided by a set of fundamental values ([Box C](#)).

Another way to look at how peer support works is whether it is implemented well.³⁴ It follows the simple idea that even effective interventions can end up with no impact if implemented poorly. This is where this handbook aims to support implementers.

BOX C

Guiding values of peer support^{40–43}



Mutual and equal

Peers strive to build an equal relationship. They make an active effort to acknowledge, be transparent about and minimise power differences and privilege. Their relationships work towards trust, respect and authenticity. Peers do not enforce or report on treatment “compliance”.



Reciprocal

Peers contribute and gain equally from their relationships. They do not claim a superior expertise or to know all the answers. Peers recognise the validity of others’ unique experiences and the potential for mutual learning.



Self-determination

Interactions between peers are non-directive and do not prescribe “treatments” or provide “solutions”. A person defines what is good for them and not what is good for someone else (“this worked for me, you need to try it”). Peers support each other in identifying solutions that fit them. All interactions are grounded in people’s individual choices and autonomy.



Empowerment

Peers strive to support each other in building self-care capacity and confidence. Interactions build on recognising and encouraging people’s existing strengths and resources. Peers act as change agents by sharing ideas and opportunities for others to move forward.



Inclusivity and safety

Peer support gives people an opportunity to come together and to feel seen and understood. It builds on a shared language, values and understanding of nuances. It works towards a safe space where people can speak without fear of being judged. Peers maintain agreed-upon rules and boundaries.



Further readings

- [Peer Support Guidelines \(Mental Health Commission of Canada\)](#)
- [Peer Leader Manual \(International Diabetes Federation, IDF\)](#)

Phase I

Plan and initiate



Summary

This chapter guides through the initial steps from a vague idea of using a peer support approach to a specific intervention design. It covers the development of objectives and practical reflections for setting up a strong project team and the potential role of various stakeholders. Importantly, all these steps should only be one part of a larger humanitarian health response and NCD model of care.

Keywords

- Rationale and objectives
- Target group
- Project team
- Choice of peer support approach
- Stakeholders
- Sustainability

Checklist

- Outline the project target group(s) and decide on a project’s objectives.
- Consider going through a (simplified) theory of change exercise.
- Assemble a multi-disciplinary project team, prioritising the inclusion of PLWNCDs.
- Develop a clear and actionable plan for the meaningful involvement of PLWNCDs.
- Develop a project plan that summarises the WHY, WHO, WHAT, WHERE, WHEN and HOW.
- Conduct a stakeholder analysis and translate it into an engagement strategy.
- Develop a handover strategy or sustainability plan, and obtain approval from relevant stakeholders.
- Review the meaningful involvement of PLWNCDs across all decisions taken.

Step 1

DEFINE THE TARGET GROUP AND OBJECTIVES

At the start of thinking about peer support interventions lies the question: Is peer support appropriate to address the needs of PLWNCDs in our context? This step builds on the assumption that PLWNCDs have been identified as one group with significant needs or care disruptions in a given setting. This insight will often stem from a routine humanitarian needs assessment. The gathered data may flag diverse humanitarian needs across multiple population groups, geographical areas or services. Implementers should use this data to reflect – together with key stakeholders ([Step 4](#)) – on the specific target group of a potential peer support intervention ([Box D](#)) and whether their needs align with the potential objectives and strengths of a peer support approach ([Table 1](#)). In addition, these insights help implementers understand existing service provision and identify opportunities for linkages with the existing healthcare system (e.g., referral facilities).

With a preliminary target group defined, implementers should explore whether peer support is an appropriate approach to address their needs. The synthesised list of objectives below may be a useful starting point, though it is not exhaustive and projects may choose additional objectives (e.g., income generation, community resilience).

BOX D

Specifying a target group

Which NCDs and geographical areas should be prioritised?

The needs assessment and complementary data sources (e.g., routine data, reports, health surveys, health information systems, community-based assessments) can help with identifying a project’s target group and areas. Given the focus of this handbook, this includes identifying specific NCDs. Humanitarian actors have extensive experience of this process and can use the factors outlined by Bausch et al.⁴⁴ as additional guidance. Their recommendations – to mention just a few – include the importance of taking into account the local burden of disease and of addressing less prevalent conditions that have a high impact on people’s quality of life. Actors should align with national priorities (e.g., national NCD strategy) or, if these are unavailable, with World Health Organization (WHO) guidance (e.g., WHO package of essential noncommunicable disease interventions).

What options are there for including people living with multiple NCDs or conditions?

While the target group is often centred around a specific NCD (e.g., diabetes), peer support rarely needs to be a vertical intervention. In fact, target group definitions can reflect the reality that – in low- and middle-income countries – as many as 40% of people living with one NCD are at the same time affected by other NCDs or conditions (e.g., tuberculosis).⁴⁵ To define which conditions and complications to include, actors should assess the similarity of people’s experiences. This similarity is not tied to a shared (NCD) diagnosis or symptoms but can relate to all aspects of living with a condition (e.g., stigma,

accessing support and resources, self-care and economic costs). Even people living with distinct conditions (e.g., HIV and diabetes) can become strong peers if their experiences are similar enough.⁴⁶ For this step, consultations with local actors and people with lived experiences can be a useful tool. As a minimum, peer support with people living with physical NCDs should address the role of disabilities and mental health, given their synergies ([Phase II](#)).

Which specific groups of people should be prioritised?

Optimally, the needs assessment should capture data on disparities in health outcomes and access to care. This data can help actors identify population groups that may be culturally, economically or socially marginalised and consider their role in a potential peer support project. In practice, disaggregated data is often unavailable and actors will need to consider other information sources, such as stakeholder consultations. Vulnerable and marginalised groups may be reflected in the target group definition or in the participant selection process ([Step 5](#)).

Is there a secondary target group?

Some projects may want to identify a secondary target group. Depending on the objectives, this can include facility-based staff (e.g., objective: reduce workload) or the caregiver and social network of PLWNCDs (e.g., objectives: reduce stigma, strengthen social integration).



Practice tip

Through these reflections, implementers should arrive at a preliminary target group definition. This can later be refined based on the project’s resources and intervention format ([Step 3](#)). For example, a well-resourced project may be able to reach two distinct target groups (i.e., groups with few shared experiences) by setting up parallel peer support groups. It may also become clear at this point that a host of other factors influence the similarity of peer experiences (e.g., age, gender, disability, education level). These are covered in [Phase II](#), as most factors can be addressed by how an intervention is implemented. However, as some of them may shape the target group definition, it is helpful to quickly scan [Step 5](#) at this point.




Exercise

To identify the most relevant objectives, actors can consider using a theory of change (ToC) process. Even if it is not possible to follow a comprehensive ToC approach, it is useful to informally reflect on how a peer support project might work ([Annex C](#)).

Table 1. Synthesised list of potential objectives of peer support initiatives

Objective	Considerations
Work towards more people-centred care	Peer support centres people’s complex experience of living with an NCD, rather than solely focusing on symptoms and treatments. This shift in perspective can be used to progressively influence routine clinical encounters, facility-based processes, and – theoretically – organisational practices. The latter are seldom seen in practice and require strong commitment and efforts to promote the meaningful engagement of PLWNCDs (Box E).
Improve people’s physical and mental health	This is typically the primary aim of peer support. It is useful to further specify it, especially across its social, clinical, psychological and behavioural aspects. Examples may include: (i) reduce people’s loneliness and strengthen networks (social); (ii) improve people’s self-efficacy and hope for recovery (psychological); or (iii) improve proxy health outcomes (clinical). Implementers can also consider the role of peer support across the full continuum of NCD care, from primary prevention to rehabilitation and palliative care. It can focus on and link to efforts across the continuum.
Reduce the workload of facilities	Often an important secondary aim, this builds on the idea of task-shifting and -sharing to relieve the workload of healthcare professionals and possibly improve the quality of care. ⁴⁷ It should rarely be the sole aim of peer support, as it tends to gravitate away from its core mechanisms and values. Projects need to ensure that all staff have the necessary skills and motivation (including incentives). Peer support, as is true for care by professionals, has its own strengths and weaknesses and should be employed accordingly. It can never replace clinical services. Importantly, peer support needs to ensure that the workload of existing staff is not increased.
Strengthen advocacy networks and skills	Bringing people together through peer support can help create or strengthen people’s ability to advocate for their own needs. This view is anchored in a rights-based approach to health. It focuses on empowering people to advocate for their rights with duty bearers. This approach may complement direct efforts to improve people’s health and wellbeing (i.e., needs-based).


CASE STUDY 2
India

Rights-based peer support

The peer support component of the QualityRights case study shows another opportunity for interventions to take a more psychosocial view of NCDs. As well as addressing the clinical dimensions of living with NCDs through the existing health systems, peer support can strengthen people’s understanding of their rights and navigating their recovery journey, building their confidence and skills to advocate for themselves.

[> Read the full case study](#)

This step’s output should be a specific description of the objectives and target group(s) of the peer support intervention. Implementers should ensure that they provide sufficient detail, as it will simplify all subsequent decision-making and help maintain the project’s focus. For example, it can inform the selection of appropriate team members ([Step 2](#)), the design of targeted materials and a practical manual ([Step 6](#)), or the definition of M&E aims and key measures ([Step 10](#) and [Step 11](#)).

 CASE STUDY 4
Kenya

Potential outcome measures

Living with NCDs influences all aspects of a person’s life. Peer support projects can reflect this reality by addressing – and measuring – a wide spectrum of potential outcomes. These can range from direct (e.g., avoiding complications) to more indirect aspects of living with an NCD (e.g., economic impact, stigma). The peer support project by the Kenyan Red Cross Society (KRCS) provides a suitable example. In parallel to addressing outcomes related to people’s health outcomes and self-care, it focused on economic empowerment. This is grounded in the understanding that the economic cost associated with NCDs can be incredibly challenging and a key priority for PLWNCDs. This example highlights not only the diversity of what peer support can focus on, but also the need to adapt to the existing context and capacities. An economic empowerment focus was feasible in this project due to KRCS’s topical expertise and the local communities’ familiarity with such approaches. Humanitarian actors – especially if their primary mandate is focused on health – need to reflect on the feasibility and resource requirements of integrating themes beyond their core expertise.

> **Read the full case study**

Step 2

IDENTIFY THE PROJECT TEAM

A peer support project – as with any humanitarian response – involves many strategic and operational decisions requiring a core project team (referred to as implementers). Humanitarian actors regularly set up project teams and are familiar with key considerations. This section only highlights specific functions and expertise relevant to peer support projects that may easily be overlooked.



People with lived experience: PLWNCDs should be at the centre of all peer support efforts. This – optimally – means that they are part of the implementing team and their opinions are equal to those of other team members. Less intensive engagement options may be considered initially or where resources are scarce, but should strive for more meaningful engagement over time. The role of people with lived experience should be detailed in a meaningful involvement plan that clearly describes how their voices will be heard and listened to.



Multi-disciplinary staff: While project teams often include people with clinical NCD expertise, other areas of technical knowledge may be forgotten. Even if a project is primarily focused on physical health, teams should involve MHPSS and social science experts, given their strong overlap. Depending on the project aim, this can include therapists, dieticians, life skills coaches and social workers. There may be other perspectives to bring in, such as economic, legal, education, protection, rehabilitation and disability, agricultural, climate change or social justice.



Local actors: A stakeholder analysis ([Step 4](#)) can provide a starting point for organisations with relevant expertise that may be able to support the overall peer support design, help reach the target group or establish referral pathways (e.g., [Referral Guidance Note for Mental Health and Psychosocial Support, Inter-Agency Standing Committee](#)). This may include national patient associations, grass-roots organisations, local community leadership, faith-based institutions and other interest groups (e.g., older people’s rights).

The optimal team composition depends on the identified project scope ([Step 1](#)) and available resources. Importantly, to ensure their agency and ownership, people recruited at this stage should be given the chance to review any decisions taken earlier. Alongside a project team, an advisory committee may be established to provide strategic guidance (e.g., other humanitarian or development actors, national authorities). Projects should explore partnerships with the Ministry of Health or – as a minimum – complement their efforts and align with national legal and strategic plans.

BOX E

The cornerstone: meaningful involvement of PLWNCDs

The meaningful involvement of people with lived experience at all stages of a peer support project is essential. Apart from its moral importance, it can help adapt the project to a specific context and, ultimately, amplify its impact. At the core lies the idea of “nothing about us without us” and the recognition that people’s lived experiences are equally important as technical expertise. While its value is recognised in humanitarian responses, efforts often lag in practice.⁵

The meaningful involvement of PLWNCDs can look different. Thinking of it as a ladder of involvement, it ranges from limited engagement (participation) to people’s full integration and ownership (co-production).^{48,49} Meaningful involvement is the opposite of tokenism or a tick-box exercise.⁵⁰ Throughout this handbook, practical suggestions for the meaningful involvement of PLWNCDs in a peer support project are included. Ultimately, people’s meaningful involvement is about changes in organisational culture. A single

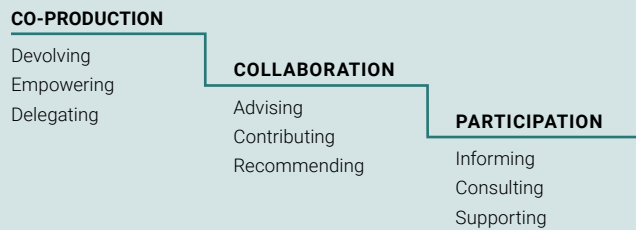
project may not be able to bring about this change but can reflect on its role in nudging this agenda forward and its role in addressing power imbalances in global health.⁵¹ Next to project-level actions, implementers may ask themselves: “What practical steps can we take to move our organisations up the ladder of meaningful involvement?”



Further reading

- [Meaningful Involvement of PLWNCDs \(NCD Alliance\)](#)
- [Framework for meaningful engagement of PLWNCDs \(WHO\)](#)
- [Prioritizing People with Lived Experience as Partners \(Médecins Sans Frontières\)](#)
- [Guidelines: Inclusion of Persons with Disabilities in Humanitarian Action \(IASC\)](#)

Figure 4. Ladder of meaningful involvement of PLWNCDs (adapted from⁴⁹)



Step 3

CHOOSE A PEER SUPPORT APPROACH

There are dozens of different peer support approaches. This is not only useful for implementers, but a core element of why peer support is valuable; it easily adapts to the needs of PLWNCDs and the wider socio-cultural context. All approaches are united by the same core mechanisms and guiding values. With the WHY of peer support defined ([Step 1](#)), this step focuses on defining an intervention outline, covering WHO (delivers the intervention), WHAT, HOW, WHERE and WHEN ([Table 2](#)).



Practice tip

Visualise the project scope at this point. For example, the locations, group numbers, expected participant numbers and potential timeline. A visual project map is incredibly powerful to bring all team members onto the same page and simplifies the communication with stakeholders.

Table 2. Potential combinations of peer support implementation choices (adapted from¹⁶)
 Implementers can choose from any of the following combinations:

WHO	WHAT	HOW	WHERE	WHEN
<ul style="list-style-type: none"> Trained peers Untrained peers Paid peers Volunteers People with certain identities or characteristics Laypeople Professionals Undefined/co-led 	<ul style="list-style-type: none"> Education (topic-based) Activity-based Peer-delivered services Discussion Mentoring Emotional and social support Practical support Accompaniment 	<ul style="list-style-type: none"> One-to-one Small groups Large group Open participation Closed participation 	<ul style="list-style-type: none"> Own home Community venue Health facility Telephone-based Online-based Text messages 	<ul style="list-style-type: none"> < 3 months/ad hoc 3–6 months > 6 months <p>HOW OFTEN</p> <ul style="list-style-type: none"> Individual session Weekly/bi-weekly Monthly Less than monthly

Example: A peer support intervention ...				
... where young people living with type 1 diabetes are supported by trained peers...	... through topic- and activity-based social, emotional and practical support...	... in closed groups of less than ten people...	... at the local community venue...	... every two weeks for a period of six months.

Exercise

To identify the most appropriate options, implementers can use the reflection questions (answer guide in [Annex D](#)) and the decision-making guide ([Annex E](#)), which explores their strengths and weaknesses.

Question 1: What role does the evolving humanitarian situation play?

Question 2: What are the preferences of the target community?

Question 3: What existing efforts can we connect with?

Question 4: What resources are available within our organisation(s)?

Question 5: How can joint implementation options be relevant?

waves (if applicable). Even once defined, this outline rarely remains untouched throughout the implementation, nor should it. Peer support approaches can continuously evolve to meet the team members’ needs ([Step 9](#)).

BOX F

A radical view of peer support?

Peer support is not simply another NCD intervention. Even when initiated by humanitarian or governmental actors, peer support can only be fully authentic when it is led by PLWNCDs. This requires actors to commit to and plan a progressive transition of the decision-making power and ownership. Practically, this may look like peer support that is fully self-organising around its members’ agreed priorities and with an organisation that fulfils a solely supportive role on a request basis (e.g., providing meeting space, arranging clinical lectures). This level of ownership requires significant capacity from within the community. It is difficult to achieve from the outset of a project, but it can serve as a blueprint and reminder towards which organisations can work. This view’s radical nature is arguably less about the peer ownership than about how it clashes with organisational processes and mandates. It requires giving up significant control, which requires navigating difficulties around donor requirements, reporting standards and financial accountability. For powerful examples, see the UK Together project¹⁰ and [Case study 4 \(Kenya\)](#).

The output of this step should be an intervention outline defining all key implementation choices. This should also allow implementers to decide on the intervention scope, including: i) the specific implementation locations (e.g., regions, towns, facilities); ii) the maximum number of peer support groups/networks/pairs/participants; iii) the intervention duration; and iv) the number of

 CASE STUDY 2
India

Project sustainability

The project was particularly successful in its sustainability efforts, with the project team actively building the continued ownership of key stakeholders. A key point in this process was a high-level dissemination meeting with invitees from the MoH, WHO, Grand Challenges Canada and other stakeholders.

While the meeting was held in English, the team invited a peer support volunteer to share their experiences in the local language, which proved one of the most captivating parts for senior decision-makers. Pushing for specific commitments, the team was able to secure a dedicated budget line from the Minister for Health at the State Department. Presenting a major success ensures continued financing for core components of the peer support model. Despite these successes, integrating the intervention in its true spirit remains a challenge. For instance, peer support volunteers – even if present at facilities – may be shifted away from recovery-based work to take over tasks from overburdened staff. Sustainability plans should thus also include clearly defined role descriptions as well as long-term development goals for peer volunteers, along with structured and ongoing supervision sessions. For example, it would help to see the PSV as a stepping stone in their recovery journey and not the end in itself. This could be achieved by either providing support for further education or employment of the peers and other service users to expand their pathways towards more formalised employment opportunities.

> [Read the full case study](#)

Step 4

STAKEHOLDER ENGAGEMENT AND SUSTAINABILITY

Identifying key stakeholders and obtaining their buy-in is an essential part of any project. A formal stakeholder analysis can be helpful; many organisations have internal tools for this. Their specific format may vary, but they typically include: i) brainstorming possible stakeholders; ii) scoring each based on certain criteria (e.g., influence, attitude); iii) prioritising the most relevant stakeholders; and iv) defining an engagement strategy (from monitoring, informing and consulting to collaborating). Implementers should use it to review the project team and advisory committee composition ([Step 2](#)).

 **Further reading**

[WHO guide to tailoring health programmes \(e.g., inspiration boxes 2 and 10\)](#)

Irrespective of whether a more formal or informal stakeholder analysis was used, there are several useful rules of thumb for engaging stakeholders:

1. Validate the stakeholder analysis: After the initial stakeholder analysis, some stakeholders in the team’s blind spot were likely missed. Implementers should try to have the stakeholder analysis validated by people with a strong contextual understanding. Actors with less visibility can include grass-roots organisations, informal support groups, local nongovernmental organisations and national representatives.

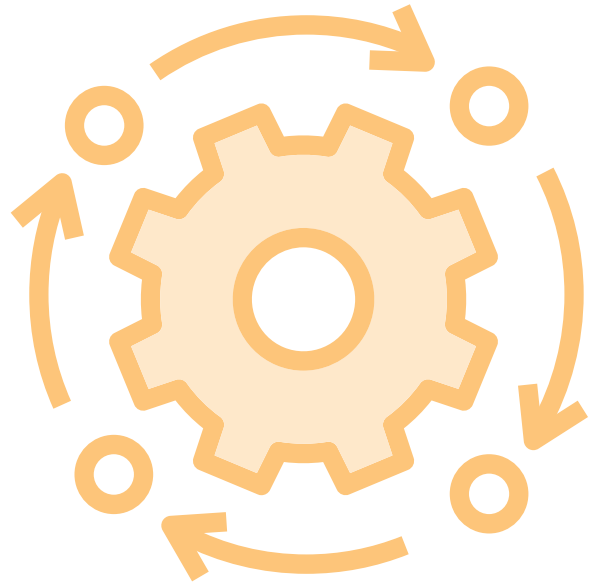
2. Engage early and proactively: It is generally best to involve stakeholders earlier rather than later. On-the-ground staff (e.g., volunteers and social workers) and PLWNCDs in particular are often only engaged once the project is fleshed out. This will miss opportunities to build on their deep contextual knowledge and they may feel little agency or ownership. Even without the space for in-depth engagement of all stakeholders, a quick conversation or a well-drafted email can go a long way.

3. Consider sustainability from the beginning: The engagement planning spans beyond the project implementation and should include stakeholders’ roles in its sustainability. Just because a peer support project seems incredibly impactful and was valued by all stakeholders does not mean it will automatically be continued by an actor with a longer-term mandate or by peers themselves. Detailed planning and working towards stakeholders’ buy-in is key.

A systematic approach to stakeholder engagement can be incredibly helpful. However, ensuring the sustainability of projects in humanitarian settings can be incredibly challenging, including due to uncertain and earmarked funding, limited capacity and competing budgets. Implementers should anticipate these challenges by developing a detailed handover plan with clear responsibilities and specific timelines. The plan should be approved – if possible before the project start – by all stakeholders with a key role in it. In the case of peer support, there is a possibility for peers to take over and self-organise after the project’s completion, often in conjunction with national health system actors. This scenario requires proactive planning as much as any other.

Phase II

Implement and adapt



Summary

This phase covers the key aspects of implementing a peer support intervention. It starts from the participant selection and spans the manual development, facilitator training, practicalities and continuous adaptation. Not all steps in this chapter will be useful for every project, and some may need to be adapted or skipped. Similarly, group-based models are frequently used as the primary example throughout this section, while the same considerations apply to other formats, such as one-to-one peer support. Before starting, it may be helpful to go through the previous chapter's checklist.

Keywords

- Participant and facilitator selection
- Training and supervision
- Role descriptions
- Technical manual
- Problem-solving

Checklist

- Criteria for selecting peer participants are defined.
- A manual is developed jointly with diverse experts (e.g., paedagogical, topical or lived experiences).
- All communication is checked based on the principles of inclusive and dignifying language.
- Criteria for selecting facilitators and a detailed role description are developed.
- Facilitators are recruited and the role description is approved.
- A training plan for facilitators is developed and implemented based on identified training needs.
- A strategy for recruiting participants is defined and processes are put in place.
- The manual is piloted and required revisions are made.
- Implementers and facilitators prepare the peer support site and arrange practicalities.
- Peer support sessions are started and adapted as required.

Step 5

SELECT AND RECRUIT PARTICIPANTS

The selection of participants is a key component of a peer support project, as it can build the foundation for positive peer interactions. Neglect of this step will likely divert resources unnecessarily, as it requires facilitators to deal with trust issues and potential conflicts.

This step identifies peer characteristics that most significantly shape their experiences of the intervention. It can serve two linked purposes: i) help select participants from the overall target group (Step 1); and ii) identify factors influencing the manual design and its implementation. The selection criteria should focus on identifying peers who are similar to each other and those who are expected to benefit most from participating.

Peer similarities are at the heart of peer support. This follows the understanding that the more similar the selected peers are, the more likely it will foster empathy and reciprocity.⁹ Importantly, this step focuses on perceived, rather than factual, similarities to prioritise people's feeling of community. There are exceptions to this rule, where bringing together mixed groups can offer unique opportunities. In such scenarios, the facilitator's role in highlighting areas of similarity becomes ever more important.

BOX G

Addressing a common misconception

Given that this handbook focuses on peer support with PLWNCDs, it may seem obvious that what matters most is peers' shared experience of living with an NCD. Put differently: "People living with type 1 diabetes benefit most from being supported by others with type 1 diabetes."

This view is limited, as it centres on the condition, not the person. Peer support cannot exclusively build on people's shared experiences of living with a condition but needs to consider other levels of similarities and differences.^{9,46} The importance of these other factors becomes clear when looking at how social identities and group memberships shape people's perceptions, values and experiences of life. Consider the fictional case of two people living with different chronic diseases (e.g., cardiovascular disease and diabetes) in the same displaced persons' camp. Their daily experiences and feelings of similarity are likely much greater than with a non-displaced person from the nearby town, even if they shared the same diagnosis and symptoms. Projects need to understand the role of these characteristics in their local setting and which factors matter most to participants.

The list below captures characteristics that are commonly relevant across settings. [Box H](#) can help implementers prioritise these factors.

- **Gender:** Gender fundamentally shapes people's lived experiences, including with NCDs. In some settings, mixed groups may be preferable, while in others they may be unacceptable, for example due to cultural or religious norms. People not identifying with traditional gender norms might prefer separate peer support groups.
- **Ethnicity, nationality and language:** People from different ethnic groups as well as displaced and host populations may often feel like distinct communities. This can – at times – translate into hostility towards the other. If the risk of tensions is too high, separate groups or sessions are required. In contrast, peer support may have the explicit aim of bridging those communities and helping to overcome hostilities by focusing on those experiences that are shared. These differences may also be present in people's (preferred) languages or local variations.
- **Social class:** How social class is understood is highly contextual. Implementers need to assess which factors shape communities' experiences around social class, especially as many factors may be intangible or covert. One common factor can be people's education level, as it influences their day-to-day experiences, including how and where they live, how much they earn, how they speak or what daily challenges they experience (e.g., access to "healthy" foods).
- **Age:** Age similarities can manifest in people's shared language, reference frames or interests. Perceptions of what constitutes separate age groups are shaped by local cultural norms. Bringing together people of similar age (e.g., separate set-ups for adults and young people) can help facilitate many peer mechanisms. On the contrary, intergenerational formats can be a powerful way to allow peer learning and can be part of efforts for more inclusive approaches that combat ageism.
- **Years since diagnosis:** People who have lived with NCDs for many years likely have different needs and perceptions than those who are newly diagnosed. As with age differences, bringing these people together can give an added value of mutual learning.
- **Geographical area:** How close peers live to each other can affect in-person sessions. For example, selecting people from the same area can simplify finding an accessible venue and allow peers to arrange informal meet-ups. Being able to bring peer support to people is especially valuable for remote communities, who often have to travel long distances to access other types of care. People from the same area also have similar environments and experiences (e.g., health facilities, public infrastructure and access to healthy foods).
- **Size of community:** Linked to the previous point, the size of the local area can also affect people's sense of belonging to the same community, as people may know each other beforehand. This can greatly speed up the trust-building process. At the same time, the lack of anonymity may interfere with peers' open sharing. People's sense of community is not necessarily based on geographic proximity. It can equally build on other similarities, such as shared interests.
- **Culture, values and world views:** Many of the listed items are intimately connected to people's culture, values and world views. Given the breadth of these concepts, there are likely other relevant aspects that were left out. This may include specific customs and norms, for example around personal and social relationships, acceptability of behaviours, shared language, or relevant institutions. In the context of NCDs, it can include people's view of their condition and their core values, such as what quality of life means to them. These are typically difficult to measure or capture. They may be more easily used when matching peers in one-to-one formats.
- **Severity of needs or vulnerability:** People's vulnerability is often measured through clinical severity (e.g., HbA1c levels). While this has been shown to positively affect project outcomes,^{26,52} vulnerability should be thought of more broadly and include all factors influencing who will have the greatest benefit of participating. Some may be hard to quantify and require a person with deep contextual understanding (e.g., people's loneliness, recent stressful events, such as a relative's death, co-morbidities, complications and loss of income due to a worsening disability).

- People's commitment:** Focusing on people showing the greatest interest and commitment is less about similarities than about generating a positive momentum for the intervention. This may ease its implementation, sustainability and efficient use of resources. Implementers should use this criterion with caution, as people with most to gain from peer support can be those most

isolated. They may not self-identify as interested in peer support or have negative experiences with and mistrust towards service providers. It is important for implementers to consider how to reach those people, building on the list of marginalised groups identified in [Step 1](#).



BOX H

Exercise for identifying relevant peer characteristics

Workshop participants: Implementers (emphasis on people with lived experience and contextual insights)

Time: 3-5 hours

Location: Online/offline

This exercise aims to identify the most important peer characteristics, including: i) those relevant as participant selection criteria; and ii) those that need to be addressed during implementation. Multi-site projects should invite people from each area, as the role of these characteristics can vary vastly across regional, sub-regional and local levels. This exercise can be performed less comprehensively.

1. Arrive in the space, welcome people and define the purpose of the exercise (10 minutes).

2. Use a clear space and pieces of paper to collect all potential factors (20 minutes)

Build on the above list to identify any characteristics that could influence people's sense of similarity or their experience and expected benefit of participating. There are no wrong answers.

3. Consolidate the listed factors (45-60 minutes)

Together, review the identified items to make sure there is a shared understanding. Next, assign a facilitator to guide a discussion with the aim of reducing the list to five priority items or less. Discuss each item and take off those that were not selected. Remember to give extra weight to the opinions of people with lived experience (e.g., veto rights) and the potential difference between implementation sites. The selection of these factors should be guided by accessibility and equity principles.

4. Focus on mutually exclusive criteria (30 minutes)

Go through the list and highlight any characteristics that would interfere with peer mechanisms if brought together in mixed groups (i.e., they are mutually exclusive). This part is especially important for group-based formats, as one-to-one approaches can more flexibly match peer leaders and participants. For peer support groups, the project's resources ([Step 3](#)) limit the maximum number of such criteria that can be considered. For example, a project with the capacity to run two parallel groups can divide participants along one characteristic (e.g., host/displaced

populations or men/women). Each additional – mutually exclusive – factor increases this number greatly. If this is the case for a given setting, implementers may have to consider narrowing their target group or switching to a one-to-one peer support format.

5. Review the remaining criteria (30 minutes)

Go through the remaining list of factors. Most, even if important for people's sense of similarity, will not be strictly mutually exclusive. These are typically not selection criteria, as they are not a requirement for people to be able to participate. They should be flagged, however, as implementers need to address them in the manual ([Step 6](#)) and during the implementation, for example by:

- Designing the manual to be inclusive of mixed groups (e.g., gender-neutral activities).
- Splitting groups into more homogeneous sub-groups for specific topics.
- Including exercises focused on peers' similarities rather than their differences.

Amongst the remaining items there may be some that are important as selection criteria for peers, especially those focused on identifying people with the greatest expected benefit. All selection criteria should be assessed based on an equity lens, i.e., who is excluded?

6. Finalise the selection and conclusion (10 minutes)

Summarise the selected criteria (per site) and their reasoning. Split them into selection criteria (jointly with the target group definition) and those that are important for the peer support implementation.

As a quality check, ask all team members:

- How confident are we that the most important factors have been included? (scale of 0-10)
- If below 7, which factors are missing or have any been dropped prematurely?
- Are any specific population groups missing? If yes, in what ways can they be involved?

Remind people that these are general guides and that facilitators have the flexibility to consider additional factors (e.g., level of vulnerability and marginalisation). Update the project plan and visualisations based on these decisions.

Based on the identified selection criteria, the recruitment of peer participants can be planned. This may be done immediately or await the development of the manual to allow more targeted communication. Various recruitment strategies may be useful, including through:

- Health facility waiting areas
- Referrals from project partners or linked programmes (e.g., community or patient organisation)
- Outreach based on patient lists
- Community health worker recruitment
- Snowballing referral

Irrespective of the chosen channels, implementers should plan clear communication messages and manage people's expectations. This especially applies to the likely scenario that a project has fewer spaces than the number of people interested. Implementers can also consider offering people the opportunity to participate in a different form of peer support or as part of the next implementation round, if available.



CASE STUDY 1
Lebanon

Selecting participants and setting up groups

The project identified three "inclusion" criteria for peer participants: 1) living with diabetes and/or hypertension; 2) unfavourable clinical indicators (e.g., HbA1c); and 3) overall vulnerability. These criteria helped identify people with the greatest expected benefit.

To assign the selected people to a specific peer support group, additional factors had to be considered to ensure a feeling of community. For this project, facilitators identified the following factors as most important:

- **Gender:** Facilitators at some sites suggested that joint groups with men and women would lead to challenges, such as the risk of women feeling "uncomfortable" or men being reserved.
- **Nationality:** At some implementation sites there were reports of tension – or outright hostility – between the Lebanese host population and Syrian refugee communities.
- **Connectedness of local community:** Smaller communities meant that people already had stronger relationships before the project, which simplified the selection.
- **Education level:** People with different education levels reportedly felt different, due to their language as well as their day-to-day experiences and problems.

As each site was able to run two groups in parallel, not all characteristics could be considered during the assigning of groups. The factors that were prioritised varied per site but most facilitators split the groups by gender or nationality. The other, non-prioritised factors were not automatically exclusion criteria and thus contributed to a group's diversity. For example, if separate groups were set up for Lebanese/Syrian nationals, they may still have experienced some diversity in terms of gender and education level.

The social workers noticed differences between more homogeneous and more diverse groups. The latter reportedly had overall "worse" relationships and experienced less harmony, compatibility and motivation. While no group experienced conflict between peers, additional effort was required by the social worker for more diverse groups. This was mirrored by feedback from peers, who valued being from "the same community". Similarities extended beyond characteristics to include experiences, concerns, values and cultures.

> **Read the full case study**

Step 6

DEVELOP A PEER SUPPORT MANUAL

A manual is a practical, day-to-day guide to the peer support intervention. It translates the high-level choices from Phase I into a step-by-step facilitation guide. This section does not present a finalised manual but reviews some considerations and suggests a potential structure. Implementers should allow enough time for this step. Depending on the available resources and experiences, it may take between four and eight hours to develop one session. Additional time is required for its testing and revision.

Step 6A

CREATE THE MANUAL STRUCTURE

The manual should cover everything the peer support facilitators need, irrespective of whether a group or one-to-one peer support format is used. At the same time, it should try to do so as simply as possible. How to strike this balance depends on: i) the facilitators' skills; ii) their familiarity with peer support; and iii) the scope of their training (Step 7). The manual may include:

- 1. Project rationale and scope:** Practically describe the core themes and mechanisms of peer support (e.g., core concepts and guiding values) and distinguish it from similar approaches employed by the organisation. Capture why the project is being implemented and what gaps it addresses. Provide a visual overview of the project (e.g., implementation sites, number of sessions/groups/participants, duration, sustainability aspects).
- 2. Description of roles (Step 7B):** Outline the key roles involved in the implementation and their scope and overlaps. Include details on the participant selection criteria (fixed and flexible). Describe decision-making and supervision processes (e.g., for the exit of a member, emerging challenges).
- 3. Session outline (Step 6B):** Outline the overall structure, including the session topics and objectives, and a simple description. A visual table of contents can help with the presentation. This section should also consider what happens between sessions.
- 4. Facilitation guide (Step 6C):** Include a detailed step-by-step guide for facilitators to run a session. Emphasise not only content or activities but also how to facilitate them. For example, remind facilitators of relevant communication skills or guiding values.
- 5. Additional content:** Check if any other content or references to existing guidelines or tools need to be added, such as internal referral pathways (including up-to-date contact details for rapid referral), existing NCD training or short learning summaries of core facilitation skills.



Practice tip

Sessions often have pre-defined themes (e.g., disease management, stress, social support) and prescriptive activities (e.g., discussion, cooking classes, role-playing). This does not necessarily need to be the case. For example, in open groups or one-to-one formats it may be preferable to use undefined sessions, which allows peers to identify and address their main priorities. Less structured approaches may not require a manual or can use an adapted format (e.g., focus on agenda-setting exercises). In many settings, sessions will benefit from being structured initially to facilitate rapport and skills-building. These can progressively become more unstructured and peer-led over time.



CASE STUDY 1 Lebanon

Manual table of contents and session example

The project's manual aimed to cover topics relevant to people living with diabetes and hypertension. Sessions integrated various themes to cover the spectrum of people's experiences and concerns. They included: i) disease education (e.g., diagnosis, symptoms, complications); ii) MHPSS and psychological aspects (e.g., coping strategies); iii) self-care (e.g., physical activity); and iv) social elements (e.g., team exercises).

> [Read the full case study](#)



Kenya

BOX 1

Language matters

Language choices matter. They shape the way people think and feel; both positively, by fostering inclusion, active participation and empowerment, and negatively, by stigmatising and alienating people. These choices can affect a project’s success and – more importantly – they can directly impact PLWNCDs’ health and wellbeing, for example by preventing people from seeking the support they need. This is especially true for peer support, as it fundamentally builds on people’s trust. Implementers should actively reflect on the choice of language across all communication, be it verbal, written, auditory or visual.⁵³ Importantly, the choice of language needs to be reflected in specific changes to organisational practices, otherwise it risks becoming tokenistic or harmful.

One of the key principles is the use of “person-first” and dignifying language.⁵⁴ Individuals should always be addressed as human beings rather than in relation to the condition or disability they are living with.

Implementers should proactively adapt the common phrases to be avoided (Figure 5) based on community preferences.



Further reading

[Age-friendly communication \(Centre for Ageing Better\)](#)

Another way to recognise people’s agency and humanity is to refer to an activity being with or by people living with NCDs rather than for, to or about them.⁴⁹ For example, using peer support with (rather than for) PLWNCDs. Similarly, implementers should avoid blaming people for an NCD or stigmatising their behaviours, for example by presenting simplified causes (e.g., too much sugar, too little physical activity) without recognising the complex genetic and structural factors at play.⁵⁴

Figure 5. Commonly used language to be avoided (original from,⁵³ CC BY-NC-SA 3.0 licence)

Patient	<p>Many individuals with lived experience prefer not to be referred to as patients. This can dehumanize the individual and perpetuate the power imbalances between the person with lived experience and the related professional.</p>	Alternatives	<p>Personal names, titles of individuals, individual with lived experience, person with lived experience.</p>
Person with (X) disease	<p>Explicitly referring and associating an individual with a disease or health condition can result in overmedicalizing and dehumanizing the individual. An individual with lived experience is much more than just a person with a disease or health condition.</p>	Alternatives	<p>Being treated for, living with, affected by, no evidence/presence of.</p>
Blaming language	<p>Attributing blame to any individual for their health condition or lived experience can be deeply traumatic and stigmatizing. The direct and indirect determinants of health are complex and should not be reduced to the sole responsibility of the individual or individual risk factors or determinants.</p>	Alternatives	<p>Concordance, suggesting active role for individuals with lived experience and the need for agreement between individuals and healthcare providers/professionals.</p>
	<p>Related terms to avoid: adherence, attributable, burden, commitment, compliance, disadvantaged, lifestyle choices, lifestyle diseases, vulnerable.</p>		

Step 6B

DEVELOP A SESSION OUTLINE

The session outline describes the general flow of the intervention, by listing topics, and their order and overall objective (Table 3). Implementers should design the intervention’s flow based on the participants’ experience of going through peer support, from the first communication until the sustainability phase.

Based on these overall session aims, implementers can develop a rough session outline. The reflection questions below (answering guide in Annex F) can help implementers with this exercise.



Further reading

- [Psychological first aid: Module 4 p.14 \(International Federation of Red Cross and Red Crescent Societies Psychosocial Centre, IFRC PS Centre\)](#)
- [Peer Leader Manual, p.16 \(IDF\)](#)

Table 3. Examples of overall objectives of peer support sessions

Overall objective	Description	Example session topics/formats	
Build trust	Often the focus of the initial session(s). The aim is to create a safe space and trusting relationships amongst the participants and/or with the facilitator.	<ul style="list-style-type: none"> • Group or buddy rules E.g., jointly define rules for the peer sessions based on a list of examples. Complement with an exercise on good communication and peer values. 	<ul style="list-style-type: none"> • Getting to know each other E.g., build a tower together based on a limited selection of materials or share personal stories. • Setting expectations E.g., write down expectations from and towards participants. Link with discussions on meeting times and locations, potential challenges of attending sessions or maximum group sizes.
Provide support	These sessions focus on addressing the project’s main outcomes, based on its ToC. Even though sessions can address multiple outcomes, it can be helpful to define a primary aim. For example, a cooking class can provide skills around healthy eating, foster social support and allow knowledge sharing.	<ul style="list-style-type: none"> • NCD educational sessions E.g., hear from experts and discuss the overlap with people’s lived experiences. • Service availability and affordability E.g., map existing services and associated costs across the continuum of care. 	<ul style="list-style-type: none"> • Psychological support E.g., identify common challenges and discuss solutions or build problemsolving skills. • Social support E.g., activities requiring social interactions, such as games, role-play and physical exercises.
Promote sustainability	Sessions focused on building peers’ ownership and anticipating the sustainability phase, whether formalised or not. The sessions may aim to nurture feelings of ownership, to develop self-organising skills or to practically plan the next steps. This represents an independent aim and is not an automatic by-product of people’s participation.	<ul style="list-style-type: none"> • Peer teaching E.g., peers teaching skills (e.g., cooking, yoga). • Shared interests E.g., peers encouraged to arrange informal social gatherings based on joint interests. 	<ul style="list-style-type: none"> • Co-facilitation E.g., peers set an agenda about a topic of interest and facilitate topical break-out rooms. • Care network E.g., explore options for peers to continue in other peer formats, such as shifting from a one-to-one buddy format to a mutual aid network



Reflection questions

An answer guide is available in [Annex E](#)

Reflection question 1

What role should peers' family and social networks play?

Reflection question 2

How can flexibility for facilitators be maintained?

Reflection question 3

How is the time in between sessions dealt with?

Reflection question 4

What happens after the defined sessions?



CASE STUDY 2 India

Caregiver support groups

Initially, both peers and their caregivers were participating in the same peer support group. Groups were separated after peer support volunteers noted a tendency for caregivers to talk over or for peers. To facilitate people's attendance, the two groups were organised to take place simultaneously in rooms next to each other. This simplified the transport for peers and caregivers while ensuring their proximity in case of emergencies.

The caregiver groups ended up with attendance rates of around 20 people on average, which was slightly higher than for the peer groups.

> [Read the full case study](#)



CASE STUDY 3 Vietnam

Integrating caregivers

The clubs were primarily established for people living with diabetes. As most participants were elderly, many had support from informal caregivers (e.g., family members) in their self-care routine, with cooking or with arranging transport to the health centre. To reflect their role, the intervention invited informal caregivers, such as spouses or adult children, to attend club sessions. In most cases, caregivers had too many other obligations to be able to participate in club activities, but in a few cases – particularly where club members had disabilities, such as eyesight or mobility problems – informal caregivers would join club meetings.

> [Read the full case study](#)

Step 6C

DEVELOPING SESSIONS

The session outline describes the general flow of the intervention, by listing topics, and their order and overall objective ([Table 3](#)). Implementers should design the intervention's flow based on the participants' experience of going through peer support, from the first communication until the sustainability phase.

With the general outline defined, the next step is to design each session in detail based on its specific objective. Implementers should seek input from people with lived experiences and topical experts (e.g., nutrition, disease management, income-generating skills). If feasible, the recruitment of a pedagogical consultant with experiences of peer support can be helpful. Each session should use a generic session template to ensure ease of use. For example, explore [Case study 1 \(Lebanon\)](#) or the [Peer Leader Manual \(IDF\)](#).

Several good practices in designing sessions and activities were captured by the case studies:

- **DEFINE clear objectives** for each session, as otherwise they may feel meaningless.
- **ENSURE an accessible, inclusive and culturally appropriate** design and content. For example, avoid text-based activities if illiteracy rates are high, or use examples with local relevance (e.g., available foods, people with relatable appearances). Specific accommodation should be put in place for people with accessibility needs (e.g., older people, people living with disabilities). More insights can be found in an open-access review by Litchfield and colleagues on how to design programs for underserved populations.⁵⁵
- **REVIEW the appropriateness of language**, aligning with participants' preferences, interests and values. This can include how to talk about people, the intervention and activities. For example, people may prefer a session if it is titled physical activity rather than yoga or movement class. Consider running activities separately or optionally if they are only relevant for a subset of participants (e.g., newly diagnosed, having accessibility requirements).

- **USE primarily engaging and diverse activities** that build on peer mechanisms. The use of one-directional or hierarchical pedagogical formats should be minimised or combined with more engaging formats. The following questions may help:
 - Do the participants have an active role in the activity? Consider using an 80/20 rule, with 80% active (e.g., role-play) and only 20% passive (e.g., lectures). This applies equally to the overall session plan and to individual sessions.
 - Do the activities encourage a focus on individual experiences rather than generic circumstances?
 - Does the session feature the core mechanisms and align with the guiding values?
 - Is there an alternative format that is used less frequently?
- **DEVELOP all the materials required** to run the activities and include them as part of the manual to reduce the facilitators' workload and preparation time. This includes ensuring visual clarity and a simple presentation of content (e.g., use of bullet points and brief summaries).
- **DESIGN the sessions as individual but interconnected.** Each session should have a start, middle and end. Remember that people live their daily lives in between sessions and may have had stressful or challenging experiences. Each session should give space for people to arrive and settle in as well as ensuring that

there is a feeling of closure at the end of it. It can be helpful to start each session with a review of the previous session's topics and goals.

- **AVOID asking the participants to bring any items.** People may not remember or be able and willing to do so. If items are included in activities, have a back-up plan to work without them.
- **PROVIDE take-home materials.** This helps people remember the skills covered and can provide opportunities to practice them at home (e.g., a printed recipe or a personal worksheet).



Practice tip

Session activities can be designed creatively. The session format is not limited by its overall aim or topic area. For example, a session focused on a seemingly knowledge-based topic (e.g., diabetes and its complications) does not require a lecture or Q&A-based activity. These sessions can – as much as any other – use activities such as game-based learning, role-play, painting and social activities. For inspiration, explore the [Peer Leader Manual \(IDF\)](#).



📄 CASE STUDY 1
Lebanon

Participant perceptions and preferences

Irrespective of how well a peer selection process is designed, some degree of participant diversity has to be expected. The group facilitators noted differences in how specific activities were received by people based on their gender and time since diagnosis. For example, men generally preferred information-based topics (e.g., diabetes) but were less engaged during drawing or breathing exercises. Women reported enjoying MHPSS topics, activity-based exercises and problem-solving skills. Similarly, service mapping exercises were more relevant for people who were newly diagnosed. By piloting the manual and engaging PLWNCDs in its design, project teams can anticipate some of these preferences and develop more inclusive sessions. Alternatively, as was the case with the project team here, improvements can be identified and implemented between two implementation waves.

> [Read the full case study](#)

Step 6D PILOTING THE MANUAL

Piloting a manual is incredibly useful. This is true even if people with lived experiences have been involved in the design. A pilot offers a relatively simple and quick opportunity to identify potential for improvement and can help facilitators familiarise themselves with the content and gain more confidence.

This step should prioritise practicality and feasibility over being accurate. The most comprehensive option is a full test run of the manual by the facilitators with selected people from the target community. Several less intensive alternatives exist:

- Limit the pilot to sessions or activities with the greatest uncertainty.
- Pilot some sessions in depth and others less comprehensively (e.g., expert review).
- Arrange a group discussion of the manual with people from the target group.
- Rely on internal review processes (e.g., from beyond the implementation team).



Practice tip

Being open to change

A pilot typically helps implementers identify which sessions and activities are (or are not) appropriate. Sometimes, people may also challenge the overall peer support design (e.g., “online groups are not feasible”). Implementers should be open to this type of feedback and consider revisions of the approach, if necessary. [Case study 2 \(India\)](#) and [Case study 3 \(Vietnam\)](#) provide great examples of adaptive projects.

Step 7 SELECT AND TRAIN PEER FACILITATORS

Most peer support approaches – except for informal or self-organising peer networks – are led by a facilitator. Irrespective of the type of facilitator, research and implementation experiences have shown that their selection and training play a key role in improving the quality of the intervention.^{56–58} A well-designed process can help ensure that the intervention is implemented as planned, strengthen the facilitators’ ability to fulfil their role and overcome some of the challenges captured in [Annex E](#). It can also help increase the facilitators’ legitimacy in the eyes of the participants if done by a reputable organisation.




Step 7A

SELECTION CRITERIA

Facilitator selection criteria are important for identifying the people who are best able to foster a space where peer support mechanisms can unfold. The criteria are used to select people from the overall pool of potential facilitators as defined in [Step 3](#). A project may, for example, have a network of 20 potential peer leaders, but wants to select five individuals to run one group each. Some projects may not need to define selection criteria, for example, if social workers were defined as facilitators but only one is present at each implementation site.


Implementers may consider the relevance of these generic selection criteria:

- **Similarity to participants:** Selecting facilitators who are similar to participants can help them in building a trusting relationship. This can build on [Box H \(Step 5\)](#). This selection criterion should be used very pragmatically, as there will rarely be a perfect match.
- **Facilitation and people skills:** These skills help facilitators engage people, deal with challenges and maintain a positive atmosphere. While facilitation skills can be trained, projects may want to select people with a communicative, open and encouraging character. Anecdotal evidence provides multiple examples where individuals skilled in these areas were the primary factors in the success of a project (or even a specific group or peer relationships).
- **Lived experiences:** The list of potential facilitators – and their potential strengths and weaknesses – were discussed and defined in [Step 3](#). For peer leaders, they may include – but are not contingent on – their own progress in self-care or a quantifiable level of disease control. Even if existing staff roles were chosen, the selection criteria may be able to identify people with lived experiences (e.g., personal or as a caregiver).
- **Knowledge level:** Peer support facilitators do not need to be experts on a specific disease. It is helpful, however, for them to be knowledgeable on the basics of the disease, diagnosis and treatment. If covered as part of the training, implementers can quantify these criteria by using post-training assessments.



Further reading
[Peer Leader Manual \(IDF\)](#)

- **Participant choice:** Some projects may allow peers to select a facilitator from amongst themselves, for example through a participant vote. This may require adaptive planning of the training scope and timelines.
- **Previous peer support experience:** People who have been through the same peer support project can be incredibly strong facilitators given their unique understanding of living with NCDs as well as participating in the sessions.
- **Local acceptability:** Implementers may choose facilitators who are known to have a positive pre-existing and horizontal relationship with the target community or enjoy high acceptability.

The list shows that the selection criteria have two connected purposes. They ensure that prospective facilitators have the skills and characteristics required by the role, and that they are perceived by participants as legitimate and acceptable. The facilitators' legitimacy may stem from any of the listed criteria. Once the selection criteria are defined, implementers can approach prospective facilitators based on the role description ([Step 7B](#))


Practice tip

In group formats, one facilitator is typically selected per peer support group. Alternatively, this step can identify a co-facilitator per group. This can be useful because it gives added flexibility, for example when attending to a participant who is showing a high level of distress. Co-facilitation allows individuals with different characteristics to facilitate. This format may be chosen as an additional training opportunity for co-facilitators before they lead their own groups as part of a second or expanded implementation round. In contrast, one-to-one approaches may have one trained peer leader working with multiple peers or acting as a supervisor for mutual support between two "participants".


Further reading
[Guidelines for the Practice and Training of Peer Support. Mental Health Commission Canada \(p 22-24\)](#)

- **Motivation and attitude:** Selecting people who are motivated to lead peer support sessions will be reflected in their efforts. Participants can often sense if someone has been pushed into the role or feels dissatisfied. If peer support is a novel concept, it can also help to select people who are open to trying new ideas and approaches.


CASE STUDY 3
Vietnam

Selecting club facilitators

Unlike that of a village health worker, the “club facilitator” role is not well established in Vietnam and did not exist at the health centres prior to the project. The selection was based on recommendations by the village health workers and people with diabetes in the villages, and decided on together with the research team. To ensure their legitimacy amongst peers and general fit, the team defined two selection criteria: (i) having lived with diabetes for an extended period; and (ii) individuals characterised locally as sociable and talkative. Club facilitators were supervised during the first two months, during which the team could recommend changing the facilitator. This option was not evoked in practice.

[> Read the full case study](#)

Step 7B

ROLE CLARITY AND DESCRIPTION

One of the key factors shaping the experience of facilitators is the presence of clear expectations and role descriptions. A lack of clarity on these points can easily cause confusion and frustration for facilitators, can lead to them being perceived as cheap labour and can risk peer support replicating traditional biomedical care approaches and hierarchies of power.^{37,46} There are a number of parallel steps that can be taken to foster this clarity:

- **Develop detailed role descriptions or terms of reference:**
 - What are the expected responsibilities?
 - What is the anticipated time commitment?
 - What is the legal status of the role (e.g., employment, volunteer, consultant)?
 - What salary or reimbursement can be expected (if any)?
 - What support or development opportunities are available for facilitators and peers (within and beyond the organisation)?

- **Arrange an initial conversation with prospective facilitators:** Describe the project and its purpose. Allow people to ask questions and make sure to answer clearly. Check that the conversation also covers the key practicalities outlined in the role description and give the prospective facilitator the opportunity to review and propose amendments to these terms.

- **Communicate with adjacent staff (e.g., healthcare professionals):** Staff indirectly working with or affected by the intervention may have concerns and reservations about the project. These can manifest in them presenting barriers to the facilitator’s work. Giving them space to voice these concerns can often prevent them from surfacing negatively. This can, for example, be a one-to-one conversation or townhall meeting to discuss:

- Why is the peer support project being implemented?
- What is the role of facilitators? What is not (e.g., administrative support)?
- How much additional work does the project require of existing staff?
- What are the overlaps with staff’s existing responsibilities?

These conversations can help ensure that arrangements and expectations are feasible and acceptable, as well as capturing people’s motivations or expectations linked to taking up the role (e.g., wanting to help, financial reasons, hoping for increased employability).⁴⁶ Workload for facilitators and existing staff is often a primary concern. Implementers will have to consider how to avoid expanding people’s workload by, for example, shifting some routine responsibilities, adding incentives or recruiting additional staff.

Step 7C

FACILITATOR TRAINING

In most cases, the people in the facilitator role will require additional training. To decide on the scope of this training, implementers should assess the target group’s training needs, perceptions and expectations, and the skills required for the role. These factors influence the weighting of the training components. In a best-case scenario, facilitators are involved early in the project design and thus require less introduction.

Practice tip

Annex G covers a potential training outline. In addition, the *Peer Leader Manual (IDF)* is one of the most detailed and well-developed peer leader training manuals publicly available. Implementers can use it as a guide to structure, topics and activities. It provides especially useful arguments for the importance of facilitation skills and how to practically train them.

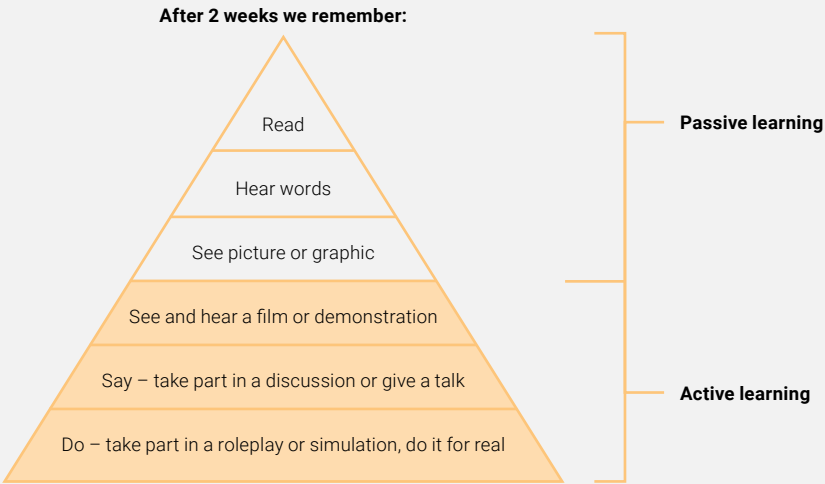
When planning the training, many of the same principles apply as for the manual development. In short:

- **Think about practicalities:** Involve training participants in its planning, for example in deciding where and when it takes place (e.g., weekdays and working hours). Implementers should try to provide culturally appropriate food or refreshments, especially if training sessions last the whole day.
- **Align with cultural norms:** Implementers should be sensitive around cultural norms, especially around communication and relationship topics. For example, the listed communication models may not be appropriate, or training sessions may have to be carried out in gender-separated groups.

- **Apply pedagogical principles:** Similarly to the peer support sessions themselves, the training should follow known good practices for adult learning. One key principle is the value of experiential learning. Evidence shows that people learn better by doing than by reading, listening or hearing (*Figure 6*). In practice, the 80/20 rule can be useful, referring to a training session’s aim to use 80% active learning. Implementers can also consider recruiting a pedagogical expert to develop the training.
- **Schedule the (re)training:** The training should be aligned with the planned start of the peer support intervention to ensure that facilitators can directly apply their learnings. Even if that is the case, there is often a need for refresher training. This may be requested by facilitators or emerge during the supervision session.
- **Train multiple objectives:** The outline above separates the training knowledge and skills into distinct learning themes. However, many of these skills can be trained together. For example, participants can further strengthen their facilitation skills during the activities from the manual.
- **Expect revisions:** The training will likely provide more insights into which sections of the manual work well and which may need improvement. Use the feedback from facilitators to revise the manual where possible.

In some settings, a training-of-trainers format can prove useful to reach remote areas or help with ensuring the project’s sustainability.

Figure 6. Retention rates per learning modalities (adapted from⁶⁷)



Step 8

PRACTICALITIES OF RUNNING PEER SUPPORT

Many decisions taken in Phase 1 require further planning and site-specific adaptation during the implementation phase. These adaptations can be planned together with the local facilitator or be left to their judgement and contextual insight. Factors that typically require additional planning are:



Meeting space

The meeting space needs to be appropriate for running peer support sessions. This typically means that it needs to be easily accessible, acceptable to peers (and their families) and fit for purpose. The space should be selected and prepared in a way that facilitates the exercises planned in the manual. This can include a variety of factors:

- What transport options are available to participants to reach the space?
- Is the location accessible for peers living with a disability?
- Are heating and cooling options available to keep the room temperature comfortable?
- How should the space be set up to facilitate trust-building and reciprocity?
- What are the options for providing appropriate refreshments?
- Does the space meet the participants' and their families' expectations (e.g., privacy, safety, reputation)?



Time management and capacity

The availability of peers can easily be taken for granted. Their time should be valued highly when planning the sessions and take into account their preferences (e.g., holiday periods, aligning with clinical consultation days). Similarly, facilitators and associated healthcare teams typically have high existing workloads and will have reasonable concerns around added responsibilities.

The project needs to ensure that it does not simply ask people to do even more within their existing working hours. Implementers should give space for staff to raise their concerns and effectively address them, for example by reducing staff's existing responsibilities or integrating with existing work processes. Similarly, the peer support manual should prioritise ease-of-use for facilitators (Step 6). The role description and supervision structures can also help ensure that the role fits people's expectations, assess their motivations and address potential frustrations. Implementers may decide to create new or update existing disease-specific standard operating procedures.



Practice tip

It can be helpful to involve the participants in the selection of the meeting space and the meeting times. For example, arrange a discussion during the first session that identifies when and where people would prefer to meet.



Supervision and support

Existing evidence highlights the essential role of supportive supervision.³⁴ Its purpose is to improve the overall quality of peer support and ensure it is implemented as planned. As a minimum, supervision should be put in place for facilitators of peer support, irrespective of whether they are internal staff (e.g., social workers) or people recruited for this purpose (e.g., peer leaders). This continuous support can help to:

- Give facilitators confidence and clarify their roles
- Provide emotional support to facilitators after challenging peer experiences
- Emphasise facilitators' essential role as valued team members
- Facilitate cross-location learning.

The frequency and format of the supervision can be decided jointly with the facilitators, ranging from informal, needs-based meetings to regular, structured group check-ins. A community-of-practice approach may also be used, where facilitators support each other.



Further reading

[Integrated Model for Supervision \(IFRC PS Centre\)](#)



Personal adjustments

There are likely other site-specific or individual adjustments that become relevant at this stage.⁵⁵ Here, facilitators or staff can be given ownership of locally relevant practical decisions. It is especially important to identify adjustments that affect people's ability to attend or engage in the sessions. The facilitators can reach out to participants individually or discuss these adjustments as part of the first sessions. Reasonable requests should be accommodated as much as possible.

These practicalities can be informed by the manual pilot and the target group's preferences identified there. Many of these factors will change over time, especially in humanitarian settings.

Step 9

FLEXIBILITY AND PROBLEM-SOLVING

Given the volatile nature of humanitarian settings, it is less a question of whether a peer support intervention needs to be adapted during its implementation than of when and how. Peer support is an incredibly flexible approach that can easily be adapted to numerous potential scenarios ([Annex H](#)).

Beyond specific scenarios, teams can build their capacity to identify and respond to emerging challenges. This includes actively building on the extensive experience of programmatic staff, ensuring close monitoring and evaluation feedback loops ([Phase III](#)), nurturing good communication, enabling integrated supervision, defining standard operating procedures (e.g., for initiating and reporting changes) and maintaining constructive working relationships with key stakeholders.



Practice tip

Peer problem-solving

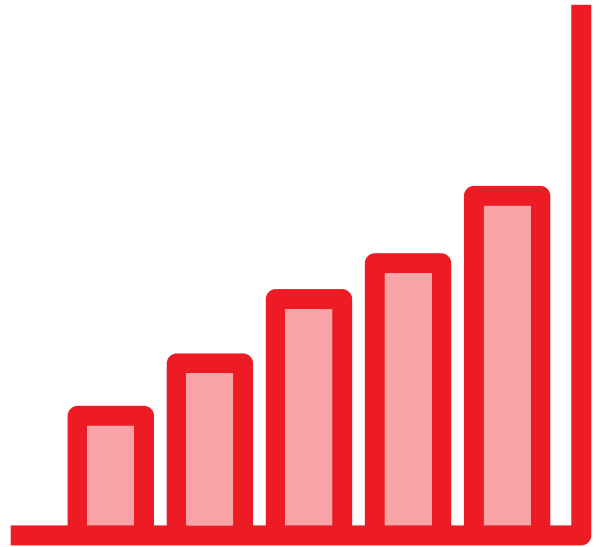
Unlike many health interventions, peer support gives space for PLWNCDs to organise themselves and respond to emerging challenges. Implementers should not underestimate the potential of peer support to foster people’s agency and ability to creatively respond to challenges. Optimally, all the listed adaptations or solutions should be initiated and led by the peers themselves. The role of the implementing organisation should – for the most part – be that of supporting this process with adequate resources. Optimally, this flexibility should be integrated into the project’s time, financial and M&E planning.



Lebanon

Phase III

Evaluate and learn



Summary

The humanitarian community is still learning about the best models of care for NCDs, including peer support. Implementation experiences and research evidence are limited but growing. Striving to be evidence-oriented – as far as possible – means using available good practices when designing interventions, as well as collecting and using project-specific data for monitoring and evaluation. M&E can support implementers by providing project- and context-specific insights into how the project is doing. This chapter provides a list of general considerations for M&E, from deciding on the key areas of focus to identifying relevant processes, and designing detailed indicators. It does not provide a detailed M&E plan but signposts useful resources that help with this.

Keywords

- M&E and research
- Continuous learning
- Indicators
- M&E plan
- Community engagement and accountability

Checklist

- An M&E technical lead is selected and onboarded.
- The purpose(s) of the M&E effort are clearly defined.
- A results framework is developed capturing all relevant components of the results chain.
- Appropriate indicators are identified and data collection tools are defined.
- A detailed M&E plan covering all steps and a detailed action plan with clear responsibilities are drawn up.
- Opportunities for meaningfully engaging PLWNCDs and their communities are identified.
- The M&E plan is approved and there is buy-in from relevant stakeholders.

M&E is a core part of most humanitarian health projects, for good reasons. M&E helps understand the project's implementation and its results, and identifies potential areas for improvement and adaptation. M&E can have several purposes (discussed below), though it typically tries to answer a set of overarching questions ([Box J](#)). Monitoring tends to be undertaken continuously, often using routinely collected data, whereas evaluation is likely to be more comprehensive, can involve the collection of additional data and often takes place at key project milestones.

Some projects can choose to add a formal research component in parallel to M&E efforts. The distinction between evaluation and research is not always clear.⁶⁰ In this handbook, evaluation is understood to be a subset of research ([Figure 7](#)), but with a fluid border between the two concepts. Research typically – though with exceptions – requires additional steps (e.g., ethical approval), is often done with external collaborators (e.g., universities) and may employ more complex methods and theory-driven analyses. In practical terms, evaluation and research are also different in respect of timelines, target audiences and key outputs (see below). For a peer support project, a research component may allow, for example, robust documentation or testing of new interventions or models of care.



Further reading

Guidance on setting up a research component can be found in the [Humanitarian Research Toolkit \(International Rescue Committee\)](#).

BOX J

Overarching M&E questions (adapted from⁵⁹)

- Did the project do what it said it would?
- Was it implemented well?
- What difference did it make (and for whom)?
- Has it done the right thing?

Figure 7. Continuum between research and evaluation (adapted from⁶⁰)





Step 10

DEFINE THE PURPOSE OF M&E


The value of M&E needs to be balanced with the reality that all data collection requires human and financial resources and technical expertise. Implementers need to ensure that M&E efforts have a clear purpose and added value, rather than unnecessarily burdening staff or collecting data that is not used. M&E design should be led by technical experts, where possible, and involve those closest to implementation (e.g., facilitators, implementing staff, PLWNCDs). M&E can serve several purposes, and it is important to define why and for whom data is collected:


Improve the intervention: The purpose is to gain insights that help improve the intervention (e.g., by measuring quality, access, sustainability). This typically involves identifying what did (or did not) work well, and recommending specific and actionable changes. Routine monitoring can also identify areas to further explore through an evaluation or research component. Several quality improvement frameworks are available that may serve as practical guides, e.g., the [Model for Improvement \(Institute of Healthcare Improvement\)](#) consisting of Plan, Do, Study, Act.

 **Primary audience**
Implementers, staff, PLWNCDs and communities.


 **Example output**
M&E indicator dashboard or progress report.


Ensure accountability: Here, the purpose is to hold organisations in power responsible for their actions and inactions, and for delivering on their commitments.⁶¹ Accountability to internal stakeholders (e.g., headquarters), funders and governments is a common purpose for M&E, whereas accountability to affected populations has traditionally received much less attention. Accountability to affected populations should, therefore, be prioritised and actively planned for ([Step 12](#)).

 **Primary audience**
PLWNCDs and communities, funder and internal stakeholders.


 **Example output**
Reports to an advisory committee, led by PLWNCDs, to make decisions.


Inform policy and practice: M&E insights may also aim to improve humanitarian practice beyond the specific project, for example by informing operational manuals and guidelines on peer support or related interventions. Implementers should reflect on how to efficiently achieve these aims, as they may require additional resources and the development of strategic engagement and advocacy plans beyond specific outputs. Adding a robust research component may provide useful evidence to aid this process.

 **Primary audience**
Internal decision-makers, advisory committees, humanitarian actors, governments (e.g., ministries of health), normative bodies (e.g., WHO), civil society and advocacy organisations.

 **Example output**
Internal report with recommendations, external report, workshop and policy briefs.

Contribute to the evidence base: M&E may contribute to the wider humanitarian community's understanding of peer support. Given the scarcity of documented evidence on peer support in such settings, each instance where an organisation's experiences are captured can add value.

 **Primary audience**
External humanitarian, governmental, civil society and academic actors.

 **Example output**
Practice or policy brief ([Case study 4 Kenya](#)), case study, project report and journal publication.

Clearly identifying the purpose of M&E ensures that the next steps are guided by an overall aim that has a clear benefit for the project and/or beyond. Implementers should also align with any existing M&E standards, reporting requirements, guidelines and data collection tools.

 **Practice tip**

This section might use different language from that in place in the implementing organisation. For example, different terms may be used for outcomes/results, aims/objectives/goals or data source/means of validation. Implementers should use their organisation's terminology.


Step 11
DEVELOP A RESULTS FRAMEWORK

Results frameworks are a structured representation of the project components and expected outcomes. As a start, implementers should ideally review (or develop) the project's ToC ([Step 1](#)). This captures the complex pathways of how change is expected to occur and can serve as the basis for the next steps.

Step 11A
DEFINE THE RESULTS CHAIN

A results framework, such as a logical framework approach (log frame), captures the full results chain of a project, ranging from its implementation (inputs, processes, outputs) to its effects (outcomes) and assumptions. Assumptions are factors that link these chain links together and are either uncertain or beyond the project's control. [Table 4](#) provides examples of things that can be measured in each stage of the results chain, using examples relevant for peer support projects in humanitarian settings.

There are as many potential measures as there are peer support approaches. Their choice and weighting will depend on the overall objectives and the project's ToC. For example, to continuously improve an intervention, input, output and process measures may be more useful in aiding continuous decision-making and rapid adaptation than clinical outcomes, which may take longer to show change. Similarly, if a project's overall objective is to strengthen people's social integration and economic empowerment, the results chain should focus on measures that are able to capture such changes (e.g., feelings of isolation, self-reported incomes). Importantly, the measures should be able to capture both positive results and potential unintended negative effects. This step should conclude with a log frame matrix (or similar tool) detailing the key components of the results chain.

 **Further reading**
[Log frame \(Tools4Dev\)](#)

 **CASE STUDY 1**
Lebanon

Measuring project outcomes

The peer support group project in Lebanon had significant capacity, allowing it to collect and analyse extended project-level data. The relevant measures were selected as part of a stakeholder workshop and a mini-ToC process at the start of the project. For most measures, validated tools were used, with additional input from LSHTM. In many settings, simpler tools may be more suitable.

Inputs/processes/outputs	Outcomes
<ul style="list-style-type: none"> • Willingness to participate (% of people who declined) • Group participation (% of sessions attended) • Drop-out rate (% of people who dropped out of the intervention) 	<ul style="list-style-type: none"> • Clinical indicators (i.e., HbA1c, blood pressure) • NCD risk factors (WHO-STEP5, Arabic version) • Medication "adherence" (MARS-5 scale) • Quality of life (WHO-QOL, Arabic version) • Person-centricity of care (collaboRATE framework)

The clinical data points were collected as part of LRC's routine care monitoring, while the remaining outcomes were gathered through a questionnaire specific to Bridging the Gap. LRC's routine data collection included selected demographic variables (sex, age, education level, nationality), allowing the team to analyse the listed variables per sub-group. A parallel implementation study, conducted by LSHTM and local research consultants, aims to understand the implementation process and context.

> Read the full case study

 **Practice tip**

Projects will often have a range of stakeholders with potentially differing views of what should be measured and how. To avoid duplicate data collection and potential wastage, projects should try to align these requests as much as possible (e.g., through a stakeholder workshop).

Table 4. Overview and examples of results chain measures relevant for peer support projects

	INPUTS & PROCESSES	OUTPUTS	OUTCOMES
Definitions	Capturing project resources or activities (inputs) and their interactions (processes) to understand the intervention’s implementation and whether it was as intended.	Capturing the immediate results or products (outputs) of activities and processes. These are different from outcomes, as they do not yet present a change that is significant and valuable to the target group.	Capturing meaningful results of a project (outcomes). Depending on the project objectives, these may include measures of physical and mental health, psychological, social, behavioural and self-care, and person-reported outcomes. ^{16,25} Some outcomes may develop over time and be difficult to measure (e.g., NCD complications such as diabetic retinopathy).
Examples	<ul style="list-style-type: none"> • Facilitator selection • Training delivery • Intervention delivery • Peer-reported experienc 	<ul style="list-style-type: none"> • Intervention reach • Intervention uptake • Participant completion and drop-out rate • Stakeholder feedback 	<ul style="list-style-type: none"> • Clinical proxy measures (HbA1c, blood pressure, depression scores) • Quality of life • Self-efficacy • Social integration

Step 11B
DEFINE INDICATORS

Each measure should be operationalised by determining one (or more) meaningful, useful, feasible indicator(s). Indicators are often quantitative (number-based; e.g., #/% of the cohort with BP < 140/90 mmHg at their last visit), but can also be qualitative (textual, visual or verbal; e.g., PLWNCDs’ perception of the person-centredness of care). Good indicators are those that can capture relevant changes while accounting for blind spots, available resources and data collection tools, and their value beyond the

project (e.g., for comparison or accountability). [Table 5](#) can serve as a rough guide.

The below table is not a rigid prescription for implementers. Many factors influence the potential M&E scope, not least organisational mandates and capacities, resource availabilities, and the cultural and socio-economic context. The reflection questions may help identify some of them.

Table 5. Suggestive guide for selecting key measures and indicators for peer support projects

Core	Projects with minimal resources and/or settings characterised by major limitations (e.g., emergency response, time pressure, access issues, volatility).	1-2 input/process/output measures 1-3 outcome measures <ul style="list-style-type: none"> • Disaggregation by: Sex, age, disability and project sites (if relevant). • Data sources: Primarily routine data. Prioritise ease of data collection with no – or limited – additional resource requirements.
Extended	Projects that are more mature, have greater resources and/or are in settings with an established humanitarian response (e.g., recovery phase).	All Core measures and disaggregation; plus a limited number of additional measures or further disaggregation with a focus on meaningful, feasible and actionable data. <ul style="list-style-type: none"> • Data sources: Mostly routine data with limited new data collection processes (e.g., patient exit surveys).



Reflection questions

- What data has already been collected, for what purpose and what audience, how and by whom?
- How is it currently reported (e.g., in aggregate at cohort level or at patient level)?
- Who owns the data and how can it be accessed (confidentiality, security, data sharing)?
- Can measures be captured with routine data collection or are “new” processes required?
- What are the existing skills and capacities within the team?
- How does the overall crisis phase influence a) the relevance, b) the impact and c) the feasibility of specific measures?
- What data is needed to fully understand the measures (e.g., gender, age, disability)?
- Have you considered equity and humanitarian principles (e.g., socio-economic, political, migrant status)?
- Are quantitative measures clearly defined to allow comparisons (numerator, denominator, timeframe and population group)?
- Are there simpler ways to gain equally or sufficiently good insights (e.g., proxy measures)?

[Annex I](#) provides a list of potential measures and simplified indicators, which can be used to develop SMART indicators, for example:

- **Training delivery:** Proportion of training participants improving pre- and post-test scores by 20% (or #/% scoring > 80% in post-test scores).
- **Clinical proxy measure:** #/% of active hypertension patients with blood pressure <= 140/90 pre and post intervention; or at most recent visit within the last six months.



Further reading

[5 SMART indicators in Monitoring and Evaluation \(Tools4Dev\).](#)

In humanitarian settings, there are often significant gaps in the most fundamental data collection and data is often not reported in a disaggregated manner, which makes it impossible to understand for whom the project is working.^{5,62} Prioritising data disaggregation should be a primary focus of implementers. Projects may also plan for a tiered expansion of the M&E scope or, if significant resources are available, consider more comprehensive or specialised approaches ([Box K](#)).

Step 12

DEVELOP AN M&E PLAN

The M&E plan is an operational tool summarising all elements of a project’s M&E. It may centre around a log frame, but covers all aspects from preparations to data collection, processing, analysis and dissemination. There are valuable open-access resources available, for example the further reading [M&E plan template \(Tools4Dev\)](#). This step explores two components of an M&E plan that may be overlooked.


Data processing and analysis

The leadership of technical M&E experts is especially critical for the data processing step. It requires an in-depth understanding of applicable standards and guidelines as well as skills in setting up (or adapting) a data management system. The protection of people’s data and privacy should be a primary concern, especially if dealing with sensitive data or “vulnerable” population groups.

To avoid collecting irrelevant data, the M&E plan should describe in detail the process of how data is translated into useful and actionable insights and outputs. For each measure, this should cover:

- Measure description
- Roles and responsibilities
- Purpose/audience
- Quality checks
- Data collection tools
- Analysis approach
- Frequency
- Data storage and transfer (privacy and protection)

The data analysis step is important but does not need to be overly complicated. Simple but useful analyses are often the most powerful, especially for quick decision-making. For example, comparing the characteristics of people who declined to participate in peer support (e.g., mostly men) can identify recommendations to make an intervention more relevant (e.g., change session timing). All routine data needs to be acted on, as otherwise it wastes limited resources, may present unnecessary data security risks and is ethically unsound.

 **Further reading**
[Analyse data \(Better Evaluation\)](#)

Community engagement and accountability

As a cross-cutting theme, implementers need to consider the role of the PLWNCDs and their community. Humanitarian actors are striving to move away from a more paternalistic approach towards a more collaborative and participatory approach involving PLWNCDs, families and communities at all stages of programme design and delivery. M&E can be a powerful tool for ensuring accountability, person-centric humanitarian responses and community ownership. Though often involved in data collection (e.g., as focus group participants), community members and PLWNCDs have less often been engaged in the other stages, such as data analysis, dissemination and decision-making (i.e., more meaningful engagement).


 **Further reading**
[Operational Guidance on Accountability to Affected Populations \(Health Cluster\)](#)

Figure 8. Examples of engaging PLWNCDs and their communities include:

CO-PRODUCTION

- Transfer of power over resources and decisions
- PLWNCDs in leadership positions

COLLABORATION

- Validation workshops
- Participatory methods
- Community advisory councils
- Reference groups

PARTICIPATION

- Focus group discussions
- Surveys
- Feedback systems
- Newsletters
- Townhall meetings

Over time, implementers may move towards co-production with all decision-making power resting with peers and their communities.



Kenya

BOX K

Comprehensive approaches for evidence generation

Well-resourced projects in a more stable setting can consider broadening their M&E efforts. This can include adding measures that are typically hard to capture (e.g., complications), expanding the data disaggregation or using more comprehensive research methodologies (e.g., implementation research) and methods (e.g., cohort monitoring).



Further reading

[Evaluation Methods and Approaches \(Better Evaluation\)](#)

Implementation research is a specific research approach focused on understanding what, why and how interventions work in “real world” settings and testing approaches to improve them.^{63(p1)} It focuses on the interaction between a project and its context through implementation variables, such as acceptability, adoption, fidelity, cost, coverage and

sustainability. Implementation research can tell implementers more about why and how an intervention works and how its findings may be generalisable to other settings. This will often require dedicated funding and strategic partnerships, e.g., with universities.

Cohort monitoring is the routine data collection of repeated and standardised measures over time for a specific group of people (cohort). This may involve a single or multiple clinical sites. For example, a humanitarian organisation collects clinical measures (e.g., blood pressure and HbA1c) from all PLWNCDs who interact with any of their services. Comparison between sites requires entering paper-based or electronic data into a common or interoperable tool or platform. This is sometimes supported by an automated data collection system (e.g., electronic medical records). Cohort monitoring allows quality monitoring and comparison across sites and can identify fluctuations over time as interventions are adapted or contexts change.

A CALL TO ACTION

With this handbook we hope to have captured how peer support can be a powerful tool for supporting PLWNCDs, including in humanitarian settings. It aims to serve as a practical guide for implementers to – ultimately – benefit PLWNCDs. This handbook and the evidence on peer support in humanitarian settings are still evolving. We thus encourage individuals to share any suggestions, feedback or implementation experiences of peer support in humanitarian settings to help improve its evidence base. Get in touch with the Danish Red Cross at info@rodekors.dk.

RESOURCE PAGES

- [Community Mental Health Good Practice Guide: Peer Support \(CBM Global Disability Inclusion\)](#)
- [Briefing Paper on Peer Support for People with Physical Health Conditions \(ImROC\)](#)
- [Peer Leader Manual and Training \(IDF\)](#)
- [Diabetes Peer Support Groups Workbook \(Lions Club International\)](#)
- [Tools and Training \(Peers for Progress\)](#)
- [Mother-to-Mother Support Groups: Trainer’s Manual \(Save the Children\)](#)
- [Policy Brief on Providing peer support for adolescents and young people living with HIV \(WHO\)](#)

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ANNEXES

ANNEX A: How this guide was developed

The use of evidence is essential when designing humanitarian health programmes. The core chapters of the handbook were informed through:

- i. a desk review of research publications
- ii. a document analysis of grey literature
- iii. stakeholder interviews
- iv. expert consultations.

Across all data sources, priority was given to materials that captured peer support interventions in humanitarian settings. Due to their limited availability, this handbook also considered evidence from low- and middle-income countries as well as from other priority areas (e.g., HIV, tuberculosis, mental health and psychosocial support).

Research studies and grey literature publications were identified based on a non-comprehensive desk review and stakeholder input. Publications were included in the handbook if they described the planning, implementation or evaluation of peer support interventions. Remote semi-structured interviews were conducted with stakeholders who had experience of implementing peer support with PLWNCDs. Interviews were prioritised if no written documentation or materials were available around the project. Expert consultations consisted of seeking formal feedback from relevant stakeholders to ensure the handbook's operational relevance and appropriateness. They included humanitarian actors, people with lived experiences and researchers. The handbook was additionally presented to the Informal Interagency Working Group on NCDs in Humanitarian Settings for feedback. All involved experts and contributors are listed in the acknowledgements section.

ANNEX B: Case Studies

- [CASE STUDY 1: Bridging the Gap: Peer Support Groups in Lebanon](#)
- [CASE STUDY 2: QualityRights: Rights-based Peer Support in India](#)
- [CASE STUDY 3: Living Together with Chronic Disease: Informal Support for Diabetes Management in Vietnam](#)
- [CASE STUDY 4: Continuity of NCD Care in Crisis Project in Kenya](#)

ANNEX C: Light-touch theory of change exercise

Participants: Implementers, community members and key stakeholders

Time: 6 hours

Location: Online/offline

Building on ToC concepts, implementers can work backwards through the project's intended lifetime. From impacts to outcomes to assumptions and to actions/interventions. Implementers start by defining the project's goals at a societal (i.e., impacts) and/or more short- to medium-term level (i.e., outcomes). These can build on the list of potential objectives above. Activities are then identified with the aim of achieving the desired changes. Assumptions are factors that are taken for granted, capturing how the specific ToC concepts are linked to each other (e.g., activities to intermediate outcomes). They should be made explicit, as an intervention is only as strong as its assumptions. All components should be evidence-based where possible. The list of possible objectives and the peer mechanisms can serve as inspiration for the team.

The insights from this exercise can help inform the intervention design and project M&E, and aid stakeholder buy-in, especially if visualised. Extensive resources on the ToC are available online.



Further reading

- [Humanitarian Innovation Guide \(ELRHA\)](#)
 - [Learning Lab \(USAID\)](#)
 - [ToCs \(Centre for Theory of Change\)](#)
-

ANNEX D: Reflection questions for choosing appropriate implementation options

Question 1: What role does the evolving humanitarian situation play?

This handbook – in theory – applies to all categories of humanitarian setting, including conflict-affected settings, disasters and complex crises. However, the type and – in particular – the phase of the crisis strongly shape whether and what type of peer support is possible.

• Preparedness phase

Experiences of implementing peer support with the purpose of preparedness or mitigation are scarce. While many of the same considerations as in protracted settings apply, additional opportunities may exist in anticipating disruptions ([Case study 4](#)). Peer support efforts may have a protective effect on participants and mitigate some of the crisis impacts.³² Organisations can review existing guidelines, manuals and peer-support efforts from a preparedness perspective. Simultaneously, links with relevant stakeholders should be strengthened to allow a quicker response during emergencies (e.g., setting up a network of people with lived experiences, proactive community engagement efforts).

• Acute/emergency response phase

The response priorities during an acute crisis phase lie with life-threatening cases and people at risk of critical acute exacerbations or complications.^{44,64} Given these ethical and safety considerations, the capacity for establishing new peer support interventions is typically lacking. Implementers can encourage the continuation of existing peer support efforts if they are well established, as they may help people cope;³² for example, if a protracted crisis with an ongoing peer support project is struck by a rapid-onset disaster (e.g., flooding).

• Recovery phase/protracted crisis

Peer support would typically be considered part of an expanded service package.⁶⁴ As such, it is generally most feasible in more stable, protracted humanitarian settings or as part of the recovery phase. Even in protracted settings, the day-to-day realities can vary widely. Several contextual factors influence the choice of implementation options:

- Access to populations (e.g., population movements, camp- vs urban-based, humanitarian space)
- Safety considerations for staff and communities
- Competing priorities and primary concerns of PLWNCDs (e.g., shelter, water and food)
- Urgency and volatility of the situation (e.g., likelihood of disruptions)
- Health system capacities and resilience

Crises are continuously evolving. Implementers need to plan for sufficient flexibility – [Step 9](#) – to ensure that the project continues to meet people’s needs. Any changes initiated by a humanitarian actor should be communicated to the participants and stakeholders clearly and early.



Further reading

[Diabetes Care and Disasters \(IDF Western Pacific Region\).](#)



CASE STUDY 4 Kenya

Facing disruptions

The peer support groups were established not only to support their members during their day-to-day living with an NCD, but also to help them handle unexpected crises. In these scenarios, peer support groups may fulfil diverse purposes, including:

- Maintaining day-to-day support: Peers can continue to provide mutual support. Peers may share practical tips for managing their condition during crises. They can provide emotional or MHPSS support by being there for each other.
- Providing information and mutual learning: Groups can prove a reliable communication channel during emergencies. Peers may be able to share information from trusted sources, provide real-time updates or map the availability of services. This can help members understand how their condition may be affected during crises and identify relevant resources.
- Engaging with stakeholders: Groups may provide an important link to health facilities, including their collaboration with healthcare workers. At a larger scale, they can advocate for the needs of their members and PLWNCDs in general, for example with national authorities.

For groups to be able to fulfil these roles, a sense of community, strong relationships and peer trust need to exist before a crisis strikes. Alongside these core features, groups can actively prepare for crisis impacts. For example, this project supported the creation of customised emergency preparedness plans and arranged practice drills for common types of emergency. All activities should be led and tailored by group members, with humanitarian actors providing support. To learn more about this project’s efforts to support people during period of disruptions, explore this practice brief.

[> Read the full case study](#)

ANNEX D: Reflection questions for choosing appropriate implementation options

Question 2: What are the preferences of the target community?

PLWNCDs are often positive towards peer support.⁵⁴ However, the success of peer support relies on people's interest and implementing an intervention that aligns with people's needs, preferences and priorities. For example, if people are struggling to meet their basic needs, few may be open to prioritising meetings to discuss their experiences of living with NCDs. This can include ensuring essential and life-saving services and products (e.g., insulin). In such contexts, peer support will need to adapt and address people's needs more directly, for example by focusing on mutual aid and medication sharing networks.

The starting point for answering these questions should be the meaningful involvement of PLWNCDs. As covered under "The cornerstone: meaningful involvement of PLWNCDs" ([Box E](#)), their involvement can range from focus group discussions to advisory committees, representation in key decision-making bodies at project level and beyond. Stakeholder consultations and a secondary data review might provide additional insights. The focus of these enquiries should be on identifying the community's preferences and their influences on implementation choices ([Step 3](#)). They can also capture broader knowledge relevant for a project's scope, for example:

- History of peer support or related approaches (e.g., network of community health workers)
- Community's familiarity and associations with peer support (e.g., community groups)
- Priorities of the target group in terms of which challenges to address with peer support
- Community preferences in peer support formats (across all implementation choices)
- Potential linkages between peer support and other services (e.g., medicines stock-out)
- Most acceptable language choices (e.g., use of peer support, mutual aid, "diabetes groups")
- Relevant contextual and cultural factors (e.g., stigma, power structures, local economy)

Question 3: What existing efforts can we connect with?

Before thinking of a new intervention, implementers should map all existing projects that use peer support or a similar approach. In many settings, supporting or complementing existing projects will be more impactful. This mapping can be done jointly with a stakeholder analysis ([Step 4](#)) and span both internal and external projects. It can range from a formal assessment to informal conversations with key stakeholders, especially individuals and actors able to represent people with lived experiences.

Examples of what to look for:

- National peer support strategies, peer training guidelines and accreditation schemes
- Existing or planned projects by other humanitarian actors
- Previous experiences within the organisation, including in other priority areas (e.g., MHPSS)
- Grass-roots peer support networks run by people with lived experience (e.g., mutual aid groups)
- Referral facilities and linkages to the existing healthcare system

Grass-roots networks are a particularly strong option to engage with or support as they are typically strongly anchored in the community. They often enjoy a unique level of trust and legitimacy, which is essential for a project's sustainability. Even when the mapping does not identify projects to support, it can offer opportunities to learn from existing efforts and help answer the remaining questions. Another option to visualise the linkages of peer support can be the use of a patient pathway mapping exercise, which can help in understanding people's experiences and avoiding fragmentation.



Further reading

[Your complete guide to patient journey mapping \(Qualtrics\).](#)



Practice tip

Implementers should ask: Who do we mean by community? The word often suggests that people are more similar than they actually are. In the project's target group, there are often multiple sub-groups with different needs and preferences. The peer support intervention can be even more tailored once the specific selection criteria for peers have been set ([Step 5](#)).

ANNEX D: Reflection questions for choosing appropriate implementation options

Question 4: What resources are available within our organisation(s)?

All types of resource should be considered, including tangible and intangible (physical, human, financial) and technical. It can be helpful to reflect on this question with the wider implementation team using a visual brainstorming method to capture the existing resources in different categories on a physical (or digital) whiteboard. This could be done as part of the stakeholder consultations.

- Which actor enjoys the greatest legitimacy with the community?
- Who can be project champions at all levels (e.g., organisational, local, regional, national)?
- What are the capacity and skills of all relevant actors relative to their suggested role?
- What infrastructure is available (e.g., meeting spaces, digital technologies, transport)?
- What support materials are available (e.g., existing manuals, education materials)?
- What are the scope and duration of the available funding? Are there options for co-funding?
- Which choice of locations could aid the implementation (e.g., pilot sites, accessibility)?

For many projects, the answers may be largely determined by project grants or funding. Even if this is the case, implementers should reflect on what other types of resource (especially intangible) are available.

Question 5: How can joint implementation options be relevant?

At this stage, the reflective questions may start to favour some of the listed implementation options. This decision-making process does not need to follow a pick-one-from-each-category logic. In fact, there are many ways to combine or integrate options. Implementers can consider joint implementation options to design an approach that fits best in a specific context. Frequently linked options are:

- **Online and offline:** Regular in-person peer support (e.g., every two weeks) linked with an online follow-up or reminders (e.g., calls by facilitators).
- **Group-based and one-to-one:** Support groups can be complemented by a buddy system, where two peers are assigned to each other for more personal support.
- **Peer and non-peer facilitators:** Even when peer support groups are facilitated by a trained peer leader, clinical staff may be brought in as experts or co-facilitators for specific sessions. Similarly, others may also act as co-facilitators, such as community health workers, volunteers and non-clinical staff.
- **Formal and informal:** Organisations can offer both organised peer support (e.g., closed groups facilitated by a trained peer leader) and informal opportunities for people to connect (e.g., open monthly meet-ups).

The examples here are simply intended to provide inspiration for implementers and are not exhaustive. There are many other joint implementation options that can prove useful if adapted to a specific setting.



Practice tip

Reflect on how joint implementation options may be able to address some of the insights and challenges identified in the previous questions.

ANNEX E: Decision-making across selected implementation options

Implementation choice		Pros	Cons
WHO	Dedicated facilitator OR	A pre-defined facilitator can be trained based on their knowledge and skill gaps. ^{30,58,65} This can help ensure that the project manual and content are implemented as planned. ³⁴ The initial period of establishing ground rules and peer principles may be simplified, especially if people are unfamiliar with the concept. This option may be prioritised if organisations have staff with strong facilitation skills that could take up this role.	When the facilitator is selected and trained by the implementing organisation, the core ownership of the peer support remains with them. Shifting the responsibility towards PLWNCDs and ensuring its sustainability may prove difficult. The training of facilitators likely requires additional resources.
	No dedicated facilitator	Having no specified person in the facilitator role, or a shifting facilitator, can help make all members feel more equal and help build their ownership. This model may be implemented progressively, starting from an initially fixed facilitator.	The organisation cedes some control of the intervention. There may be significant differences in how sessions are run. Peers may struggle initially to self-manage, given the lack of established trust and relationships.
	Clinical facilitator OR	Clinical staff can contribute with medical knowledge, which can complement people's lived experiences. The prospect of getting additional attention from a healthcare professional may also serve as an incentive for peers' attendance.	The presence of clinical staff, especially as facilitators, poses the risk that the sessions return to traditional hierarchies (experts and patients) and may centre around biomedical views of NCDs. Staff do not usually have the capacity to cover additional responsibilities and are already overburdened. ³² Additional recruitments or a reduction in responsibilities may be needed.
	Non-clinical facilitator	Non-clinical facilitators benefit from not falling into traditional health system hierarchies or not having pre-established relationships with participants. They are often outside routine clinical care and may be better able to put across the core ideas of peer support and its biopsychosocial view of disease.	The risk of using non-clinical staff is the possibility of false information being spread, given legitimacy by the linkage to a health centre or organisation. ³⁷ A combined approach where peer leaders are supported by clinical staff for specific topics may counteract some of this risk.
	Paid facilitator OR	The payment of facilitators can be a question for internal staff (i.e., additional incentives) as well as people specifically recruited. It can help increase people's motivation and ensure the recognition of their contribution. It can also help recruit people who are fitting facilitators but unable to contribute voluntarily.	Paying facilitators can give rise to challenges with their status in national employment laws and can have implications around labour rights. Implementers should seek guidance on applicable laws and regulations. For example, the implications of an "employee with salary" compared to a "volunteer with reimbursement".
	Unpaid facilitator	Running peer support groups with volunteers may allow an intervention to be implemented with a limited budget where it would otherwise not be possible. Even if facilitators are not paid, other forms of benefit should be considered (e.g., skill training, employability, and travel or food reimbursement).	Not paying facilitators suggests that their work or expertise is not valued and will likely make people feel unappreciated. It may also incentivise overburdening them as "cheap labour" in the name of task-shifting. ^{46,66} A lack of incentives may also increase turnover, irrespective of the type of facilitator. ⁵⁷
	Peer leader OR	Participants may perceive facilitators who have lived experiences with NCDs and similar characteristics as more legitimate. ^{34,37} Their similarity and a shared language may facilitate people's trust-building. The entanglement between facilitator and participant can also be positive. ³⁷ Participants may be more easily able to distinguish peer support from routine care.	Peer facilitators may find it difficult to navigate holding a space (i.e., facilitating) while also participating (i.e., sharing) themselves and the risk of emotional entanglement. ³⁷ Unless they have held similar roles before, specific training on facilitation skills is often needed to help navigate this space. While presumably equal, peer facilitators are also at risk of falling into power hierarchies (e.g., helping a person lacking something). ³⁷
	Non-peer facilitator	Non-peer facilitators may find it easier to maintain their specific role, as there is a clearer difference between facilitator and participant. Some organisations may recruit non-peer facilitators more easily, as fewer criteria apply and relationships may already exist.	Non-peer facilitators may risk falling back into a hierarchical or traditional biomedical way of viewing and engaging with participants. Opportunities for building trust and engagement may be missed if a strong understanding and rapport with the community are lacking.

ANNEX E: Decision-making across selected implementation options

Implementation choice		Pros	Cons
	Defined content OR	Having pre-defined content (e.g., a list of topics, activities, exercises) simplifies the planning and resource management and can be more easily replicable. Potential participants may prefer the clarity on what they commit to. ³⁴	The selected topics may be perceived as valuable to implementers but not to participants. There is also a risk that people are not met where they are, which may lead to them disengaging.
	Undefined content	The peer support can be more flexible and adapt to the needs of its participants. The ownership lies with participants, as they decide what is important to them. This may work best after an initial settling-in period and require ongoing technical and financial support from external organisations.	Participants may expect peer support to be similar to a “typical” health service, where the scope is clearly defined. Concepts of flexible sessions or co-design may feel unfamiliar and initially unattractive. Open-session formats may also risk facilitators falling back into traditional, hierarchical pedagogical approaches.
WHAT	Type of session	<p>The format of peer support sessions can be incredibly diverse and creative. Only some considerations are captured here and implementers should complement these with the best available understanding of the target communities’ needs and preferences (Step 3 and Step 6).</p> <p>Informational topic-based sessions (e.g., on diabetes education, healthy eating, physical activity, sleep, stress) are often a primary choice. They allow the anchoring of sessions in specific topics and the following of ideas of “patient education”. Their main risk lies with them feeling like top-down lectures, contrary to the core peer support mechanisms. To avoid this, informational sessions should use multiple formats (e.g., discussions, activities, games) and primarily aim at peer engagement and mutual learning.</p> <p>Activity-based sessions (e.g., sporting meet-ups, cooking classes, role-play) can be an entertaining way for participants to engage with each other. The selection of appropriate activities for peers can prove difficult, as sub-groups may have different needs and perceptions. For example, cooking or yoga classes may not be interesting for men in some settings (Case study 1).</p> <p>Emotional, practical and social support (e.g., discussing challenges, sharing experiences and helping find solutions) is closely linked to the core mechanisms of peer support. Sessions can focus on bringing people together to support each other with specific challenges they experience. This can also involve using structured approaches, such as goal-setting exercises or active listening. Research has shown that sessions with a behavioural or affective focus (i.e., moods, attitudes, feelings) can be more impactful than those just focused on informational content alone.^{17,34,37}</p>	
WHERE	Health facility OR	Organising peer support at people’s health facilities may simplify their travel, especially if coordinated with routine follow-up or medicine pick-up. The familiarity may help people feel more at ease. It can be the best option if staff members are chosen as facilitators or if additional rooms are available at the facility.	Facilities often lack space, especially spaces that are appropriate and fit the peer support needs. Locating peer support in the health facility may lead to people feeling more like patients, interfering with the core ideas of peer support. It can also be biased towards participants who live more centrally or are able to attend care frequently.
	Community space	Community spaces are often central and easier to reach for many. They can help differentiate peer support from their routine care. These spaces may offer opportunities to collaborate with key partners and allow more varied activities	Community space, though often closer for participants, may require people to travel in addition to their medical appointments. Renting spaces might also incur additional costs.
	In-person OR	In-person peer support may facilitate trust-building, for example through small non-guided interactions during breaks. Facilitators may also be more familiar with this format and feel more at ease.	Peer support may miss people from the target group who are unable to travel. In many settings, this group constitutes people who are already often neglected and hardest hit by crises.
	Online/ remote	Remote peer support (e.g., via telephone or internet calls) provides opportunities similar to digital health concepts. It can be most beneficial in settings where physical accessibility is – or becomes – limited or where peers prefer an added layer of privacy.	Online peer support brings its own technical accessibility challenges, including access to phones, connectivity and digital literacy. Facilitators may need additional training on the specifics of online peer support and digital facilitation skills.

ANNEX E: Decision-making across selected implementation options

Implementation choice		Pros	Cons
HOW	Groups OR	Group support often uses fewer resources than one-to-one formats. This may be especially true for larger groups (> 10 people), which also allow more social interactions. Smaller groups may feel more intimate and trusting. ³⁴ In peer groups, “buddies” or sub-groups often form based on people’s relationships either naturally or encouraged by facilitators.	Ensuring that group members perceive themselves and their experiences as similar can be more challenging than in one-to-one formats. Too large groups (e.g., > 25, context-dependent) may negatively affect the intervention ³⁴ and people’s feelings of cohesion, confidentiality and trust. In some settings, people may hesitate to discuss private matters in group settings. Small groups may risk cancellation. ³⁴
	One-to-one	Peer selection and matching in one-to-one formats can ensure people have more similar experiences than would be possible in groups. This approach can be beneficial in settings with a fragmented community and possibly sensitive topics. A training-of-trainers approach may be useful.	It requires more resources to recruit and train a larger group of facilitators. One-to-one approaches may offer fewer opportunities for addressing people’s social needs, especially if online.
	Open groups OR	Groups that are open (i.e., allow new members to join) can be the best option for settings with great variability and population movement. More established group members can support “newcomers” and model the group’s rules and culture. This can be a strong option for peer-owned formats or those that are transitioning towards them.	Open-group membership requires planning the process for how new members can join. It can also struggle to bridge the needs of more established and newer members; for example, arranging informational sessions on topics repeatedly. Group coherence and trust may be harder to maintain if members change frequently.
	Closed groups	Closed groups (i.e., fixed membership) may allow people to build trust more easily, given the pre-established group. They typically provide a more defined intervention with clear start and end dates, which may better align with humanitarian project cycles.	Commitment and drop-outs may be challenging. People may be unable to maintain their engagement and groups can struggle to bring together enough members regularly.

ANNEX E: Decision-making across selected implementation options

Implementation choice		Pros	Cons
WHEN	Ad hoc	Needs-based meetings can increase the willingness of people to participate, especially if they have a voice in deciding when and where meetings take place. Participants can continuously decide whether peer support is adding value for them relative to other – competing – priorities.	The number of participants may fluctuate widely. The lack of continuity and the possibility of low participation numbers may disrupt the development of relationships and the building of peer dynamics.
	OR		
	Pre-defined meetings	Projects with pre-defined meetings may require people to commit to the full project period to the best of their ability. This may facilitate their attendance and set expectations of participants. The continuity can help ensure participants are on the same page and have regular opportunities to interact.	Finding a schedule that works for all participants can be difficult, especially in more volatile settings. This planning will often require flexibility on behalf of the facilitators and co-planning with participants to ensure the best possible fit. Participants might feel obliged to participate even in sessions with topics they are not interested in.
	> 3 months OR	Shorter-term interventions can be useful in settings with limited resources or time. They can also offer opportunities to pilot the concept of peer support and its acceptability within specific communities. Participants may find it easier to commit.	Peer relationships may not fully form and interactions can be limited. Without the time to build trust, many of the core mechanisms of peer support can be hard to foster. Even if positive results are observed, their sustainability is questionable.
	< 3 months	Peer support takes time to establish its full potential, including the slow process of building trust and relationships between peers. For these reasons, longer-duration interventions (e.g., 3-6 months) generally seem more effective. ²⁸	Peers may struggle to commit for the full duration, especially in volatile settings. Higher drop-out rates need to be expected in some settings. ³⁴ Lack of resources of funding cycles may prevent longer project periods.
Frequent OR	Lacking a clear definition, once a month or more is considered frequent. Higher frequency can facilitate all outcomes, as it makes peer support a more consistent part of people’s lives and allows greater interactions and support. ²⁶	Attendance and its associated opportunity costs can become difficult for participants. People may initially be unwilling to commit to high-frequency meetings, especially if doubting the peer support value. ³⁴	
Infrequent	Best suited for settings where people have to travel far and struggle to afford it. It may more easily align with clinical check-ups or medication pick-ups, as they may be less frequent than monthly.	Peers may find it hard to implement insights from the support session in their daily lives without the continued support of peers. Linking in-person peer support with online platforms may help counteract this.	

ANNEX F: Reflection questions for designing a manual

Reflection question 1: What role should peers’ family and social networks play?

Peers’ immediate social networks, especially caregivers, can also be considered people living with NCDs and they shape the peers’ experiences, perceptions and ability for self-care.⁴⁹ Their involvement can strengthen the impact of peer support while posing some risks.

Potential benefits	Potential risks
<p>Among the main benefits is the opportunity for peers to share this experience with people close to them. Their involvement may facilitate peers’ ability to implement learning in their daily lives. For example, peers’ community learn about and become more involved in their self-care. Peers may even actively request their involvement, as happened in Case study 1 (Lebanon). Involving peers’ caregivers can be especially valuable, including for children or people living with disabilities. In joint groups, for example, caregivers may attend instead of peers if they are unable to. Caregivers may also be in need of support, especially as they may have an active role in people’s (self-)care routine.</p>	<p>The main risk is that of caregivers not sharing the same similarities and experiences as peers, thus affecting group cohesion and core peer support mechanisms. They may also dominate the peer support sessions, interfering with the trusted space created by peers, either overtly (e.g., speaking for the peer) or covertly (e.g., peers hesitating to share openly). Participants’ networks might also have the same attitudes and behaviours as peers, some of which might negatively impact people’s self-care and health.</p>
<p>Examples of involving peers’ networks:</p> <ul style="list-style-type: none"> • Plan specific sessions where peers can invite others. • Run separate sessions for peers’ network members (e.g., caregivers). • Have peers and their social networks attend the same group. <p>This decision may be taken together with participants. Irrespective of the type of involvement, the ownership of the space must remain with the peers. Facilitators play a key role in maintaining a safe space and managing potential conflicts. To limit the risks, it may be worth focusing initially on strengthening peer relationships before involving people’s networks.</p>	

Reflection question 2: How can flexibility for facilitators be maintained?

How sessions are received by participants, no matter how well planned, will likely differ across implementation sites or peer support waves. The manual should consider including and encouraging options for facilitators to adapt it to their local context. For example:

- Mention that facilitators can adapt any examples to be relevant locally.
- Keep activity descriptions as bullet points to allow facilitators to use their own phrasing.
- Add different options for how facilitators can run an activity.
- Have facilitators ask participants for examples or stories, where relevant.

These options should be explicitly and simply spelled out as part of the peer support manual.

Reflection question 3: How is the time in between sessions dealt with?

In the manual design, there is a tendency to focus on the specific session topics. The time in between sessions plays an equally important role. It can help peers digest the content, provide continuous support, maintain their engagement and – hopefully – allow them to start implementing changes in their day-to-day lives. In the manual, implementers can consider including:

- **Providing take-home materials:** Developing materials for people to take home can help them digest the session content. This can include content summaries, day-to-day exercises and reflection activities. Exercises may focus on supporting behavioural change, for example a self-paced worksheet such as a personal diary or goal-setting experiences. All materials should reflect local preferences and literacy levels.

ANNEX F: Reflection questions for designing a manual

- **Setting up a space for peers to connect:** This can include setting up an online chat group or a buddy system between pairs of peers. It can allow peers to actively check in on each other and share relevant information. How these platforms are used can be left up to the participants. For example, they may prefer it to be a social space (e.g., share pictures of the session days with people's explicit consent). Facilitators should initiate the platform and encourage people to join. This choice should balance its perceived value with its accessibility (e.g., exclusion of group members without access to reliable internet) and data protection concerns.
- **Follow-up with peers:** It can be helpful for facilitators to actively follow up with peers between sessions. By taking the time to reach out, peers may feel more valued and appreciated. Facilitators

may also remind people of upcoming sessions or other relevant information. Given the extra work this causes, it needs to be agreed on as part of facilitators' role description.

Reflection question 4: What happens after the defined sessions?

If implementers are using session topics to structure the intervention, they need to think about the period after the last defined session. Peer support can either continue similarly to the existing format or take a completely new form. For example, peers may lead the groups independently or the organisation may provide some limited support. The manual should consider and prepare the group for this "sustainability period". The communication platform used throughout can be a useful resource to build on.

ANNEX G: Potential facilitator training themes

1. Introduction to the project (10%)
 - a. Project plan and objectives
 - b. Structure and scope of the peer support project
 - c. Facilitator role description (addressing questions and concerns)
2. Fundamentals of peer support (10%)
 - a. What is peer support? Definitions, key features and mechanisms
 - b. Peer support values (see Introduction) and their practical application³⁶
3. Facilitation mindset and skills (30%)
 - a. Introduction to facilitation
 - i. What makes a good facilitator? Resource: [Peer Leader Manual \(IDF\)](#)
 - ii. How is facilitating different from other roles?
 - iii. Challenging views that contrast with peer support values, such as autonomy and equality (e.g., helping, solving, teaching)
 - iv. Facilitator's self-care
 - b. Practicing facilitation skills:
 - i. Communication skills, for example:
 - Active listening (Resource: [Peer Leader Manual \(IDF\)](#), p. 30)
 - OARS model ([OARS communication skills, AHRQ](#))
 - Non-violent communication
 - Conflict management
 - Leading difficult conversations/ holding space
 - ii. Building motivation: motivational interviewing and goal-setting
Resource: [Peer Leader Manual \(IDF\)](#), e.g., pp 19-20 and [chapters 2-3](#)
 - iii. Setting boundaries
4. Technical knowledge (10%)
 - a. Fundamentals of NCDs: disease, diagnostics, complications and treatment. Align with organisational, national or other relevant guidelines. Resource: [Peer Leader Manual \(IDF\)](#)
 - b. Overlaps between NCDs, mental health and disability
 - c. Strengths and limitations of the facilitator role
 - i. Strength in experiential – not clinical – knowledge
 - ii. Importance of saying “I don't know”
5. Specific manual training (30%)
 - a. Overall logic and flow of the manual
 - b. Hands-on walk-through of all planned activities
 - c. Adherence to manual versus local flexibility
6. Complementary training (10%)
 - a. Common misconceptions and potentially harmful attitudes. These may centre around NCDs or any participant characteristics (e.g., ethnicity, refugee status, education level)
 - i. Stigma and discrimination
 - ii. Social determinants of health
 - iii. Diversity and social inclusion
 Resource: [Guidelines for peer support, pp 30ff \(Mental Health Commission Canada\)](#); meaningful Involvement of PLWNCDs and language choice ([Step 2](#) and [Step 6](#))
 - b. Psychological first aid and trauma-informed approaches
Resource: [Community Based Support \(IFRC PS Centre\)](#) and [the Supportive Voices Guide \(IFRC PS Centre\)](#)
 - c. Organisational processes and guidelines (including referral pathways and tools)
Resource: [Referral Guidance Note \(IASC\)](#)

ANNEX H: List of selected implementation challenges and potential solutions (adapted from¹⁶)

Challenge	Example	Potential solution
Difficult to engage a specific sub-group	Men are harder to recruit or do not participate in peer support sessions	<ul style="list-style-type: none"> Align activities with sub-groups' interests Review the language choice in all communication Adjust timing to fit participants' needs For groups, consider separating groups
Transport becomes unavailable or unaffordable for participants	Worsening economic situation or reliance on family members to provide transport	<ul style="list-style-type: none"> Link with clinical consultation days Provide cash-based transport vouchers Arrange travel options Shift to more accessible locations Consider online formats
Some participants are unable to attend due to cultural norms or their family's hesitation	Women needing permission to leave the house, or a mourning period requiring a person to stay at home	<ul style="list-style-type: none"> Shift to acceptable location Enable remote participation Use a buddy format where peers provide one-to-one support Arrange an information meeting with peers' families or the community
Participants are unavailable at the specified meeting times	People are unable to attend due to work commitments, cultural or religious practices, or health issues	<ul style="list-style-type: none"> Co-decide on meeting times Use flexible session scheduling Align with clinical consultation days
Participants lose interest over time	Selective attendance of sessions based on interest	<ul style="list-style-type: none"> Rethink the intervention's value Emphasise the importance of attending Post session topics ahead of time Develop a buddy or follow-up system
Peer support fosters negative comparisons amongst peers and gives rise to interpersonal conflict <small>8,37</small>	Peers may negatively compare themselves to each other, for example, "whose condition is worse?"	<ul style="list-style-type: none"> Plan a session on group rules Provide communication skills training Facilitators to re-guide conversations
Peer leaders or facilitators use a hierarchical teaching approach ³⁷	Trained peer leaders may step into the role of a teacher based on the skills learned during the training	<ul style="list-style-type: none"> (Re-)train peer leaders in essential facilitation skills Discuss the role descriptions with facilitators and emphasise holding the space rather than helping (i.e., a hierarchy of giver/receiver) Strengthen peer participant ownership of the sessions
Weakening of technical advice by word-of-mouth dissemination	Facilitators share information with peers verbally during sessions	<ul style="list-style-type: none"> Provide visual take-home materials Share session summaries in group chat Revisit previous session topics at the start of a new session
Peer questions go beyond the skills and training of the facilitator	Peers ask the facilitators technical questions that they are unable to answer	<ul style="list-style-type: none"> Add supervision structures where facilitators can clarify Emphasise the limitations of the facilitator role Involve technical staff in sessions (e.g., a question-and-answer format)

ANNEX I: Selective list of potential M&E measures and indicators

Type	Measure	Indicator examples
INPUTS & PROCESSES	Facilitator selection	# of people approached vs selected (disaggregated)
	Training delivery	# of facilitator training sessions conducted
	Intervention delivery	# of sites, groups, sessions undertaken during a given time period
	Costs	Project costs (direct, indirect)
	Peer experiences	Person-reported experience measures
OUTPUTS	Training delivery	# of facilitators (and associated staff) trained
	Intervention reach	# of participants / # eligible participants from the target population (disaggregated)
		% declined participation (disaggregated)
	Intervention uptake	# and characteristics of participants/groups
	Participation rate	% of participant attendance
	Loss to follow-up	% of participants completing vs dropping out of intervention (disaggregated)
	Stakeholder acceptance	Qualitative data around acceptance
	Complaint mechanism in place and working	# of complaints received/addressed
OUTCOMES	Training delivery	Pre- and post-training knowledge test scores
	Clinical proxy outcomes (e.g., diabetes)	Average changes in participant's blood glucose levels
		Average changes in participant's HbA1c level
		Changes in depression scores
	Complications and "hard" outcomes*	% of people with tertiary referral
		% of people treated for a complication
	Quality of life*	Changes in quality-of-life scores (e.g., WHO-QOL)
Social outcomes*	Changes in social support or isolation scores	

ANNEX I: Selective list of potential M&E measures and indicators

Type	Measure	Indicator examples
OUTCOMES	Self-care and behavioural change*	% of people following treatment as prescribed
		Changes in behavioural risk factors (e.g., WHO STEPS)
	Daily functioning*	Average changes in disability scores (e.g., WHO-DAS)
	Psychological outcomes*	Changes in knowledge test scores
		Stress levels (e.g., diabetes-related distress scores)
		Changes in self-efficacy score
Healthcare utilisation	# of clinical visits (or overlap with treatment guidelines)	
* Measures that often require additional data collection beyond routine clinical monitoring and screening.		