Petrina M. Hilton
Graham Brown
Adam Bourne

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Australian Research Centre in
Sex, Health and Society

W3 Project

Locating evidence against the W3 Indicators for peer-led work

https://w3framework.org

W3 Framework

Australian Research Centre in Sex, Health and Society

Copies of this report or any other publications from this project may be obtained by contacting:

Australian Research Centre in Sex, Health and Society (ARCSHS)
Building NR6
La Trobe University, Victoria 3086 Australia

T (03) 9479 8700

E arcshs@latrobe.edu.au

latrobe.edu.au/arcshs

W3 Project: Locating evidence against the W3 Indicators for peer-led work

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Author affiliations:

Petrina M Hilton and Adam Bourne: Australian Research Centre in Sex, Health and Society (ARCSHS), La Trobe University

Graham Brown: Centre for Social Impact (CSI), University of New South Wales

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Contents

About this report

The W3 Project works with peer-led organisations and programs working in Australia's HIV and hepatitis C response to better understand their system-level role and to support their ability to evaluate and demonstrate the full impact of their work.

This report provides an overview of work currently being undertaken with Australian organisations led by people living with HIV (PLHIV) and people who use drugs (PWUD) to locate evidence against the W3 Indicators (1).

It can be a challenging process to locate evidence against a set of system indicators about which organisations have not previously collected information. A common question that comes up during our discussions with our partners is: What kinds of evidence do the other organisations have for this indicator?

The purpose of this report, therefore, is to take pause and summarise what we have learned so far through the process of locating evidence to:

- Ensure our partners can learn and benefit from each other's work
- Provide insights for other organisations endeavouring to identify and locate evidence against system-level indicators

Funding

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Acknowledgements

We thank everyone who has supported and worked with the W3 Project. We are especially grateful for the time and commitment of the peer workers who have shared their insights and expertise with us. It is no exaggeration to say that this work would not be possible without them.

Since its inception in 2013, the W3 Project has worked with peer-led organisations and programs across Australia, including national and state-based organisations led by:

- People living with HIV
- People who use drugs
- Gay and bisexual men, and other men who have sex with men
- Sex workers

Terminology and acronyms

Adaptation: The W3 Function about how the peer response changes the way it works to keep up with its changing environment.

Alignment: The W3 Function about how the peer response interacts with, partners with, and learns from the broader health sector and policy environment.

AOD: Alcohol and other drugs.

BBV: Blood-borne virus.

Community: One of the systems that peer work is a part of. It includes diverse individuals, families, social networks, cultures, tensions, community spaces, and other grassroots organisations and businesses with shared (or overlapping) backgrounds, experiences, identities, attitudes, and/or interests.

Engagement: The W3 Function about how the peer response interacts with, participates in, and learns from, its communities.

Health sector and policy environment: One of the systems that peer work is a part of. It includes government, health services, social services, other community organisations, research, politics, media, policies, laws, enforcement practices, and any other formal structure or system that can impact the health of communities.

Influence: The W3 Function about how the peer response achieves or mobilises change within its communities as well as within the health sector and policy environment.

KPI: Key performance indicator(s).

MOU: Memorandum of understanding.

PLHIV: People living with HIV.

PWUD: People who use drugs.

PWID: People who inject drugs.

STI: Sexually transmissible infections.

W3 Framework: An evaluation framework for peer-led work within the broader community and health sector/policy environment systems.

W3 Functions: The four system-level functions that must be occurring strongly for peer-led work to maximise its impact.

Background

The Australian National HIV and Hepatitis C Strategies affirm the importance of community- and peer-led approaches (2,3). These approaches have a unique and important role in the HIV and hepatitis C response.

The effectiveness of these approaches stems from the strong, positive influence that peer work has on communities and on the health systems and policies that affect communities' health (4). Despite this, the types of evaluation that funders ask for often focus only on individual-level factors that fail to measure system-level impacts and synergies (5). This makes it hard for peer-led responses to show the full extent of their impact and value.

Since 2014, the W3 Project has worked closely with staff from peer-led organisations and programs in the HIV and hepatitis C sectors. Using a systems-thinking approach, the W3 Project worked with more than 90 peer workers across Australia to better understand how their work fits within their communities and the broader public health system. Through this process, we developed the W3 Framework, a program theory that positions peer-led work within both the peer community and the broader health sector and policy environment (4).

THE W3 FUNCTIONS

The W3 Functions are the four key system-level functions through which peer-led responses create positive change: engagement, alignment, adaptation, and influence. The W3 Functions are central to the W3 Framework.

Engagement:

How the peer organisation or program interacts with, participates in, and learns from its communities

Alignment:

How the peer organisation or program interacts with, partners in, and learns from the broader health sector and policy environment

Adaptation:

How the peer organisation or program changes the way it works to suit its changing environment

Influence:

How well the peer organisation or program is able to affect its community as well as the broader health sector and policy

Full details and guides about the W3 Framework and the W3 Functions are available at https://w3framework.org.

W3 Project Stage 3

Stage 3 of the W3 Project is a national study of how well peer-led responses achieve and sustain impact in their work across the four W3 Functions. In this stage, we are pooling resources and data from selected peer-led responses in multiple states across Australia. This will help us generate stronger and clearer evidence of what works, and why, and provide insights and guidance for the investment and scale-up of peer programs in priority populations.

Aims

This project aims to create a consolidated evidence base showing the quality and impact of peer-led HIV and hepatitis C programs, and to guide investment in targeted peer-led health promotion programs. This will support peer-led responses to:

- Demonstrate their full impact and value
- Enhance the implementation, quality, and impact of their programs
- Respond quickly and confidently to rapid changes in the broader HIV and hepatitis C responses

We are working with partner organisations to pool and analyse their monitoring and evaluation data to:

- Create a consolidated evidence base that demonstrates their effectiveness and impact
- Compare peer-led program models in different organisational, geographic, and policy contexts
- Provide guidance for funding, monitoring, and evaluating peer-led responses

Methods

Data collection and analysis

To guide our work, we are using the **L**ocate evidence, **E**valuate evidence, **A**ssemble evidence, inform **D**ecisions (LEAD) framework for assembling evidence and informing decisions (6).

This framework was chosen due to its relevance in guiding the identification and collection of diverse, heterogeneous, meaningful evidence to help inform decisions around complex public health problems using a systems-thinking approach.

Table 1 provides an overview how we are applying the LEAD Framework during Stage 3 of the W3 Project, and our progress so far.

Collaborative process

All activities throughout the process are being conducted collaboratively with our partner organisations.

During Stage 2,[1] we have been working in partnership with:

- Australian Injecting and Illicit Drug Users League (AIVL)
- Harm Reduction Victoria (HRVic)
- Living Positive Victoria
- National Association of People with HIV Australia (NAPWHA)
- New South Wales Users and AIDS Association (NUAA)
- Peer Based Harm Reduction WA
- Positive Life NSW
- Queensland Positive People (QPP)

Our partners have been (and continue to be) instrumental in:

- Guiding the priorities of the project
- Developing the indicators
- Identifying and collecting data and information against the indicators

We will continue working closely with our partners to ensure they have a strong role in helping us:

- Understand, analyse, and contextualise the information we collect
- Develop outputs that will benefit them and their work
- Produce guidance and recommendations, for funders and policymakers, that will support peer-led organisations and their work with their communities

1 Due to the COVID-19 pandemic, not all organisations have had the capacity to be involved in all activities. All organisations, however, have been involved on our advisory committee and helped guide the development of the project's goals and priorities.

THE LEAD FRAMEWORK

The LEAD Framework outlines five key tasks: specify questions, Locate evidence, Evaluate evidence, Assemble evidence, inform Decisions.

Although depicted as a linear process, due to the nature of locating evidence within and across diverse contexts and data sources, the process is not linear in practice but, rather, intended to be undertaken in a cyclic, iterative process.

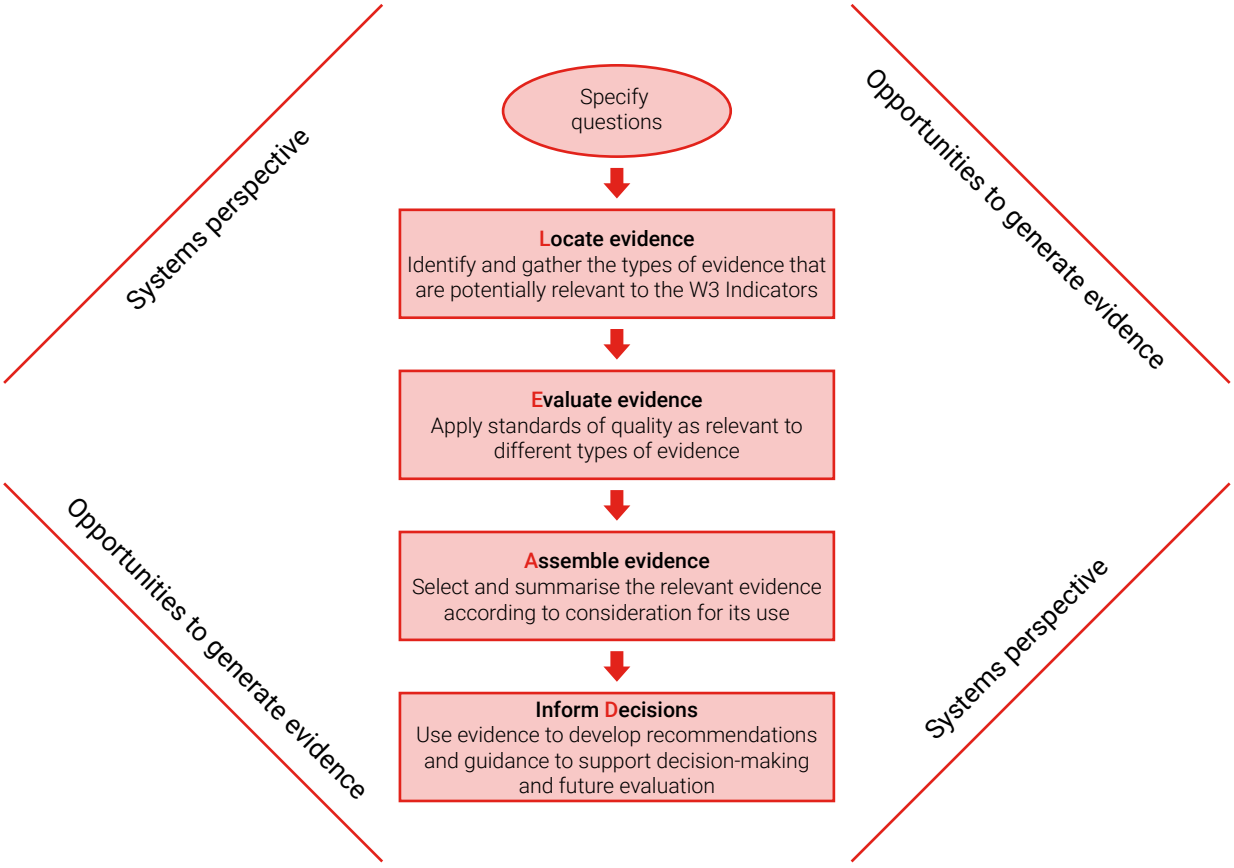


Diagram adapted from Figure 3-1 'The Locate Evidence, Evaluate Evidence, Assemble Evidence, Inform Decisions (L.E.A.D.) Framework for obesity prevention decision making' in 'Bridging the evidence gap in obesity prevention: a framework to inform decision making', by the National Academy of Sciences, 2010, Washington, DC: The National Academies Press. (7)

Table 1: Overview of data collection and synthesis activities and methodologies for Stage 3 of the W3 Project at each level of the LEAD Framework

Task	Timeline	Description	Progress
Specify questions	May 2020-June 2021	Collaboratively develop a set of indicators for each of the four W3 Functions to identify how well peer-led responses achieve and sustain impact in their work across the Functions For each indicator, we ask: How well is the peer-led response achieving this indicator?	• We developed an initial list of W3 Indicators using a modified Delphi process (1) - Our expert panel comprised: • Leaders and staff from national peak and state-based peer-led PLHIV and PWUD organisations • Representatives working in BBV and alcohol and other drugs (AOD) policy from a state government health department • As we identify gaps in the indicators through the process of analysing evidence, we are refining these lists further
Locate evidence	Apr 2021-Sep 2022	Work collaboratively with peer-led programs and organisations to identify and gather the types of evidence that are potentially relevant to each of the W3 Indicators	• We began identifying potential sources of evidence against each indicator as part of the process of developing the indicators • We have held 15 meetings and workshops have been held with our partner organisations since November 2022: - With state-based peer-led PLHIV and PWUD organisations - Ranging from 1-2 hours in duration - Involving 17 peer staff in a diverse range of roles, including: • Executive leadership • Program management/coordination • Communications • Program evaluation • Service delivery
Evaluate evidence	Mar-Nov 2022	As evidence is located and assembled, it is evaluated for its descriptive power and rigour	• As we locate evidence, we are assessing the quality and coding it against a list of all indicators • As we continue building a bank of evidence, we are constantly assessing what evidence best demonstrates the extent to which the indicator is or is not being achieved

Task	Timeline	Description	Progress
Assemble evidence	Jun-Dec 2022	Information assessed to be of satisfactory quality, rigour, and descriptive power is synthesised using a framework synthesis, utilising the W3 Indicators as the framework	• As evidence is assembled, we are assessing: - Where there is evidence of impact or quality that is not reflected by the current W3 Indicator lists, prompting us to return to 'Specify questions' to add or revise the indicator list - When indicators are lacking evidence regarding quality or impact, prompting us to return to 'Locate evidence' or define gaps - Where there is a range of evidence against particular indicators, prompting us to return to 'Evaluate evidence' to identify the strongest evidence
Inform Decisions	Jan-Jun 2023	We will draw on framework synthesis, complemented by thematic synthesis and textual narrative synthesis to generate: • A consolidated evidence base of the impact of peer-led work within Australia's BBV response • Recommendations to support: - Peer organisations to evaluate and demonstrate the full impact of their work - The strategic use of peer insights to inform peer work and policy participation - Funders and policymakers to create enabling environments for peer-led work	This work will begin once we are confident that we have located the majority of the evidence our partners are able to provide.

Locating evidence against the W3 Indicators for peer-led work

To gather evidence relevant to our questions, the LEAD Framework invites us to discover opportunities for generating evidence and to conceptualise evidence as quite broad (8). This aligns well with one of the core purposes of the W3 Framework, which is to help peer-led responses convert organisational knowledge and peer insights into compelling evidence.

Method

The initial project plan and timeline has been significantly altered in the wake of lockdowns and other restrictions related to COVID-19. The COVID-19 pandemic and response disproportionately impacted the communities with which the peer organisations work — and to which their staff belong.

Many of the pressures on our partner organisations significantly impacted their capacity to commit time and resources to a research project and to absorb additional work into their already significant workloads. These challenges are ongoing.

In order to adhere to COVID-19 restrictions and alleviate pressure on our partners, the W3 Project needed to:

- Reconceptualise and redevelop project activities that were initially planned as one-day to multi-day workshops
- Adapt to the changing priorities and capacity of our partner organisations — all community health organisations — in the context of a pandemic

The following provides a short summary of the method we have used so far to locate evidence against the W3 Indicators. As indicated in Table 1, this is an ongoing process.

Preliminary identification of evidence sources

Preliminary identification of potential evidence sources for each indicator began during the process of developing the indicators between February and June 2021 (1). This process utilised a modified Delphi method.

An initial list of potential evidence sources was developed by the W3 Project research team. This list drew from our experiences:

- Developing indicators with our partner organisations during Stage 1 of the W3 Project
- Piloting the W3 Framework with Living Positive Victoria and HRVic in Stage 2 of the W3 Project
- Conducting an evaluation of national peak organisations in the second half of 2020

The list was further refined and built upon by the panel of peer experts involved in the process of developing the W3 Indicators.

The examples of potential evidence sources in the list provided a starting point for organisations to begin thinking about how they may be able to demonstrate achievement of each indicator.

Brainstorming workshops with partner organisations

In November 2021, we conducted a series of meetings with five partner organisations, including three PLHIV-led organisations (six participants) and two PWUD-led organisations (three participants). Participants were from a variety of roles within their organisations, including executive leadership (four participants), program management/coordination (two participants), program evaluation (one participant), and service delivery (two participants).

These meetings were brainstorming sessions that built directly off the lists of potential evidence sources developed at the same time as the W3 Indicators. Both organisation-level and program-level indicators were covered in these sessions.

The purpose of these meetings was to gain an overall sense of the types of information that exist within peer-led organisations. Peer staff were asked to think about the kinds of evidence that might help demonstrate achievement of each indicator, and to indicate the kinds of evidence they:

- Have in a format they can share
- Have in a format that they cannot immediately share (e.g. because it would need to be summarised or collated before being shared)
- Have but cannot share (e.g. due to privacy concerns)
- Do not have

While these meetings were broadly helpful in identifying general categories of evidence, we found that focussing on both organisation-level and program-level indicators during the same session was both difficult and time-consuming.

Evidence identification for organisation-level indicators with partner organisations

A second round of meetings were held in March to April 2022 with available partner organisations, including two PLHIV-led organisations (six participants) and one PWUD-led organisation (four participants). Again, participants were from a variety of roles within their organisations, including executive leadership (one participant), program management/coordination (four participants), communications (two participants), and service delivery (three participants).

These meetings focussed exclusively on the organisation-level indicators and their purpose was to:

- Drill more specifically into what the organisation-level indicators meant

Harnessing peer knowledge

PLHIV-led organisation Positive Life NSW has developed and incorporated a formal process that allows them to harness the knowledge, insights, and observations of their peer workers to generate an evidence base.

Peer workers come from, and are constantly engaging with, their community. This gives them a uniquely nuanced understanding of their community and its members. This understanding helps them:

- Engage deeply and authentically with their community
- Develop rapport with clients and consumers, even if their identity or experiences aren't the same
- Pre-empt and adapt to their community's changing needs
- Predict how changes to the environment the peer response is working in might impact their community
- Understand how (and why) their community might respond to these changes

Peer workers are also often the health sector and policy environment's only source of real-time information about:

- What is happening in communities
- How changes impact communities
- How community members are responding

This reality is central to the unique ability of peer-led organisations not only to work effectively with their communities but also to provide support and policy advice that improve the health sector and policy environment. However, it is often difficult to generate evidence that demonstrates this central role of on-the-ground peer knowledge.

Positive Life NSW's process helps generate this evidence.

Positive Life NSW's community have been intrinsic partners in developing the process. Positive Life NSW attributes its responsive successes on emerging issues in NSW to the evidence generated through this process.

The forms themselves are evidence for several of the W3 Indicators for **adaptation**, including:

- The peer organisation adapts priorities and strategies to the changing needs of its community
- The peer organisation draws on community … insights to improve future work
- The peer organisation draws on community … insights to improve (update and refine) policy advice
- The peer organisation regularly gathers … insights from community and insights from social research, epidemiology, health service usage data, and other sector knowledge
- The peer organisation uses information and insights from engagement … to identify and to guide reorientations and responses to emerging priorities

The process is also strong evidence for the **engagement** indicator: 'Structures, processes, and opportunities are in place to support peer workers to learn from each other's insights and maintain a current overall understanding of their diverse communities'.

Additionally, actions resulting from this process may also be used as evidence of **adaptation**, and any impacts resulting from these actions can provide evidence of **influence**.

to each organisation in the context of their specific work
- Provide more specific prompts to help identify existing evidence

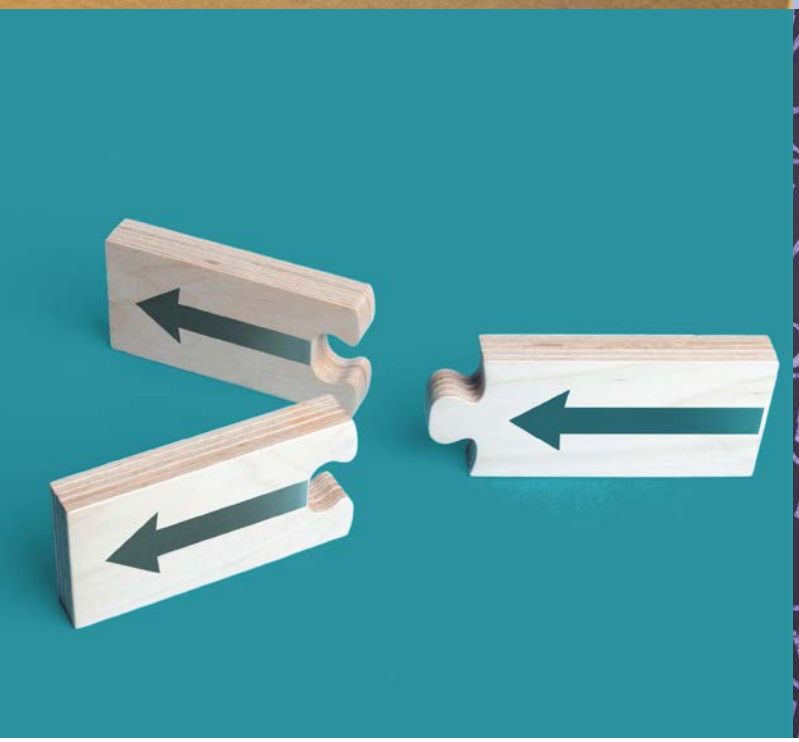
Peer staff were asked to think about:

- What they would need to see happening to be confident they were achieving each indicator
- What they do (or could) count or measure to help show they were achieving each indicator
- Whether they already measure or report on each indicator
- Where they do (or could) get information about each indicator from both internal and external sources

Desktop research to locate evidence

To alleviate some of the pressure on partner organisations, the W3 Project team is undertaking desktop research to help locate potentially relevant existing sources of evidence, including:

- Scans of the information available on partner organisation websites
- PubMed searches for journal articles published between 2018 and 2022 by authors affiliated with partner organisations
- Google searches for partner organisations for content created by other organisations between 2018 and 2022



Types of evidence

In the following sections, we list the types of evidence we have identified that are potentially relevant to the organisation-level W3 Indicators.

These sections provide an overview of the different types of evidence that are emerging so far. They also provide insights into the some of the enablers and barriers to locating evidence within each W3 Function.

The first table outlines the types of data we see emerging overall.

The subsequent tables list the data we see emerging against each of the organisation-level indicators.

Overall evidence types

Type of evidence	Examples	Availability
Originating within the peer organisation		
General communications	• Websites • Blogs • Social media • Media releases • In-house magazines • Factsheets • Webinars • Service brochures	• Publicly available

Reports	• Annual reports
	• Reports to line managers, the board
	• Reports to funders
	• Website and social media analytics reports
	• Summary reports from:
	  - Community consultation activities
	  - Client/member surveys
	  - Internal or external evaluations
		• Some publicly available
		• Some available within organisation; generally shareable or shareable with modification[1] or restrictions[2]

Policy participation publications	• Position statements • Policy papers/submissions • Submissions to Royal Commissions/public inquiries	• Generally publicly available
Guiding documents	• Constitution • Policy documents (policies, procedures, standards, guidelines) • Strategic plans • Strategies and frameworks • Program plans • Templates and forms	• Some publicly available • Some available within organisation; generally shareable or shareable with restriction
Internal records	• Intake data • Attendance records • Phone call/enquiry records • Client/community feedback • Referral information • Correspondence from health sector and policy environment actors • Staff records and board membership • Make up and topics of advisory committees, working groups • Activity plans • Schedules • Meeting minutes • Internal bulletins • Emails • Peer worker notes • Staff performance evaluations and self-reflections	• Available within organisation • If shareable, generally only with modification

1 For example, de-identifying (to protect privacy), collating, summarising, describing, and contextualising the data
2 For example, documents that cannot be made public but that can be shared with the research team under a strict privacy and ethics code

Type of evidence	Examples	Availability
Originating either inside or outside the peer organisation		
Research outputs	• Journal articles • Conference papers/posters/presentations • Research reports	• Generally publicly available
Partnership documents	• Funding contracts • Memorandums of understanding (MOUs) • Signed research project information and consent forms	• Available within organisation, generally only shareable with modification or restrictions
Expert knowledge[1]	• Case examples of: • Specific pieces of work or interactions • Informal/undocumented processes and practices • Observations, perceptions of peer organisation value and impact	• Elicited through interviews with peer organisation staff and sector partners
Originating outside the peer organisation		
General evidence from broader community[2] **and sector partners**	• As for example evidence listed above for: • General communications • Reports (publicly available only) • Policy participation publications	• Publicly available
Health sector and policy environment documents	• National and state public health strategies • Health department reports • Legislation • Policy documents (policies, procedures, standards, guidelines) • Reports from Royal Commissions/public inquiries	• Publicly available

1 Extensive understanding and experience of the peer organisation's communities, systems, processes, activities, and/or impacts
2 Produced, for example, by other peer-led or peer-owned organisations, networks, and businesses; peer leaders; and other individuals from within the peer community

Engagement and influence within the community

Engagement is how the peer organisation or program interacts with, participates in, and learns from its communities.

Community influence is how the peer response promotes change by participating in communities and using peer insights and understanding of the community's existing ways of doing things.

Many of the engagement and community influence W3 Indicators align closely with peer organisations' contracted KPIs, making it easier to locate evidence demonstrating impact. Much of this information is readily available, either publicly (organisations' websites and annual reports) or internally (e.g. evaluation reports and reports to funders).

However, other W3 Indicators for these functions focus more on the unique way peer organisations gain knowledge through the peer insights and lived experience of their peer workers (see the peer work case example on page 9).

It is more difficult to locate existing evidence about these indicators, as these processes are often:

- Organic or informal
- Less well recognised by funders as relevant and therefore not included among contracted KPIs (traditionally, any processes occurring outside the immediate activities of a program are considered as 'confounding factors')

The following tables provide a summary of the types of indicators emerging against the organisation-level W3 Indicators for engagement and community influence.

Evidence types that demonstrate engagement

For examples of the evidence types written in bold, refer to the table of overall evidence types on pages 11-12.

#	W3 Indicator	Commonly identified evidence types
Quality/process indicators		
ENQ1	The diversity of community members[1] that access and/or engage with the peer organisation reflects the diversity within the peer organisation's target community group(s).	Evidence for the diversity of community members accessing/engaging with the peer organisation: • Summaries of demographic information (e.g. from **reports**, **internal records**) about community members who, for example: - Access services and attend events - Participate in community consultation activities (e.g. community forums, surveys, outreach) - Contact the peer organisation with enquiries or feedback - Subscribe or contribute to communications (e.g. blogs, in-house magazines) - Are peer organisation staff, volunteers, board members, or on advisory bodies or working groups Evidence for the peer organisation's target community group(s): • Statements (e.g. from **guiding documents**, **partnership documents**) identifying target community groups Evidence for the diversity within the peer organisation's target community group(s): • Descriptions (e.g. from **research outputs**, **health sector and policy environment documents**) of demographics within target community groups
ENQ2	The peer organisation identifies, engages, and responds accordingly to community members who are less able to participate in consultation.	Evidence for identifying and engaging: • **Guiding documents**, **internal records**, and **expert knowledge** that describe or support relevant structures, strategies, processes, or practices (e.g. community engagement strategies) • Examples (e.g. from **reports**, **internal records**) of community consultation activities (e.g. community forums, surveys, outreach) • Examples (e.g. from **internal records**, **partnership documents**) of collaborations with peer/community organisations representing other communities Evidence for responding accordingly: • **General communications**, **guiding documents**, and **internal records** that demonstrate diversifying ways of engaging with communities (e.g. services or resources are multilingual, culturally appropriate, online, available after hours, accessible for people with disability) • Examples of outputs (e.g. **general communications**, **reports**, **policy participation publications**, **guiding documents**) generated in response to information emerging from community consultation activities (e.g. community forums, surveys, outreach) • Summaries of demographic information (from **ENQ1** 'The diversity of community members that access and/or engage with the peer organisation reflects the diversity within the peer organisation's target community group(s)') demonstrating increasing or changing diversity
ENQ3	Structures, processes, and opportunities are in place to support peer workers to learn from each other's insights and maintain a current overall understanding of their diverse communities.	• **Guiding documents**, **internal records**, and **expert knowledge** that describe or support relevant structures, strategies, processes, or practices, for example: - Support and supervision frameworks - Peer workforce strategies - Relevant team meetings, learning forums, workshops, and in-services • Examples (e.g. from **reports**, **internal records**) of the peer organisation supporting peer staff to participate in relevant activities (e.g. conferences, seminars, webinars)

1 Wording changed from 'clients' to 'community members' to better reflect the diversity of ways community members engage with peer organisations

#	W3 Indicator	Commonly identified evidence types
Impact indicators		
ENI1	Community members recognise the organisation as peer-led and as an important part of and resource to their community.	• Summaries of information (e.g. from **reports**, **internal records**) describing trends in the: - Number, diversity of community members who: • Are members of the peer organisation (if applicable) • Access services and attend events • Participate in the peer organisation's community consultation activities (e.g. community forums, surveys, outreach) • Subscribe or contribute to the peer organisation's regular publications (e.g. blogs, in-house magazines) • Contact the peer organisation with enquiries or feedback - Number, percentage, diversity of: • The peer organisation's activities (for community members) that are generally booked out/at capacity • Participants in ongoing or recurring activities (e.g. multi-session workshops, regular social groups, annual events) who participate on an ongoing or recurring basis • New clients/members who were self-referred or referred by community members • Board members, staff, and volunteers who are peers • Applicants to advertised positions who are peers - Themes, topics, mood in: • Social media and website engagement • Community feedback • Examples (e.g. from **reports**, **internal records**, **expert knowledge**) of: - Sustained, meaningful involvement of the peer organisation within its community over time - New sector partners engaging with the peer organisation after learning about it from community members - Community members engaging with the peer organisation because it is peer led - Community members referring other community members to the peer organisation because is peer led
ENI2	Policy advice and peer leadership is based on current community needs and experience.	• **Guiding documents**, **internal records**, and **expert knowledge** that describe or support relevant structures, strategies, processes, or practices, for example: - Policy advice templates - Community consultation processes - Processes for collecting information from peer workers about their insights and observations • Examples (e.g. from **reports**, **internal records**, **expert knowledge**) of actions taken in response to emerging community needs, for example: - Establishing new advisory bodies and working groups - Conducting community consultation activities (e.g. community forums, surveys, outreach) - Email threads demonstrating development of policy advice • Examples of outputs (e.g. **general communications**, **reports**, **policy participation documents**, **guiding documents**) generated or adapted in response to community consultations or emerging community needs
ENI3	Relationships with different community members and networks are built or strengthened as a result of the peer organisation's activities.	• Summaries of evidence from **ENI1** ' Community members recognise the organisation as peer-led and as an important part of and resource to their community' demonstrating: - Sustained or increased number, percentage, diversity (where relevant) - Sustained or increasingly positive or diverse community feedback and social media and website engagement • Summaries of information (e.g. from **reports**, **internal records**, **partnership documents**) demonstrating sustained or increasing number, diversity of: - Collaborative relationships with peer/community organisations from different community groups - Activities run and resources produced in partnership with other peer/community organisations - New community members engaging with the peer organisation as a result of its partnerships with other peer/community organisations

Evidence types that demonstrate community influence

For examples of the evidence types written in bold, refer to the table of overall evidence types on pages 11-12.

#	W3 Indicator	Commonly identified evidence types
Quality/process indicators		
CIQ1	The peer organisation has a strong profile within its community and is endorsed by peer networks (including both online and offline).	• Examples (e.g. from **general evidence from broader community**) of the community sharing, disseminating, and adapting the peer organisation's work • **Policy participation documents** that are: - Jointly authored by the peer organisation and other organisations from within the peer organisation's communities - Authored by the peer organisation and endorsed by other organisations from within the peer organisation's communities - Authored by other organisations from within the peer organisation's communities and endorsed by the peer organisation • Plus evidence from: - **ENI1** ' Community members recognise the organisation as peer-led and as an important part of and resource to their community' - **ENI3** 'Relationships with different community members and networks are built or strengthened as a result of the peer organisation's activities'
CIQ2	The community is aware of and supports the policy advice and participation of the peer organisation.	• Summaries of information (e.g. from **reports**, **internal records**) describing trends in: - The number, diversity of community members who, for example: • Engage with the peer organisation's community consultation activities (e.g. community forums, surveys, outreach) • Participate in relevant advisory bodies or working groups chaired by the peer organisation • Engage with topical social media posts • Provide feedback about the peer organisation's policy advice and participation - Community feedback about the peer organisation's policy advice and participation, for example the: • Percentage of feedback that is positive • Number, percentage, diversity of pieces of policy advice/instances of policy participation about which the community provides feedback • **Guiding documents**, **internal records**, and **expert knowledge** that describe or support relevant structures, strategies, processes, or practices (e.g. media release templates) • **Policy participation documents** jointly authored with, or endorsed by, other organisations from within the peer organisation's communities • Examples (e.g. from **general evidence from broader community**) of the community sharing and disseminating the peer organisation's policy participation documents
CIQ3	The peer organisation receives increasing referrals from community members (including those who are not current or former clients).	• Summaries of information (e.g. from **internal records**) describing trends in the: - Number, percentage, diversity of new clients/members who were referred by community members - Number, diversity of people bringing their friends to activities (e.g. forums, social groups)
CIQ4	The organisation supports peer leaders to build their confidence, skill and experience in community and personal advocacy.	• **Guiding documents**, **internal records**, and **expert knowledge** that describe or support relevant structures, strategies, processes, or practices, for example: - Leadership training provided to peer board members - Peer facilitator training provided to community members - The peer organisation facilitating participation and involvement by community members on advisory bodies or working groups - Peer speaker and peer leadership development programs • Summaries of information (e.g. from **reports**, **internal records**, **expert knowledge**) demonstrating that peer leaders have built their confidence etc. with the peer organisation's support

#	W3 Indicator	Commonly identified evidence types
Impact indicators		
CII1	Coordinated peer leadership results in a strong collective community voice that contributes to policy recognition of diverse needs and experiences within the community.	Evidence for coordinated peer leadership and strong collective community voice: • **Policy participation documents**: - Jointly authored by the peer organisation and other organisations from within the peer organisation's communities - Authored by the peer organisation and endorsed by other organisations from within the peer organisation's communities - Authored by other organisations from within the peer organisation's communities and endorsed by the peer organisation • Summaries of information (e.g. from **policy participation documents**, **internal records**) describing trends in the number, diversity of: - Pieces and types of policy participation - Topics and issues - Organisations/bodies for whom the policy advice is intended • Summaries of information (e.g. from **internal records**) demonstrating growth of demand from mainstream/non-peer organisations for peer-led education programs Evidence for contribution to policy recognition of diverse needs and experiences within the community: • **Health sector and policy environment documents** that: - Reference or acknowledge the peer organisation's input - Incorporate the peer organisation's advice
CII2	The peer organisation's engagement activities are achieving its stated impact goals (e.g. increased client knowledge; informed health management, treatment, or harm reduction decisions; improved client quality of life).	Evidence for stated impact goals: • Statements (e.g. from **reports**, **guiding documents**, **internal records**, **partnership documents**) defining the peer organisation's impact goals Evidence for achieving stated impact goals: • Summaries of information demonstrating the impact of the peer organisation's engagement activities (e.g. from **reports**, **internal records**, **expert knowledge**)
CII3	Community-level research indicates a trend of improvements in priority health-related outcomes (e.g. quality of life, resilience, health behaviours, knowledge, behaviour etc.).	Evidence for priority health-related outcomes: • Statements (e.g. from **guiding documents**, **partnership documents**, **health sector and policy environment documents**) defining priority health-related outcomes Evidence for trends indicated in community-level research: • Summaries of information (e.g. from **research outputs**, **health sector and policy environment documents**) describing trends in priority health-related outcomes

Alignment and influence within the health sector and policy environment

Alignment is about how the peer organisation or program interacts with, partners with, and learns from the broader health sector and policy environment.

Health sector and policy environment influence is how the program achieves or mobilises influence on processes and outcomes within this system.

Indicators within these functions are about sector partnerships and policy participation. How well organisations' contracted KPIs align with indicators within these W3 Functions depends largely on their funding environment. Some organisations may have KPIs around some kinds of sector partnerships.

Some funders, however, explicitly prohibit organisations from participating in 'advocacy' activities, which the W3 Framework has identified as an extremely important part of the overall role of peer organisations. If communities do not see their peer organisations advocating on their behalf, communities lose faith in the peer organisations' work, leading to decreased engagement and community influence.

Due to the nature of sector partnerships and policy participation, there is a large body of existing evidence in these areas, such as examples of:

- Partnerships or of the sector valuing peer organisation input (e.g. MOUs, listing of the peer organisation as a key partner in national and state BBV strategies)
- Peer programs embedded in mainstream services (e.g. PLHIV peer navigation)
- Policy participation (e.g. submissions to Royal Commissions and inquiries, joint statements)
- Impact of policy participation (e.g. reports from Royal Commissions that reference peer organisation submissions)

The following tables provide a summary of the types of indicators emerging against the organisation-level W3 Indicators for alignment and health sector and policy environment influence.

Evidence types that demonstrate alignment

For examples of the evidence types written in bold, refer to the table of overall evidence types on pages 11-12.

#	W3 Indicator	Commonly identified evidence types
Quality/process indicators		
ALQ1	The peer organisation actively seeks to create partnerships with stakeholders across the health sector and other relevant sectors, particularly at the senior management level.	Evidence for actively seeking to create partnerships: • **Guiding documents**, **internal records**, and **expert knowledge** that describe or support relevant structures, strategies, processes, or practices, for example: - Stakeholder management plans - MOU templates - Templates of presentations for promoting the peer organisation to potential partners • Examples (e.g. from **internal records**, **expert knowledge**) of the peer organisation actively seeking to create partnerships (e.g. approaching potential partner organisations and inviting cooperation, setting up/chairing working groups) Evidence for creating partnerships: • **Partnership documents** • **General communications**, **reports**, and **research outputs** co-authored by the peer organisation and other organisations • Examples (e.g. from **reports**, **internal records**, **expert knowledge**) of: - Informal collaborations - Activities co-produced/co-hosted by the peer organisation and other organisations • Summaries of information (e.g. from **reports**, **internal records**, **partnership documents**) describing trends in the number, diversity of: - Ongoing and new partnerships - Partner organisations and partner organisation types - Partnership types - Sectors within which the peer organisation has partnerships Evidence for creating partnerships at the senior management level: • **Partnership documents** signed by senior management
ALQ2	The peer organisation collaborates with beneficial and relevant research and policy initiatives.	• **Research outputs** authored by peer organisation staff • **Research outputs** and **health sector and policy environment documents** that reference or acknowledge the peer organisation's contribution • **Policy participation publications** • Examples (e.g. from **general communications**, **internal records**, **partnership documents**) of: - Research on which peer organisation staff are investigators - Research for which peer organisation staff are on advisory bodies or working groups - Setting up/chairing advisory bodies or working groups to develop policy advice - Promoting opportunities to community members to be involved in research - Being involved in developing state and national public health strategies - Undertaking additional policy participation (e.g. in round tables, forums) • Summaries of information (e.g. from **reports**, **policy participation publications**, **internal records**, **research outputs**, **partnership documents**, **health sector and policy environment documents**) describing trends in the number, percentage, diversity of: - Research projects that are currently researching peer communities and with which the peer organisation is collaborating - Relevant policy initiatives with which the peer organisation collaborated/is collaborating - Relevant strategies to which the peer organisation contributed or in which the peer organisation is acknowledged or listed as a partner

#	W3 Indicator	Commonly identified evidence types
Quality/process indicators continued		
ALQ3	The peer organisation actively communicates with sector partners to improve each other's understanding of emerging issues and practices, how these might impact communities, and how best to respond.	• **Guiding documents**, **internal records**, and **expert knowledge** that describe or support relevant structures, strategies, processes, or practices (e.g. stakeholders management plans) • Examples (e.g. from **general communications**, **reports**, **internal records**) of active communication, for example: - Regular communications with sector partners (e.g. through emails, meetings, newsletters) - Setting up, chairing, or contributing to advisory bodies, working groups, advocacy groups, and communities of practice - Programs or activities run for the purpose of sharing information between the peer organisation and sector partner staff (e.g. in-services, peer-delivered education or information sessions for non-peer/mainstream audiences) - Peer organisation staff holding teaching positions or delivering guest lectures at higher education institutes • Summaries of information (e.g. from **internal records**) describing trends in the number, diversity of: - Information-sharing activities run by sector partner organisations and attended by peer organisation staff - Information-sharing activities run by the peer organisation and attended by sector partner staff - Peer organisation and sector partner staff participating in information-sharing activities
ALQ4	The peer organisation actively seeks out opportunities for policy contributions and advocates for creating safer and effective ways for community members to participate in the health and policy sector's response.	Evidence for actively seeking out opportunities for policy contributions: • **Guiding documents**, **internal records**, and **expert knowledge** that describe or support relevant structures, strategies, processes, or practices (e.g. policy participation strategies) • Examples (e.g. from **internal records**, **expert knowledge**) of unsolicited policy participation (e.g. developing submissions to Royal Commissions without being invited to do so, proactively contacting organisations with concerns about existing policies and guidelines) Evidence for advocating for creating safer and effective ways for community members to participate: • Summaries of information about relevant advocacy (e.g. from **internal records**, **policy participation documents**) describing trends in the number, diversity: - Pieces and types of advocacy - Topics and issues - Organisations/bodies for whom the policy advice is intended • Summaries of information (e.g. from **general communications**, **reports**, **internal records**) demonstrating that the peer organisation has facilitated safe, effective community participation, for example through: - Ensuring that research processes are safe and appropriate through direct involvement in research (e.g. as investigators or on advisory bodies or working groups) - Promoting safe opportunities for community members to be involved in research - Creating safe spaces for direct policy participation by community members (e.g. community forums)

#	W3 Indicator	Commonly identified evidence types
Impact indicators		
ALI1	The peer organisation is informed about changes within the health sector and policy environment and assesses how they might affect its communities and/or its work.	• Summaries of information (e.g. from **general communications**, **reports**, **internal records**, **expert knowledge**) demonstrating the peer organisation's awareness of changes, and outlining assessment of their potential effects • Examples of outputs (e.g. **general communications**, **reports**, **guiding documents**, **policy participation documents**) generated or adapted in response to changes within the health sector and policy environment
ALI2	Key players from the broader health sector and policy environment recognise the peer organisation as credible, trustworthy and an essential partner in the overall public health response.	• Examples (e.g. from **internal records**, **partnership documents**) of formal and informal collaborative partnerships • **Health sector and policy environment documents**: - On which peer organisation staff are co-authors - That reference or acknowledge the peer organisation • Summaries of relevant stakeholder feedback (e.g. from **internal records**, **expert knowledge**) describing trends in feedback topics and mood • Examples (e.g. from **general evidence from sector partners**, **health sector and policy environment documents**) of key players: - Acknowledging the peer organisation's expertise - Sharing, disseminating, and adapting the peer organisation's work • Summaries of information (e.g. from **general communications**, **internal records, partnership documents**, **general evidence from sector partners**) describing trends in the number, diversity of: - Research projects on which peer organisation staff are investigators - Research projects for which peer organisation staff are on advisory bodies or working groups - Activities co-hosted by the peer organisation and key players - Resources co-produced by the peer organisation and key players - Referrals and feedback from key players • Funding contracts with key players - Information-sharing activities (e.g. communities of practice, information workshops, in-services) run by the peer organisation, with which key players engage - Key players engaging with information-sharing structures/activities run by the peer organisation - Contributions by key players to relevant publications (e.g. blogs) • Plus evidence from **ALI3** 'Key players from the broader health sector and policy environment seek advice and contributions from the peer organisation'
ALI3	Key players from the broader health sector and policy environment seek advice and contributions from the peer organisation.	• Examples (e.g. from **internal records**, **expert knowledge**) of invitations/requests to the peer organisation from key players to: - Develop policy submissions - Deliver information/education to their staff - Be involved in research (as investigators or on advisory bodies or working groups) - Participate in advisory bodies or working groups - Comment on, provide feedback on, or endorse documents • Summaries of information (about the above examples) describing trends in the number, diversity of: - Invitations/requests - Key players inviting or making requests - Topics and issues

Evidence types that demonstrate health sector and policy environment influence

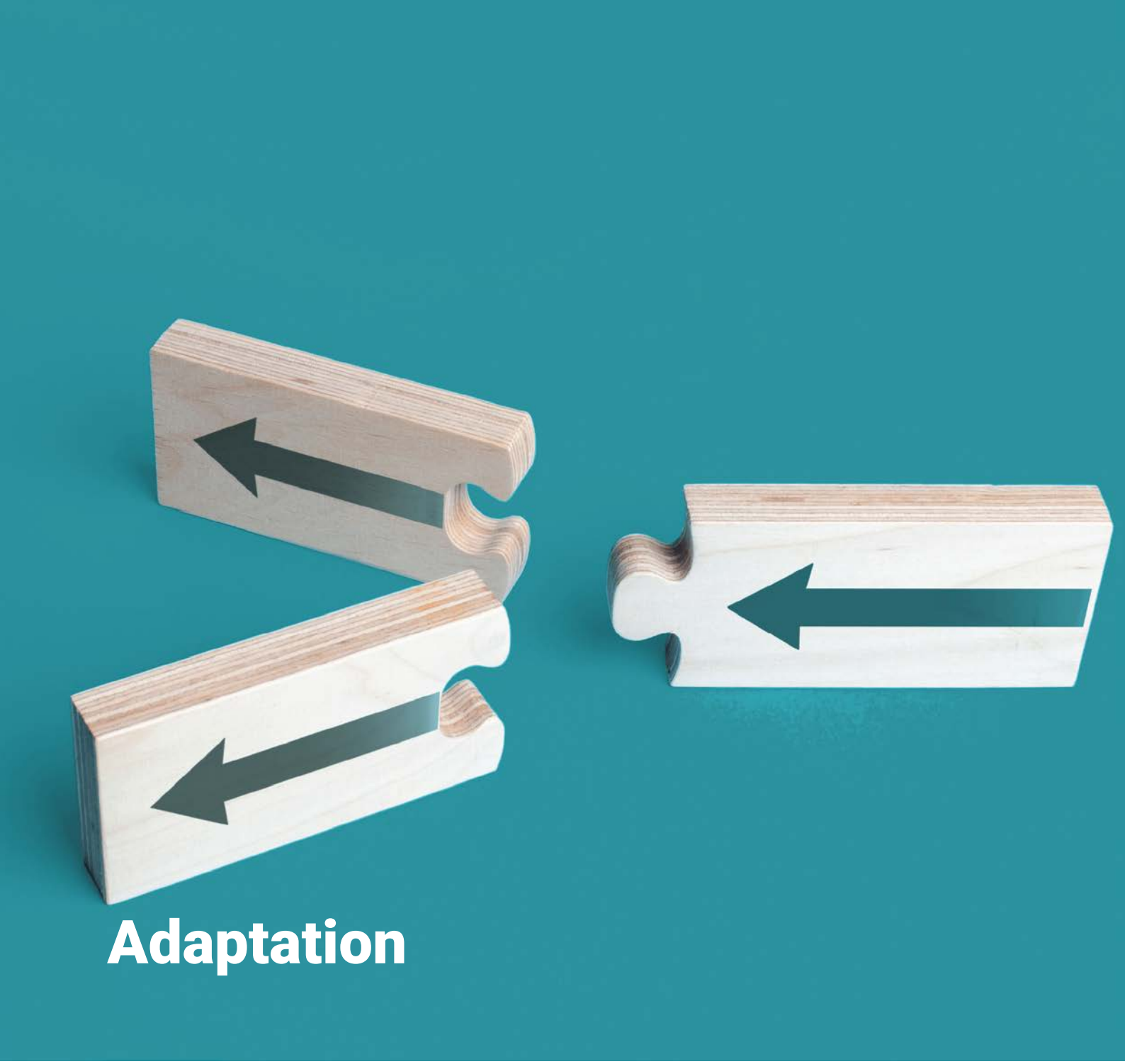
For examples of the evidence types written in bold, refer to the table of overall evidence types on pages 11-12.

#	W3 Indicator	Commonly identified evidence types
Quality/process indicators		
PIQ1	The peer organisation can demonstrate outcomes of policy advice and participation and achieve buy-in from stakeholders to advance community needs.	• **Health sector and policy environment documents** that: - Reference or acknowledge the peer organisation's input - Incorporate the peer organisation's advice • Examples (e.g. from **internal records**, **expert knowledge**) of times the sector followed up with the peer organisation regarding their policy advice and participation (e.g. invitations to attend forums on the basis of submitted policy participation publications)
PIQ2	Policy advice is ready when needed and peer leadership is responsive to opportunities for policy participation.	• **Policy participation publications** • Summaries of information about strategically important policy participation opportunities (e.g. from **internal records**, **policy participation publications**) describing the number, percentage, diversity of opportunities that were taken
PIQ3	The peer organisation translates the needs/ experiences from the community into different languages used in policymaking.	• Final outputs of **ENI2** 'Policy advice and peer leadership is based on current community needs and experience' (e.g. **general communications**, **policy participation publications**) for mainstream/non-peer audiences
PIQ4	The peer organisation maintains control over the use and interpretation of the information they share with external stakeholders, and advocates for appropriate privacy and data usage policies to protect their communities (data sovereignty).[1]	• **Guiding documents**, **internal records**, and **expert knowledge** that describe or support relevant structures, strategies, processes, or practices (e.g. privacy policies) • **General communications** for community members about protecting their own data • **General communications** for mainstream/non-peer audiences and **policy participation publications** related to ethical use of community member data

1 Indicator amended to close identified gap and to better reflect the full breadth of work undertaken by peer organisations related to data sovereignty

#	W3 Indicator	Commonly identified evidence types
Impact indicators		
PII1	The contribution of peer leadership in consumer representation and policy advocacy is recognised and sought out.	Evidence that the contribution is recognised: • **Health sector and policy environment documents**, for example: - That reference or acknowledge the peer organisation - On which peer organisation staff are co-authors • Summaries of relevant stakeholder feedback (e.g. from **internal records**, **expert knowledge**) describing trends in topics and mood Evidence that the contribution is sought out: • Same evidence sources as for **ALI3** 'Key players from the broader health sector and policy environment seek advice and contributions from the peer organisation'
PII2	Insights from the peer organisation are recognised as current and useful.	• Same evidence sources as for: - **ALI2** 'Key players from the broader health sector and policy environment recognise the peer organisation as credible, trustworthy and an essential partner in the overall public health response' - **PII1** 'The contribution of peer leadership in consumer representation and policy advocacy is recognised and sought out'
PII3	Policy, media, and funding environments support (or do not impede) innovative and culturally relevant approaches to community health.	• Examples (e.g. from **reports**, **internal records**, **expert knowledge**) of successfully implemented innovative and culturally relevant approaches to community health • Summaries of information (e.g. from **reports**, **internal records**, **partnership documents**) describing trends in the: - Number, percentage, diversity of: • Funding contracts that do not restrict advocacy or censor health promotion messaging • Funding contracts that incorporate KPIs reflecting the peer organisation's key priorities • Campaign ideas and plans that were successfully implemented within the existing policy, media, and funding environments • Innovative and culturally relevant approaches to community health that were funded or co-developed by non-community sector partners
PII4	The peer organisation's partnerships and policy advice have influenced positive change in the health sector and policy environment.[1]	• **Health sector and policy environment documents** that: - Reference or acknowledge the peer organisation's input - Incorporate the peer organisation's advice • Summaries of information about mainstream services and policy partners that the peer organisation has worked with (e.g. from **reports**, **internal records**, **expert knowledge**, **evidence from the broader community and sector partners**) describing trends in: - Service safety, equity, appropriateness, and accessibility - Service provider and policymaker understanding of the peer community and its needs - Levels of stigma/discrimination experienced by community members from mainstream service providers and policymakers

1 New indicator added to close identified gap and to accommodate located evidence that did not fit well against other indicators



Adaptation

Adaptation is about how the peer organisation or program changes the way it works to suit its changing environment.

These indicators are all about process: the way the organisation learns from engagement and alignment, and uses this knowledge to adapt the way it works to continue having strong impact.

These processes are often organic and can happen rapidly in times of change and crisis. As such, they are not necessarily documented well or documented at all.

Evidence of adaptation most frequently emerges through narratives of processes or pieces of work (e.g. the peer work case example on page 9). However, evidence can be found by looking at things like social media and website/blog activity. For example, almost immediately when the COVID-19 pandemic arrived in Australia, peer organisations' websites and social media pivoted to providing a wealth of information about COVID-19 risks, protective behaviours, and the constantly changing restrictions and recommendations. This new information was all targeted specifically to the unique needs of their communities.

The following table provides a summary of the types of evidence we have located against the organisation-level W3 Indicators for adaptation.

Evidence types that demonstrate adaptation

For examples of the evidence types written in bold, refer to the table of overall evidence types on pages 11-12.

#	W3 Indicator	Commonly identified evidence types
Quality/process indicators		
ADQ1	The peer organisation regularly gathers feedback and evaluation results from peer service participants and insights from community (engagement) and insights from social research, epidemiology, health service usage data, and other sector knowledge (alignment).	• Summaries (of the evidence below) describing the: - Range of information gathered - Range of information sources - Range of information-gathering activities - Frequency of information-gathering activities • Evidence to include: - **Guiding documents**, **internal records**, and **expert knowledge** that describe or support relevant structures, strategies, processes, or practices, for example: • Evaluation frameworks and schedules • Summaries of staff subscriptions to relevant mailing lists, newsletters, and research updates • Pathways available for peer workers to report/discuss what they are seeing, hearing, learning, and doing - Evidence from **ENQ2** 'The peer organisation identifies, engages, and responds accordingly to community members who are less able to participate in consultation' - Evidence from **ENQ3** 'Structures, processes, and opportunities are in place to support peer workers to learn from each other's insights and maintain a current overall understanding of their diverse communities' - Evidence from **ALQ2** 'The peer organisation collaborates with beneficial and relevant research and policy initiatives' - Evidence from **ALQ3** 'The peer organisation actively communicates with sector partners to improve each other's understanding of emerging issues and practices, how these might impact communities, and how best to respond'
ADQ2	The peer organisation uses information and insights from engagement and alignment to identify and to guide reorientations and responses to emerging priorities.	• Summaries (drawing upon the evidence below, **internal records**, and **expert knowledge**) describing the decision-making and planning processes used to identify and guide reorientations and responses to emerging priorities • Draw upon evidence from: - **ENI2** 'Policy advice and peer leadership is based on current community needs and experience' - **ALI1** 'The peer organisation is informed about changes within the health sector and policy environment and assesses how they might affect its communities and/or its work' - **ADQ1** 'The peer organisation regularly gathers feedback and evaluation results from peer service participants and insights from community (engagement) and insights from social research, epidemiology, health service usage data, and other sector knowledge (alignment)'
ADQ3	The peer organisation's practices are guided by peer knowledge and insights.	• **Guiding documents**, **internal records**, and **expert knowledge** that describe or support relevant structures, strategies, processes, or practices, for example: - Mission and value statements explicitly valuing peer input - Policies relating to peer positions on boards of directors, advisory bodies, or working groups - Job description templates with statements explicitly encouraging peers to apply • Summaries of staff or board member demographics (e.g. from **internal records**) demonstrating that the majority of leadership roles are filled by peers

#	W3 Indicator	Commonly identified evidence types
Quality/process indicators continued		
ADQ4	The peer organisation draws on engagement with membership and partnerships with the sector to develop evidence-based positions.	• Summaries (drawing upon the evidence below, **internal records**, and **expert knowledge**) describing the decision-making and planning processes used to develop evidence-based positions • Draw upon evidence from: - **ENI2** 'Policy advice and peer leadership is based on current community needs and experience' - **ALI1** 'The peer organisation is informed about changes within the health sector and policy environment and assesses how they might affect its communities and/or its work' - **ADQ1** 'The peer organisation regularly gathers feedback and evaluation results from peer service participants and insights from community (engagement) and insights from social research, epidemiology, health service usage data, and other sector knowledge (alignment)'
ADQ5	The peer organisation supports staff to acquire skills in peer leadership, evaluation, and policy participation.	• **Guiding documents**, **internal records**, and **expert knowledge** that describe or support relevant structures, strategies, processes, or practices, for example: - Support and supervision frameworks - Peer workforce strategies - The peer organisation providing relevant opportunities (e.g. training, in-services, mentoring, external supervision) - The peer organisation supporting its staff (e.g. through monetary support, flexible hours or leave to study or sit exams) to participate in additional learning activities • Summaries of information about staff participation in relevant activities (e.g. from **reports**, **internal records**) describing trends in the: - Number, percentage, diversity of staff - Number, diversity of activity types and learning topics

#	W3 Indicator	Commonly identified evidence types
Impact indicators		
ADI1	The peer organisation adapts priorities and strategies to the changing needs of its community.	• Summaries of information (e.g. from **general communications**, **guiding documents**, **internal records**, **expert knowledge**) describing: - Changing community needs that led to adaptations by the peer organisation - Priorities and strategies that were adapted in response to changing community needs - The evidence-gathering, decision-making, and planning processes that underpinned the adaptations - Trends in the number, percentage, diversity of changes in community needs to which the peer organisation adapted its priorities and strategies • Plus evidence from **ENI2** 'Policy advice and peer leadership is based on current community needs and experience'
ADI2	The peer organisation draws on community and sector insights to improve future work.	• **Guiding documents**, **internal records**, and **expert knowledge** that describe or support relevant structures, strategies, processes, or practices (e.g. quality improvement frameworks) • Summaries of information about past improvements (e.g. from **guiding documents**, **internal records**, **expert knowledge**) describing the: - Improvements made - Evidence-gathering, decision-making, and planning processes that underpinned the improvements
ADI3	The peer organisation draws on community and sector insights to improve (update and refine) policy advice.	• Summaries of information about pieces of improved policy advice (e.g. from **policy participation publications**, **internal records**, **expert knowledge**) describing the: - Improvements made - Evidence-gathering, decision-making, and planning processes that underpinned the improvements
ADI4	The peer organisation translates research and community insights into accessible language and practical policy and program advice.	• Summaries of information about knowledge translation and policy and program advice (e.g. from **general communications**, **reports**, **policy participation publications**, **internal records**, **expert knowledge**) describing the: - Information that was 'translated' - Processes underpinning the translation of the information - Number, percentage, diversity of available documents/resources for: • Community members that are in easy-to-understand English, or that are available in languages other than English • Health sector and policy environment actors that provide practical policy or program advice
ADI5	The peer organisation assesses and synthesises diverse views of the community and leads advocates on key priorities for the broader public health response.	• Summaries of policy participation and advocacy led by the peer organisation (e.g. from **general communications**, **reports**, **policy participation documents**, **internal records**) describing the: - Information that was synthesised - Decision-making and planning processes underpinning the identification of key priorities and how to lead advocates - Number, diversity of: • Key priorities • Fellow advocates

Enablers and barriers to locating evidence

Throughout the process of locating evidence, we have regularly found that organisations were confident they were achieving an indicator, and could articulate examples, but struggled to identify evidence that would demonstrate this achievement.

We have noticed some recurring structural and environmental enablers and barriers to organisations' ability to locate this evidence.

The following tables provide an overview of the factors we have identified that help or hinder the location or generation of evidence that relate to the:

- Organisation's funding and policy environment
- Organisation itself
- Methods we use to help locate evidence

Enablers

Enabler	Reason(s)
Funding and policy environment–related enablers	
Funders that value policy participation and input from peer organisations	• Peer organisations are more likely to have strong alignment and health sector and policy influence
National and state strategies recognise community development and leadership roles of peer organisations	• Peer organisations are more likely to have the freedom to define and report on their own priorities and indicators (e.g. quality of life, community development, and policy participation and reform)
Organisation-related enablers	
Existence of formal processes for capturing peer insights	• Formal processes facilitate the generation of evidence that peer organisations are learning from their communities and turning this knowledge into positive impacts (see peer work case example on page 9)
Evidence location process–related enablers	
Working through narratives	• As peer workers describe pieces of work that demonstrate impact, potential sources of evidence emerge
Reminding staff that they should focus on what they are achieving	• Peer workers often want to make major change for communities; they don't always recognise the shorter-term impact they are achieving • Peer organisations have a strong ethos of consultation and meaningfully involving their communities in their decisions, and they don't always recognise the strength and value of the peer insights and knowledge of peer workers and networks they interact with on a daily basis; for example: - One piece of work was initially not recognised as 'policy advice and peer leadership being based on current community needs and experiences' because there had been no time for community consultation prior to preparing a submission - In fact, it was an example of how the peer organisation, staffed with peers, could rapidly develop a submission based on the peer insights and expertise that stemmed directly from their extensive work and lived experience within their communities

Barriers

Barrier	Reason(s)
Funding and policy environment–related barriers	
Funder focus on own goals and priorities (to detriment of organisation's goals and priorities)	• Limits the scope of the KPIs that organisations can collect information about and report on • Through limiting resources for evaluation, funders can actively prevent peer organisations from collecting information about their impact on priorities that are important to their communities
Funding of discrete projects rather than organisations	As above, plus: • Minimises evidence for the impacts of organisation-level work, including policy participation • Minimises evidence for the overall impact that a collection of projects has on both community wellbeing and the organisation's sector partner
Funder focus on individual-level impacts	As above, plus: • Minimises evidence for community-level impacts and impacts on the health sector and policy environment
Criminalisation of target populations	• People from communities who are criminalised (e.g. PWUD) are less likely to feel comfortable volunteering identifying information about themselves • Organisations that work with these communities can find it harder to generate evidence that demonstrates reach and client diversity
Organisation-related barriers	
Existence of informal processes	• Informal processes do not leave a 'paper trail', making it difficult to demonstrate impact
Staff turnover	• Because peer organisations are often very small, departing staff often take huge amounts of organisational knowledge with them
Evidence location process–related barriers	
Process is time-consuming	• Organisations have limited capacity to absorb additional work into their already significant workloads
The indicators were built from a system	• Because the W3 Framework is a system-informed framework, the W3 Functions interact with each other, meaning the indicators also interact with each other • Often a single piece of work or process is demonstrative of several indicators (see peer work case example on page 9) - This can make it difficult to tease out which indicator(s) evidence is best demonstrating - Descriptions of pieces of work can be difficult to frame as 'evidence'

Where to next?

The W3 Project will continue working with our partner organisations to collect and consolidate evidence across Australian peer-led organisations and programs working in HIV and hepatitis C.

Together we will:

- Finalise locating, evaluating, and assembling evidence against the organisation-level indicators
- Locate, evaluate, and assemble evidence against the program-level indicators for selected peer-led programs
- Synthesise the available evidence to inform decisions and provide recommendations

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La Trobe University proudly acknowledges the Traditional Custodians of the lands where its campuses are located in Victoria and New South Wales. We recognise that Indigenous Australians have an ongoing connection to the land and value their unique contribution, both to the University and the wider Australian society.

La Trobe University is committed to providing opportunities for Aboriginal and Torres Strait Islander people, both as individuals and communities, through teaching and learning, research and community partnerships across all of our campuses.

The wedge-tailed eagle (*Aquila audax*) is one of the world's largest.

The Wurundjeri people – traditional owners of the land where ARCSHS is located and where our work is conducted – know the wedge-tailed eagle as Bunjil, the creator spirit of the Kulin Nations.

There is a special synergy between Bunjil and the La Trobe logo of an eagle. The symbolism and significance for both La Trobe and for Aboriginal people challenges us all to 'gamagoen yarrbat' – to soar.

Contact

ARCSHS
Australian Research Centre
in Sex, Health and Society
Building NR6
Bundoora VIC 3086
Australia

General enquiries
T +61 3 9479 8700
E arcshs@latrobe.edu.au

latrobe.edu.au/arcshs

facebook.com/latrobe.arcshs
twitter.com/LTU_Sex_Health