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What Works and Why (W3) Project

GMSM Peer Network Targeted Health Promotion System Logic and Draft Indicators

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Table of Contents

Introduction

This document provides a detailed description of the gay men and other men who have sex with men (GMSM) Peer Network Targeted Health Promotion System Logic and Draft Indicators developed in stage 1 of the What Works and Why (W3) Project. This work draws on a series of workshops conducted in 2014 with the Victorian AIDs Council (VAC), and supplemented by discussions with Australian Federation of AIDS Organisations (AFAO).

This document should be read in conjunction with

> Graham Brown and Daniel Reeders (2016). What Works and Why – Stage 1 Summary Report. Melbourne: Australian Research Centre in Sex, Health and Society, La Trobe University. Available at www.w3project.org.au

The above report provides details of the project background, methods and the W3 Framework. An excerpt from the report is provided below.

> **Executive Summary**
>
> The Australian HIV and hepatitis C response is undergoing the most rapid change in decades. Community and peer-led programs needed a better way to demonstrate their unique role and contribution to achieving the goals of the National strategies, their capacity to adapt with the rapid changes, and the role of the HIV and hepatitis C partnership in supporting this role.
>
> Working in collaboration with ten peer-led community organisations, the What Works and Why (W3) Project used systems thinking and participatory methods to develop a better understanding of how peer-based programs work, formulated a framework to evaluate the role and contribution of peer-based programs, and developed quality and impact indicators and tools to best capture and share insights from practice. This involved a series of 18 workshops ranging from one to two days each with the ten peer-led community organisations working with gay men, people who use drugs, sex workers and people living with HIV. Some workshops were with single organisations and some with up to four organisations, and over 90 people were involved across the workshops.
>
> *W3 Framework*
>
> We found that peer-led programs are operating within and between two interrelated and constantly changing sub-systems – the community system and the policy (or sector) system. We found there are four functions that are required for peer-led programs to be effective and sustainable in such a constantly changing environment:
>
> - **Engagement**: How the program maintains up to date mental models of the diversity and dynamism of needs, experiences and identities in its target communities
> - **Alignment**: How the program picks up signals about what's happening in its policy / sector environment and uses them to better understand how it works and to achieve better synergies
> - **Adaptation**: How the program changes its approach based on mental models that are refined according to new insights from engagement and alignment
> - **Influence**: how the program uses existing social and political processes to influence and achieve improved outcomes in both the community and the policy/sector.
>
> The combination of these functions is required for peer based programs to: demonstrate the credibility of their peer and community insights; influence community, health, and political systems; and adapt to changing contexts and policy priorities in tandem with their communities.
>
> *Feasibility Trial of Indictors and Tools*
>
> We worked with nine of the W3 project partners to develop tailored indicators under each of the four functions, and then piloted a range of different tools for gathering insights against the indicators and functions with peer-led projects within seven organisations. The main aim was

to identify what would be feasible within the resources of community and peer-led organisations.

Generating System Logic Diagrams for Peer Based Programs

The W3 Project applied a systems thinking approach that conceptualises peer based programs, and the communities and policy environments they engage with, as complex adaptive systems. We held a series of workshops with each of our partner programs to map out the complex flows of knowledge and influence that underpin their effectiveness within their target communities and policy environment. The result was 'system logic' diagrams that were used in conversation with partner programs to identify four key functions at which a peer and community based program needs to succeed in order to be effective (W3 Framework – see www.w3project.org.au).

The system logic diagrams illustrate the contribution of peer insights and leadership at the individual level in service provision; in health promotion targeting networks and cultures of sexually adventurous men within the broader gay community; and in positive leadership and policy participation at the state/territory and Commonwealth jurisdictional levels.

For each one we drafted a range of indicators that could inform program evaluation and quality improvement.

We worked with four groups of programs from Australia's responses to HIV and hepatitis C, chosen because they have the longest history of using peer and community based approaches:

- Western Australia Substance Users Association (WASUA) and Australian Injecting and Illicit Drug Users League (AIVL) – PWUD peer service provision and policy participation map

- Victorian AIDS Council (VAC) and Australian Federation of AIDS Organisations (AFAO) – GMSM peer network-targeted health promotion map

- The Positive Action Group (PAG) consisting of the National Association of People Living with HIV Australia (NAPWHA), Positive Life NSW, Queensland Positive People, and Living Positive Victoria – PLHIV peer leadership and policy participation map

- Scarlet Alliance, the National Sex Worker Association and members. This map contributed to the area of sex worker peer leadership and policy participation, however has not yet reached a level of completion to be released publically

Full details of the methods and processes are described in:

> Graham Brown and Daniel Reeders (2016). What Works and Why – Stage 1 Appendices. Melbourne: Australian Research Centre in Sex, Health and Society, La Trobe University. Available at www.w3project.org.au

Reading the GMSM Peer Network Targeted Health Promotion System Logic

Theory statement	• A high level description of the approach: how practitioners and program managers think it works, in plain English.
System logic diagram	• A diagram of the causal loops and processes that shows how the program engages with the community and its policy and funding context.
Explanatory text	• Brief definitions of the items and key relationships from the system logic diagram.
Strategic dynamics	• Aspects of the map that practitioners said they'd most want to monitor in order to confirm and revise their understanding of the system and whether the program was working.
Worked example	• We take one strategic dynamic and talk through the mechanism that produces it -- the causal loop and other structural features of the map -- as well as indicators that could be used to monitor it.

GMSM Peer Network Targeted Health Promotion System Logic

This case study is based on the Sexually Adventurous Men's (SAM) project of the Health Promotion Team at the Victorian AIDS Council, which uses peer workers to engage with sexually adventurous networks and cultures. The case study title distinguishes this program from the more traditional 'community-based health promotion' that is the cornerstone of Australia's partnership approach to HIV prevention. The term 'network' refers to something smaller and more fragmentary than a community, but it is recognised that networks still have their own local cultures formed around shared interests, values, meanings and practices. Peer workers participate in those networks and cultures and develop knowledge and relationships the program can draw on to create innovative and relevant 'cultural products' that are carefully targeted for circulation and consumption among sexually adventurous men.

a. Program theory statement

Participants in workshops to create this map focused extensively on what happens in the community and its broader social and political environment. We started with a broader focus on rapid testing for sexually adventurous men, but we shifted over time to focus on what we are calling 'peer network-targeted health promotion'. That reflects the detailed discussion in the workshops about how peer and community based health promotion works to engage with groupings of people that exist within the gay community (networks) around shared interests in specific and diverse sexual practices (cultures).

The idea of 'community' is conceptually broad and may gloss over the diversity that exists among gay men and MSM. We were particularly interested in the Sexually Adventurous Men project because it shows a community based approach to engaging at that more diverse and specific level.

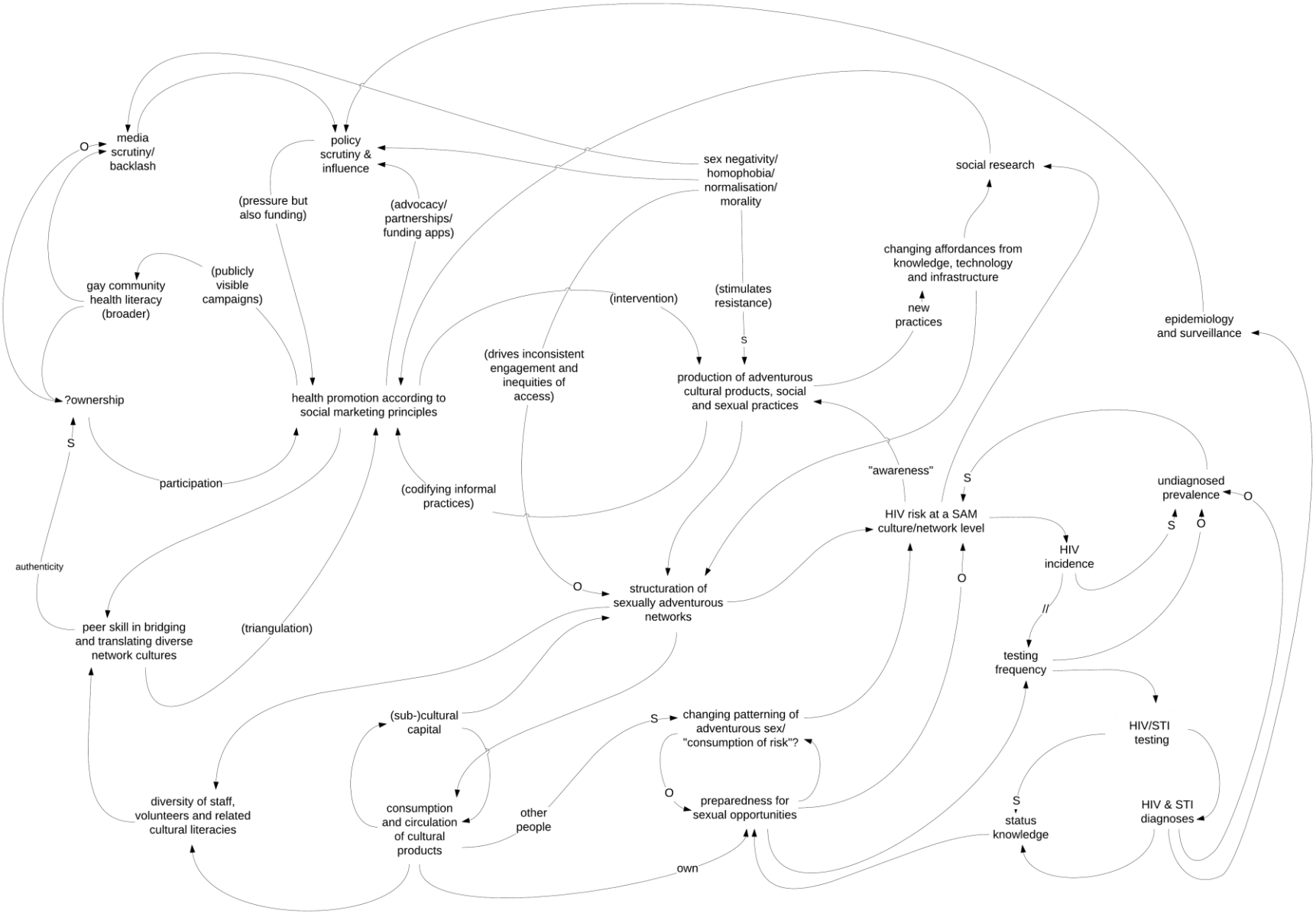
A criticism sometimes made of community development is that it reflects romanticised ideas of direct communication and leadership within communities. The SAM project shows a more up-to-date response that engages at the level of culture, via targeted cultural production and circulation of cultural products. In particular it engages with the challenge of developing the relationships and literacies needed to target small and diverse networks in ways that are credible and meaningful to them.

As a complex adaptive system, sexually adventurous men adapt to internal and external changes by producing new cultural products (including sexual practices), whose impact and uptake is patterned by media and interpersonal channels of distribution, and which contribute to changing patterns of risk consumption and preparedness for risk.

Health promotion can produce its own cultural products and engage in targeted action intended to shift those patterns at different leverage points. Health promotion is an integrative practice that incorporates diverse forms of knowledge (social and behavioural and epidemiological and clinical) according to a collective perspective informed by workers and volunteers who have literacy in diverse and dynamic network cultures and the peer skill needed to represent this effectively.

HIV prevention and HIV risk at a network and cultural level are emergent properties of the system; they can't be finally traced back to either individual risk consumption or protective practices or local prevalence but arise from the interaction of all three.

b. System logic diagram



c. Explanatory text

Adventurous cultures and networks (middle of the map)

Sex negativity

Sex negativity has many different sources, including religious morality around casual sex and homosexuality, conservative politics, homophobia, and even movements for the 'normalisation' of gay men and gay marriage equality. Sexual adventurism can be understood *partly* as a reaction and form of resistance against the way sex negativity constrains sexual agency and self-expression. Sex negativity can drive reactions to sexually explicit or adventurous themes in HIV prevention materials. Sex negativity both in the gay community and the broader society were extensively discussed at the workshops as barriers that need to be negotiated in this work.

Changing affordances from knowledge, technology and infrastructure

Affordances refers to the potential for action that arises from new *knowledge* (e.g. to have unprotected serodiscordant sex with a partner who has suppressed viral load is an affordance from the PARTNER study findings) or *technology* (such as pre-exposure prophylaxis) or *infrastructure* (such as serosorting for partners on PrEP using the drop-down menu bar on barebackrt.com).

Cultural production

'Cultural products' covers a long list of things from the classic example of a porn movie to a greeting card with a cartoon of a teddy bear in a leather harness to a party called Woof to a Facebook picture update with "Hot Daddy of the Week".

Importantly, cultural products include *practices* like fisting or watersports or barebacking.

Cultural production can lead to the development of social and sexual practices, based on new or changing affordances from knowledge, technology or infrastructure, that can lead to reduced individual and network-level risks of HIV transmission.

This isn't automatic or inevitable, though. An important aspect of cultural production is the idea of *selective consumption* of prevention knowledge and technologies.

Health promotion and social marketing is just one of the many ways in which the prevention affordance of a new practice can be validated, codified, and distributed.

Structuration of adventurous sexual networks

This is a serious piece of jargon and we are open to replacing it with something less theoretical that captures the same idea. It describes how sexual networks are formed and shaped through the interplay of structural factors (such as HIV stigma) and individual agency (choices). It is useful in the way it captures how some things like sexual attraction effectively merge aspects of structure and agency.

It has inbound linkages with cultural production and cultural capital as well as a more diffuse influence from *changing affordances from knowledge, technology and infrastructure*.

Case study example of structuration

The emergence of barebacking as a practice among positive guys created a market for barebackRT.com, which created an infrastructure (the site) and an affordance (the 'looking for status' field) where negative men could look for negative partners for bareback sex, which via 'repeat business' over time may have contributed to the creation of negative sexual *networks* where a single person entering acute HIV infection might result in a whole number of people taking much higher risks of infection than if they were a disconnected set of stranger dyads. The outcome of this

could be a greater year-to-year variability of community-wide HIV diagnoses – more people seroconverting one year reducing the number the next year (because they are removed from the 'susceptible' column by their infection the previous year).

It has outbound linkages with *updating mental models* (via *diffusion*) and with *patterning of adventurous sex/consumption of risk*.

Circulation of cultural products

This refers to the planned and organic distribution and reach of cultural products within the diverse networks of sexually adventurous men.

Circulation is highly contingent on who interacts with whom in sexual networks and cultures, which is driven by *structuration* (above). The linkages and gaps created through this process can assist or impede the circulation of cultural products.

Circulation isn't instantaneous – it happens over time, and some will pick up new cultural practices and products earlier than others (e.g. diffusion of innovations).

Cultural capital

We use this on the map to refer to the credibility, desirability and standing a cultural producer (such as the SAM project) can have within sexually adventurous networks.

There is a loop between *cultural capital* and *structuration* indicating the way cultural capital interacts with the structure of networks: people with more cultural capital may be associated with more social and sexual networks.

There is also a loop linking cultural capital to *consumption and circulation of cultural products,* because it influences the likelihood of cultural products being *shared*, and sharing in turn impacts on the producer's cultural capital.

Consumption and circulation of cultural products (including sexual practices) has outbound influences on two key items: *changing patterning of adventurous sex/consumption of risk* and *preparedness for sexual opportunities*.

If we adopt an individual perspective for a moment, then circulation of new cultural products and their consumption by *other people* can influence the patterning of adventurous sex in ways our individual gay men may not be prepared for.

On the other hand, adoption of new meanings and practices by individuals can drive the changing patterning of adventurous sex at a group or collective level, and this consumption of cultural products contributes to preparedness for sexual opportunities.

This reversibility is what enables health promotion to create cultural products that contribute to safer practice (individual level) or patterns of sexual practice that result in less risk (network/cultural level) *that circulate in exactly the same way as any other cultural product or social practice among sexually adventurous networks.*

From a strategic perspective this explains why health promotion is more likely to succeed when it engages with communities 'where they live', rather than creating new spaces (such as online communities) and inviting the community to use them.

Preparedness

Preparedness includes skills and knowledge. At an individual level, HIV risk can arise in the gap between preparedness for a sexual opportunity and the demands of the moment as it eventuates. This reflects research into 'intensive sex partying', specifically the way sexually adventurous men prepare ahead of time for complex and demanding events, in ways that preserve the improvisational or 'in the moment' character of sexual adventure.

At an interpersonal level, i.e. during a sexual interaction – which might be sex itself or a chat about it – asymmetrical preparedness creates the possibility of sexual learning (McInnes et al. 2002), i.e. onward circulation and consumption of cultural products.

At a collective level, preparedness sustains a culture of care and initiation of newbies and the acknowledgment of cultural capital possessed by experienced practitioners. But the relationship between experience and cultural capital could create an incentive to conceal gaps in preparedness and 'go with the flow' in tricky situations.

Patterning of adventurous sexual encounters and consumption of risk

This is where the sex actually happens, but the focus of this component is on how the myriad sexual encounters that occur each year in Victoria *are patterned* in ways that matter to *HIV risk at a SAM culture/network level* and prevention generally.

This component is part of a loop with *preparedness for sexual events/opportunities* (see below) that contributes to *HIV risk at a SAM culture/network level* and from there to *HIV incidence*. As discussed below under *preparedness*, that loop can sometimes lead to a 'preparedness gap'. But this can be seen as a *deficit model* of sexual (mis)adventure. Deficits are part of the picture but not the whole picture.

An *asset based* account of sexual adventure can be developed using the concept of *consumption of risk*, according to which, new knowledge and technologies (see *changing affordances from knowledge, technology and infrastructure* below) allow sexually adventurous men to 'consume more risk' without exceeding a subjectively-defined unacceptable likelihood of seroconversion.

This is consistent with the finding from the PASH study that adventurous men are not reckless with regard to HIV – if possible, they do want to avoid infection – but there is a limit on the constraints they are willing to accept on their sexual learning and agency to prevent it.

HIV risk at a culture/network level

This refers to risk of HIV transmission assessed at a higher level from the factors that predict individuals' risk of acquiring or passing on HIV. It describes the reasons why it makes sense to engage at a culture and network level with sexually adventurous men, rather than (say) targeting the whole gay community with messages for individuals about adventurous sexual practices.

The main inputs are from *structuration* and *patterning* as well as *undiagnosed prevalence* (much of it among men who were recently infected). These describe:

- The odds of being in a network or space with undiagnosed people
- The odds of being in an encounter with an undiagnosed person
- The odds of the sexual acts practiced leading to transmission

The main outputs are to *HIV incidence* and *changing affordances from knowledge***,** *technology and infrastructure.* Via an indirect route, the causal outcomes feed back into *patterning* via *testing frequency*, *HIV/STI testing* and *status knowledge* (which enables decisions that can affect *structuration*).

Some of the *HIV incidence* resulting from this component do not reflect 'protection gaps' (see above) but rather the failure rate inbuilt in partial protective strategies.

Activities (left hand side)

Health promotion and social marketing

Health promotion practice could merit a system map of its own: it incorporates a dense network of activities for intake and processing knowledge in a more deliberate and systematic way than occurs in *selective consumption* by sexually adventurous men, as well as for working out how to knit together knowledge produced by different disciplines such as social research and epidemiology or clinical practice, and for developing messages and cultural products that engage with the diversity of networks and local cultures produced by

structuration.

On this map *health promotion and social marketing* includes health promotion as a knowledge practice and social marketing as a consumer-oriented framework for intervening in the structural and agentic dimensions of gay men's everyday life.

This map is specifically about peer culture and network-targeted work with sexually adventurous men, so the health promotion item includes all the activities that go into this within the Victorian AIDS Council and relevant partnerships within it (e.g. with services like PRONTO) and external to it (e.g. with Living Positive Victoria).

Health promotion has an impact on sexually adventurous culture and networks through *cultural production* (keeping in mind this includes events and codification of social and sexual practices). It also has an impact on *changing affordances, policy scrutiny* (below) and *gay community health literacy*.

Peer skill in bridging and translating SAM culture/networks

This refers to the ability of peer workers to critically reflect on and effectively represent knowledge from their practice as members of sexually adventurous networks and cultures for incorporation in health promotion ('translation').

Peer skill enables workers to establish relationships with other stakeholders in those networks and cultures that enable the flow of knowledge in both directions ('bridging').

Over time it involves the ability to take a *collective perspective* judging and balancing how a message or theme might resonate differently in the diverse networks and cultures that exist under the broader umbrella concept of the 'gay community'.

Someone with this understanding could not know everything but might have a better chance of knowing what he doesn't know – and who else might know. There was extensive discussion at the second workshop about how a person working in community-based health promotion might take a different approach to exactly the same task, e.g. formulating a campaign message, compared to a public servant working at Department of Health, even though the public servant might be a gay man himself and very well informed.

This account positions sexually adventurous culture as a site of comparatively greater fragmentation of networks and proliferation of specific cultural products within the broader context of the gay community, so that someone who was not himself personally and continuously engaged in those spaces might struggle to form mental models that enable effective engagement with them. This is consistent with systems thinking principles about the non-computeability of complex adaptive systems creating the need for mental models and 'try it and see' engagement approaches, rather than first amassing enough knowledge to 'intervene decisively'.

Peer skill could be defined, against this lengthy background, as the ability to gather and use personal knowledge of sexually adventurous culture and networks in a way that supports effective health promotion engagement with them.

Diverse cultural literacies among staff and volunteers

Structuration can produce networks and cultures that are not easy to see or understand unless you're part of them or close neighbours with them. Trying to produce cultural products for these cultural spaces can be a tricky endeavour if you are not 'literate' in the interpretive communities they create. Hiring staff and recruiting volunteers and stakeholders with diverse identifies and experiences makes these *diverse cultural literacies available* for consideration and incorporation via the integrative practice of health promotion for inclusion in cultural production.

Broader gay community health literacy

This item refers to what social marketing researchers call 'persuasion knowledge', which is

not 'having facts about prevention' but *understanding the strategies used in preventive communication*. (We would probably refer to cultural production rather than communication.)

The key aspect of this element is the way prevention literacy in the broader gay community can lag behind sexually adventurous men in cultural production that leads to updated mental models of the affordances of new prevention technology.

This is partly *because of sex negativity* and also partly *a cause of* it, in that the lag can produce *media backlash* and *policy scrutiny* that reinforce sex negativity.

Ownership

This results from broader gay community health literacy keeping pace with the strategies being used for health promotion with sexually adventurous men. When it doesn't keep pace, there is increased *media scrutiny/backlash*. When it does, there may be increased participation in health promotion activities, e.g. by volunteering, taking part in focus groups, sharing cultural products with friends etc.

Policy scrutiny and influence

When there is mainstream or gay community backlash against a health promotion initiative, or there is input from epidemiology and surveillance reports, and sometimes simply as a result of structural homophobia or sex negativity, there may be increased *policy scrutiny and influence* on health promotion and potentially on cultural production by sexually adventurous men.

The relationship between *policy scrutiny and influence* and *health promotion* is complex. Its outbound linkages include both scrutiny and pressure but also funding – they are all ways of causing health promotion to act in one way and not another. The inbound linkages include policy advocacy, partnerships and funding applications, which are all ways in which health promotion can act on government. It is not a relationship of complete domination, since the government at one level *wants* some separation from how health promotion engages with cultures and practices that are subject to critical or sensationalist *media scrutiny/backlash*, which is the other major inbound linkage into policy scrutiny and influence.

Epidemiology – testing and incidence (right hand side)

Testing frequency

Testing frequency is not just a rate variable – number of tests per gay or bisexual man per year, or months between tests on average – it includes all the different factors and processes that influence the amount of time that passes between a person acquiring HIV and getting a test that diagnoses it.

There is an inbound link from *HIV risk at a SAM culture/network level* which reflects the calculations men might make about how soon they need a test, either based on their own recent sexual encounters. A link from *visibility of diagnoses* captures the 'mental availability' of the possibility of seroconversion. A link from *visibility of testing* captures the idea of a norm of testing that may strengthen or wane over time, as well as cultural production about testing experiences, such as discussing an experience of using PRONTO on Facebook. A link from *changing affordances* captures the idea that making a rapid test available at a non-clinical, peer-led, community setting might increase testing frequency and reduce incidence.

Undiagnosed prevalence

This item refers to the number of people and the amount of time they are living with HIV without knowing it, based on epidemiological research that suggests a majority of new infections are passed on by people who don't know their status has changed. Prevalence includes an aspect of locality – in the sense of the spaces or networks in which people with undiagnosed prevalence are finding partners for sex.

The major inbound link is from *HIV incidence* (new transmission episodes). There may need to be a loop drawn from this item back to HIV incidence via *structuration* and *HIV risk at a culture/network level*, reflecting that aspect of locality and its influence on new infection rates.

The difference between one person and ten people being newly infected depends almost entirely on structuration of networks – is the 'locality' a monogamous relationship, leading to one other person seroconverting, or is it a group of fuck buddies who play every weekend, leading to four or five new infections?

Very diverse forms of knowledge can shed light on this question – from phylogenetic analyses of infection 'clusters', which are authoritative but slow and expensive, or word of mouth among sexually adventurous men, which is less authoritative but more timely.

HIV/STI testing (cloud)

This is presented as a cloud because we think it can be understood as a whole separate system map in its own right.

The main inbound link is from *testing frequency* as the major driver of testing. The major outbound links are to *HIV & STI diagnoses* and *status knowledge* (which are separate items because you can have negative status from a non-diagnosis).

There is also an outbound link to *early cut service data* which is part of an action pathway to *health promotion* (it is one of the triggers for a change in approach or a new initiative).

HIV & STI diagnoses

This refers to people finding out they have HIV or have (had) an STI. This has a link up to *epi data/surveillance*, although it is slashed to indicate a delayed effect, since it could be anywhere up to a number of years before the data generated by a new HIV infection is reported in an annual surveillance report with a breakdown by age, gender, and sexuality (presumed from transmission route).

Epidemiology and surveillance

This item refers to the collection of surveillance data from HIV and STI testing, as well as (sometimes) 'early cut' findings from data collected on service usage. This has outbound links to *policy scrutiny***,** and via that to *health promotion***,** reflecting the different action pathways that can lead from a surveillance report (or early cut data) to health promotion action.

There was discussion at the second workshop about how different action pathways can have different consequences in terms of the time they take, the thoroughness of planning they enable, and the amount of funding they make possible. For example, there may be a rush to develop a 'quickie' campaign about a particular STI in response to an uptick in quarterly diagnoses, so that health promotion is 'seen to be doing something' already by the time *media scrutiny* occurs.

However, participants also discussed how this can pose risks to the organisation's reputation among sexually adventurous men, who may be closer to the personal impact of syphilis diagnoses – and vocally critical if they perceive the response to be token or inadequate. Getting the balance right was a key function of the *community perspective* taken by community- and peer-based health promotion.

There was also discussion of how changes in trends in epi data don't make sense on their own, and knowledge from peer network-targeted health promotion can contribute to understanding these changes.

d. Strategic dynamics

Strategic dynamics are higher level strategic considerations that emerge from interactions among the processes and relationships depicted on the system logic diagram.

Dynamic #4 describes a 'dynamic interplay' between, on one hand, other people's consumption of sexually adventurous cultural products influencing shifting patterns of sexual practice and creating a 'preparedness gap' between an individual's skills and knowledge and the demands of the moment in a sexual encounter, and that individual's ability to close the preparedness gap *via* the same process that created it – consumption of cultural products.

It is the reversibility of this dynamic – it can both create and ameliorate risk – that the peer network-targeted health promotion approach *exploits*, by creating cultural products that are sexy, relevant, innovative, and therefore circulate among the same channels that adventurous gay men use to meet and communicate with each other. This helps to explain why health promotion needs to 'work with people where they are', rather than creating *separate* social or cultural spaces (such as online communities) that they have control over.

However, since the circulation and consumption of cultural products is not evenly distributed – it is heavily patterned by the *structuration* of adventurous networks and cultures – a key indicator for health promotion equity and effectiveness is whether the program understands where the gaps are between networks, and uses mass as well as targeted communication to reach people who may be intermittently engaged or less well-connected with networks.

1. Distance between the engagement and influence of peer based health promotion and the outcomes observed in social and sexual practice, clinical service provision and epidemiology.
2. HIV incidence and therefore prevention are emergent effects.
3. The size and complexity of the system creates different 'scopes' with their own different perspectives, knowledge practices, and time delays.
4. Dynamic interplay between consuming cultural products and the preparedness gap.
5. Backlash, policy and media scrutiny and sex negativity energise the dynamism and diversity of the target networks and cultures, but operate as delayed effects on health promotion responses to them.
6. Recognising innovative practices within sexually adventurous networks and cultures.
7. Testing frequency is an emergent pattern that can't be directly intervened upon.
8. HIV risk at a culture/network level is not directly visible to participants or observers.
9. Structuration of sexually adventurous networks and culture is powerful but only visible through its effects.
10. Peer skill is critical.
11. Sexually adventurous culture and networks as a complex adaptive system.
12. Size and structure can create differences of perspective within the same organisation.
13. Contributing real time knowledge to the broader HIV sector in Victoria.
14. Early cut data in the policy sphere demands a health promotion response.
15. Balancing policy demands (e.g. quick response) against demands as a participant in target networks and cultures. Earning and maintaining credibility.

Indicators for GMSM Peer Network Targeted Health Promotion

Drawing on the W3 Framework (www.w3project.org.au) and the program theory, system diagram, and strategy dynamics described above, the following indicators were drafted.

The wording of these indicators are subject to change according to feedback from the Victorian AIDS Council (VAC) and the Australian Federation of AIDS Organisations (AFAO).

Domain	Draft indicators
Engagement	Program workers use personal experience and cultural knowledge to communicate and work effectively with clients who are may be quite different from them
	Clients feel they have something to contribute and a sense of shared ownership in the service
	Strategic opportunities to create new relationships with people and networks in the community are identified and taken during service provision and program activities
Learning and adaptation	Turning information acquired through service provision into organisational knowledge and using it to adapt the service in order to improve its influence
	Program and organisational learning and leadership
	Packaging strategically relevant knowledge for influence on diverse stakeholders
Influence	**Influence within the community system –**
	Reducing the gap between preparedness (skills, knowledge and required equipment) and the short and longer term pressures on people who use drugs
	Reinforce and contribute to sustaining an ongoing culture of safer use amongst PWUD
	Influence within the complex policy system –
	The contribution of peer leadership in consumer representation and policy advocacy is recognised and sought out
	Knowledge produced from peer insights in service provision is shared and used in the broader sector and policy environment
	Policy advice, consumer representation and training using peer insights and packaged knowledge to improve quality and inclusion for PWUD at other services
	Sustaining and strengthening policy support for a peer and community based approach in harm reduction and BBV prevention
Integration	There are enough flexible resources to support learning and adaptation
	Organisational leadership supports a peer approach in workplace culture and organisational strategy
	Performance indicators and funding mechanisms reflect the complexity of the service provided
	The broader sector and policy system includes and values the peer approach and insights it generates
	The organisation has strategic and supportive relationships with key players within its sector, policy and funding environment