LA TROBE UNIVERSITY

Australian Research Centre in Sex, Health & Society

AUSTRALIAN RESEARCH CENTRE IN SEX, HEALTH AND SOCIETY

August 2016

What Works and Why (W3) Project

Stage 1 (Jul 2013-Jun 2016)

Appendices

Graham Brown and Daniel Reeders

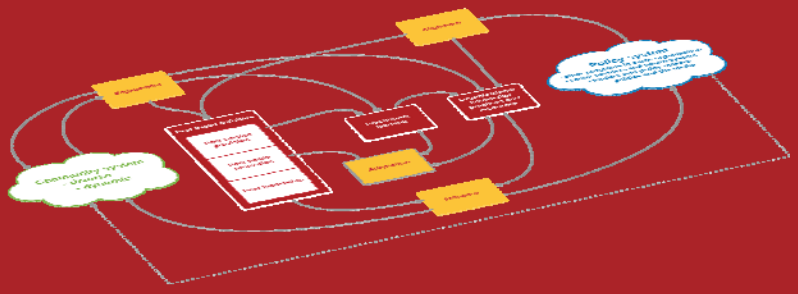

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Table of contents

1.0 Methods in developing the W3 Framework (W3 Methods paper excerpts)

1.1. Participatory workshops

Over a two-year period, The W3 Project conducted a series of 18 workshops ranging from one to two days each with the ten programs. Some workshops were with single organisations and some with up to four organisations. Over 90 people were involved across the workshops.

Facilitated discussion of a narrative

We shared a narrative of an event (see supplementary materials) that was written to highlight the differences between a peer and non-peer model of service. A modified version of Maani & Cavana's 'iceberg model' (1) was used to frame questions for facilitated small group discussions, and the researchers wrote insights from this discussion onto Post-It notes. Facilitated discussion using the iceberg model makes it possible to reconstruct, from the mental models that different participants recruit to understand and explain a single event, the system that might produce an event of that kind. (A similar principle applies to air crash investigations.)

Modified iceberg model

In its original format Maani & Cavana's 'iceberg' model invites reflection on events, patterns, structures, with mental models at the base(1) . In our version of the model we emphasise events, patterns, structures and *cultures* – since cultures are how mental models are transmitted and inculcated in the first place.

Affinity methods

With the whole group, affinity methods were used to discuss different ways of grouping the insights into higher-level themes. It is important to take enough time for discussion during this process, and if possible to make notes about the decisions participants make on why items can group together. The affinity method increases the abstraction of the end product, and as such, involves a loss of data, and for subsequent analysis it helps to have brief records of the discussions that went into building the model.

Building a modified causal loop diagram

Causal loop diagrams are a standard tool used in systems thinking to identify the regular (i.e. cyclical) relationships or 'loops' among quantitative variables that interact in a problem situation. They provide a visual language for specifying bivariate correlations and labelling the overall impact of feedback loops in a closed cycle of relationships between multiple variables. Loops can be reinforcing ('amplifying') or balancing ('target-seeking'). All arrows are meant to be labelled ('s' for positive correlation, 'o' for negative). All items are meant to be nouns referring to quantities or measures that can go up or down. When computer simulation is intended, this can result in a certain amount of conceptual 'forcing', using proxy measures to represent items that cannot be directly measured.

In 'system logic' mapping our goal was to offer program theories that get closer to the complexity of peer based programs in practice. We repeatedly found that the CLD conventions threatened to exclude representation of processes that were central to the mental models we were mapping. As such, we departed from conventions in a couple of ways: by allowing some arrows to be unlabelled, functioning simply as 'pipes' taking output – knowledge or influence -- from one process to another place. We also included some items that could never be quantified with a scale or a unit.

Most applications of the systems approach have taken place in the fields of science or business, where there are concrete, measurable variables. CLDs that relax these conventions may still have value in depicting

complex 'repetitive action situations' (Ostrom) reflecting an interplay of human agency and social structure over time. However, it meant we needed to find alternative ways to check the internal logic of the model and validate its fit with practitioners' mental models and their outlook on the challenges ahead in their work.

Iterating and validating the model

The initial model was developed by the researchers themselves in the evening on day one of a two-day workshop. On day two, we presented the map by picking an issue on the participants' 'radar' as an emerging concern, and a starting place on the map, and followed along the pathways to invite discussion of how it might 'play out' on the system depicted onscreen. We asked participants to tell us what was missing and what needed to be changed. We simulated the map in discussion by asking 'what would happen if *x (item) changed drastically?*' These discussions repeatedly generated identification of items that are considered important in practice but missing on the map, or that were conceptually necessary according to the inherent logic of the map.

Analysing within the CLDs

Subsequently, the research team sat down and mapped out causal loops and longer multi-loop 'pathways' among the items on the maps, identifying their strategic implications. For instance, with the West Australian Substance Users Association, the flexibility of the peer service meant it often saw more clients with complex needs than non-peer services, which reduced the overall number of clients it is able to see, yet its performance is still compared with the other services on number of clients seen. This pointed to the importance of using stories from successes with its caseload to advocate for being valued on different terms compared to non-peer services. We identified these implications based on the maps and then presented them to participants and stakeholders of the programs, who affirmed their accuracy, saying 'this is what keeps me awake at night'. It was also possible to identify quality indicators by asking participants to nominate what points in the map it would be most important to monitor.

1.2 Analysing across CLD to develop the W3 Framework

This is another place where the system logic methodology departs from STM, which often assumes that models are 'representations of reality' that can be validated by computer simulation and comparison of the results to the situation on which the model was based. In our analysis of the four maps we had developed, we began using the analytical method – breaking them apart into their components and seeking to label them to find common features. The result was an explosion of decontextualized elements and indicators, illustrating the argument that analysing items out of context is unproductive in complex systems settings. However, in part because of its focus on models *as* reflections of reality, there is not much guidance in STM on how to analyse CLDs as *artefacts of meaning-making* that require interpretation and do not speak for themselves.

At this point we drew on the theoretical resources described above. Pawson and Tilley describe using abstraction to facilitate the accumulation of knowledge and generalisation of findings across cases of realist evaluation (2). The theoretical question we asked came from resilience theory in ecological systems, which describes the functions that an organism needs to be equipped with in order to learn about and adapt to changes in its environment. Building on this, we asked what functions a peer based program needs to be able to fulfil in order to be effective and sustainable as it mediates between continually changing community and policy environments. This led to the development of a draft framework of learning and evaluation in peer based programs.

The draft framework was presented at a series of workshops and meetings with W3 partners and stakeholders, where feedback and discussion resulted in refinements and a deepening of our understanding of the functions we had identified. This led to the final W3 Framework.

1. Maani K, Cavana RY. Systems thinking and modelling: Understanding change and complexity: Great Britain; 2000.
2. Pawson R, Tilley N. Realistic evaluation. . London Sage; 1997.

2.0 Report on feasibility trials and tools

2.1 Piloting indicators of quality and influence

W3 Project built on the work to develop the W3 Framework and worked with nine of the project partners to develop tailored indicators under each of the framework functions. The indicators were defined as 'things that would *be happening* if this function were being fulfilled'. Initially relatively generic indicators across three peer program areas were developed and refined with the partners. These included peer leadership with PLHIV, peer health promotion with gay men, peer service delivery with people who use drugs. The initial draft of these were described in the January 2015 report. These sets of indicators were refined, and then used as a foundation to develop project specific indicators and tools to pilot in the feasibility trials.

2.2 Piloting Methods for gathering insights

To make it manageable within the timeframe and program resources available, we focused on specific issues or projects, rather than whole programs or organisations. These are detailed in table 1 below.

Table 1 – The W3 Collaboration

W3 Project Partner	Participated In System Mapping Workshops	Participated In Framework Development	Participated In Development Of Tailored Indicators	Participated In Feasibility Trial Of Indicators And Tools
Australian Federation of AIDS Organisations,		✓	✓	
Australian Injecting and Illicit Drug Users League (AIVL),		✓	✓	
Harm Reduction Victoria,		✓	✓	✓
Living Positive Victoria,	✓	✓	✓	✓
National Association of People Living with HIV/AIDS,	✓	✓	✓	✓
Positive Life NSW.	✓	✓	✓	✓
Queensland Positive People,	✓	✓	✓	
Scarlet Alliance – Australian Sex Workers Association,	✓	✓		
Victorian AIDS Council,	✓	✓	✓	✓
Western Australian Substance Users Association,	✓	✓	✓	✓
Australian Research Centre in Sex, Health and Society, La Trobe University	✓	✓	✓	✓

Over a 15-month period we piloted a range of different tools for gathering insights against the indicators and functions, guided primarily by the needs of our partner agencies and the questions they wanted to answer within their community and policy systems. These are listed in table 2 below. The goal was to create a flexible set of tools and methods that can be used to gather a wide variety of different insights from practice, and that *add value to existing practices* without creating too much additional labour. The main aim was to identify what would be feasible within the resources of community and peer-led organisations.

During and after the trials interviews were conducted with key stakeholders in the organisations to gather insights as to the feasibility and usefulness of the tools and the indicators, and changes or adaptations required.

Table 2: List of Project specific tools piloted in the feasibility trials

Peer Activity Focus	Partner Organisation	Feasibility Trial	Tools
Peer Service Delivery	Harm reduction Victoria	Monitor the roll-out of a peer distribution project with a coalition of partners in a new area	Coding Indicator matrix Learning meetings
	WA Substance Users Association	Increase capture of insights across projects in an outreach program	Indicator matrix Learning meetings
	Victorian AIDS Council: PRONTO peer based rapid HIV testing	Understand the strengths, weaknesses and opportunities of the peer model in point of care HIV testing for gay men	Focus group schedule (peer staff) Focus group schedule (clients) Coding
Peer Health Promotion	Victorian AIDS Council: SAM project	Evaluate the project's reach among discrete networks of sexually adventurous men	Interview schedule Coding Indicator matrix
	Victorian AIDS Council: SAMESH program	Plan for learning and evaluation to capture insights and success stories in first year of operation	Program logic tool Learning meetings Information system
Peer Leadership	Positive Leadership Development Institute (PLDI)- Positive Life Victoria and partners:	Evaluate the strength of the functions of a partnership among PLDI member organisations	Survey tool Indicator matrix
	Positive Life NSW	Improve capture of real-time insights from peer programs about the experience of community prescribing rolling out in NSW, Queensland and Victoria	Survey tool Indicator matrix

2.3 Two modes for the tools

Most of the tools could be categorised as using either or both of modes described below

- **Capture mode** uses functions from the W3 framework to 'code' insights or in combination to express quick theories about emerging issues/changes. This is done as an add-on to existing documents – e.g. minutes from program meetings or supervision, or focus group or interview transcripts.
- **Rating mode** is used with a key staff, stakeholder, or program partner. It invites them to rate their confidence that certain indicators are being met, and then to specify what they've seen/heard that informs their confidence rating. This can be used as the basis for a discussion about different perspectives and expectations that key stakeholders may hold.

Capture mode

The framework can be used to 'code' (or annotate) the documents that are created during the routine activities of a health promotion program or team. A single code 'ENG' might signal that an insight documented in the minutes of a team meeting was obtained through community engagement. The codes might be combined to describe a proposed action, e.g. 'ENG → L&A' could signal an intention to consider the insight in revising a program activity.

Lastly, the codes can be strung together to create brief, shorthand notations for describing the mental models or 'working theories' of emerging issues. The coded documents can be saved in any system that allows in-text searching, such as Windows or Mac file folders, or Dropbox, or a more advanced system for qualitative data analysis such as Atlas.ti or NVivo. This makes it easy to recall at a later date and analyse whether indicators developed for each of the four key functions in the W3 framework are being met.

Rating mode

In this mode, the program and its key stakeholders both rate their confidence that different indicators are being met under the four key functions in the framework. For each indicator they are invited to note down brief details of things they have seen happening that inform their confidence rating.

Indicator	Confidence rating	What informs your confidence *in the relevant time period?*
Something specific to the scope of the enquiry (e.g. issue, project, program, etc) that needs to be *happening* in order to say with confidence that a particular function is being fulfilled.	-2 -1 0 +1 +2	[open text field]

If their confidence ratings do not match up, the program and the stakeholder can have a conversation about what they are seeing and how that informs their confidence. These may include current data being collected, insights from the field, or other insights from the community or policy systems. This provides an opportunity for the program to provide its experience directly to the stakeholder, but also for the program staff to get a better sense of the stakeholder's perspective and what signals matter to them. The closed mode is meant to be used at regular intervals. The longer the time period the harder it may be to recall signals from earlier on, and setting a time period helps to 'bracket out' historical influences on confidence and focuses the conversation on recent events. This mode works best when supported by the 'open' mode described above, because it will help the program to collate and review all the insights it has captured that are relevant to the different functions and indicators.

3.0 Publications and Presentations

The following is a list of publications (published and in preparation), conferences, and sector presentations conducted by the W3 Project.

Publications from W3 Project

1. Brown G, Reeders D, Dowsett GW, Ellard J, Carman M, Hendry N, Wallace J (2015). Investigating combination HIV prevention: isolated interventions or complex system. Journal of the International AIDS Society. 2015;18(1). doi: **10.7448/IAS.18.1.20499**

2. Brown, G., & Reeders, D. (2015). Practical insights: Strengthening programs, informing partnerships, making better policy. What Works and Why (W3) Project Resources, Melbourne: Australian Research Centre in Sex, Health and Society, La Trobe University.

3. Brown, G. O'Donnell, D., Crooks, L., Lake, R. (2014), Mobilisation, politics, investment and constantly adapting: Lessons from the Australian health promotion response to HIV. Health Promotion Journal of Australia, 25, 35–41 IF 1.089

Manuscripts Under Peer Review

4. Carina Marbler, Graham Brown, Frank Michael Amort, Aryanti Radyowijati , Ursula von Rueden, Matthias Wentzlaff-Eggebert, (under review) Review of quality criteria and quality assurance approaches in HIV primary prevention,

5. Graham Brown, William Leonard, Anthony Lyons, Jennifer Power, Dirk Sander, William McCall, Ronald Johnson Cary James, Matthew Hodson, Marina Carman (Under review) Stigma, gay men and biomedical prevention: The challenges and opportunities of a rapidly changing HIV prevention landscape, Sexual Health

Manuscripts in Draft

6. Brown G, Reeders R, Madden A, Lake R, Cogle A, Fawkes J (Draft) How can we meaningfully enhance and demonstrate the role of peer leadership in the response to HIV: findings from the W3 project

7. Brown G, Reeders D, Cogle A, Cooper C, Allan B, O'Connor S (Draft) The value of the peer leadership of people living with HIV (PLHIV) to in the HIV response

8. Brown G, Reeders D, Perry G-E, Lobo R, Gavin N, Madden A (Draft) The role of peer insights for strengthening harm reduction programs and policies for people who use drugs,

9. Brown G, Reeders D, Batrouney C, Sepulveda C (Draft) The application of complex systems to understand peer network health promotion with sexually adventurous men

10. Reeders D, Brown G (Draft) Articulating the system logic of peer and community based prevention programs

Conference and Sector Presentations

International Conferences and Presentations

11. Graham Brown (2016) W3 Project and Quality Improvement, Quality Action Conference, Berlin, 26-27 January 2016

12. Graham Brown (2016) "Sex, Drugs and Politics – Understanding community and peer-led health promotion as a complex system" London School of Hygiene and Tropical Medicine, London, 21 January 2016

13. Johnston, K, D. Reeders, G. Brown, M. Carman, N. Hendry (2016) What works and why (W3): applying a systems thinking approach to evaluation and quality improvement for peer based community HIV programs, 20th International AIDS Conference (AIDS 2014). Melbourne, 24 July.

14. Brown, G., Shiell, A., Wentzlaff-Eggebert, M., Adam, B., Hecht, J., James, C., Batrouney, C., & Uulate, V. (2014). Understanding What Works and Why: New developments in demonstrating the role and impact of community interventions within combination prevention. Presentation and Panel Discussion at Australian Research Centre in Sex, Health and Society (ARCSHS) Satellite at 20th International AIDS Conference (AIDS 2014). Melbourne, 24 July.

15. Powell, S., Braybrook, N., Bryen, D., Burgess, C., Collins, D., Krishnasamy, E., Leitinger, D., Wright, J., Pedrana, A., & Brown, G. (2014). PRONTO! Expanding the peer experience - strengthening HIV communities from the inside out. Poster Exhibition at 20th International AIDS Conference (AIDS 2014). Melbourne, July.

16. Wentzlaff-Eggebert, M., Brown, G., & Noestlinger, C. (2014). Quality action: Improving quality in HIV prevention. Invited Scientific Development Workshop at 20th International AIDS Conference (AIDS 2014). Melbourne, 23 July.

17. Lisa Power, Norman Fowler, Graham Brown, Jim Hyde, Ian Muchamore (2014) *Australian HIV Policy – where to next?* Presentation and Panel Discussion at Deakin University Policy Satellite, 20th International AIDS Conference (AIDS 2014), Friday 18th July, Melbourne

18. Graham Brown, Alan Shiell, Matthias Wentzlaff-Eggebert, Barry Adam, Jen Hecht, Cary James, Colin Batrouney, Veronica Uulate (2014) *Understanding What Works and Why: New developments in demonstrating the role and impact of community interventions within combination prevention*" Presentation and Panel Discussion at Australian Research Centre in Sex, Health and Society Satellite, AIDS2014 Conference, 24 July, Melbourne

National Conferences and Presentations

19. Graham Brown and Jen Power (2016) Community engagement and response to HIV Cure Research, National Gay Men's HIV Health Promotion Conference : 'New Challenges: Big Ideas' , Manly, NSW 18-21 April

20. Graham Brown (2016) Research into Action and the W3 Framework Workshop, National Gay Men's HIV Health Promotion Conference : 'New Challenges: Big Ideas' , Manly, NSW 18-21 April

21. Graham Brown (2016) Leveraging and demonstrating peer leadership in a rapidly changing prevention landscape National Gay Men's HIV Health Promotion Conference : 'New Challenges: Big Ideas' , Manly, NSW 18-21 April

22. Graham Brown and Jen Power (2016) The health and wellbeing of PLHIV: emerging opportunities and challenges for the HIV response and GIPA National Gay Men's HIV Health Promotion Conference : 'New Challenges: Big Ideas' , Manly, NSW 18-21 April

23. Graham Brown (2016) The application of complex systems to understand peer network health promotion with sexually adventurous men, Social Research Conference on HIV, Viral Hepatitis & Related Diseases, University of NSW, Sydney, 31 March - 1 April 2016

24. Graham Brown (2016) How can we meaningfully embed and enhance peer leadership in Australia's response to HIV and hepatitis C? Social Research Conference on HIV, Viral Hepatitis & Related Diseases, University of NSW, Sydney, 31 March - 1 April 2016

25. Graham Brown (2016) Does a partnership investment in PLHIV leadership enhance meaningful engagement with PLHIV in the HIV sector? Social Research Conference on HIV, Viral Hepatitis & Related Diseases, University of NSW, Sydney, 31 March - 1 April 2016

26. Graham Brown (2016) Role of peer insights in harm reduction programs and policies for people who use drugs, SiREN Symposium Innovation in Practice'., 9 – 10 June 2016 Curtin University, Bentley Western Australia.

27. Graham Brown (2016) Enhancing peer leadership in health promotion and policy: an on the ground application of systems thinking, 23rd National Australian Health Promotion Association Conference. 19-22 June 2016, Scarborough Western Australia.

28. Reeders, Daniel and Brown, Graham (2015) "From promise to practicalities: Applying complex systems concepts and methods in evaluation research with peer and community based programs" Australasian Evaluation Conference, 7-9 September, Melbourne

29. Allan, B., Brown, G., Coogle, A., Fisher, M., Gray, J., Lake, R., O'Connor, S., & Ruth, S. (2015). Ramping up the Partnership Response – The Positive Leadership Development Institute (PLDI) Australia. Poster at Australasian HIV & AIDS Conference. Brisbane, 16-18 September

30. Brown, G., Reeders, D., & Perry, G.-E. (2015). Peer skill in service provision and policy advocacy. Poster at Australasian HIV & AIDS Conference. Brisbane, 16-18 September.

31. Brown, G., Reeders, D., & Cogle, A. (2015). Positive leadership and policy advocacy: Findings from the What Works and Why project. Poster at Australasian HIV & AIDS Conference. Brisbane, 16-18 September.

32. Reeders, D., & Brown, G. (2015). From promise to practicalities: Applying complex systems concepts and methods in evaluation research with peer and community based programs. Oral paper at Australasian Evaluation Conference. Melbourne, 7-9 September.

33. Reeders, D., Brown, G., & Batrouney, C. (2015). Peer network targeted health promotion: Findings from the What Works and Why project. Poster at Australasian HIV & AIDS Conference. Brisbane, 16-18 September.

34. Brown, G. (2015). W3 Project Presentation to Poz Action Group, Members Meeting, National Association of People Living with HIV Australia, 10 March.

35. Brown, G., & Reeders, D. (2015). Evaluating Peer Based PWUD Programs – lessons from the W3 Project. CREIDU Evaluation Workshop, Burnet Institute. Melbourne, 21-22 April. http://creidu.edu.au/events/28-creiduevaluation-workshop.

36. Brown, G. (2015). Here for research: W3 project feedback session. ACON. Sydney, 17 November.

37. Brown, G. (2015). Not just individuals and information – lessons from the W3 Project Presentation. Harm Reduction Victoria. Melbourne, 26 March.

38. Brown, G. (2015). Practical Insights: The application of systems thinking to better understand and strategise peer and community led health promotion. School of Psychology and Public Health, La Trobe University. Bundoora, 7 October.

39. Brown, G. (2015). Understanding what works and why in peer and community based programs for HIV and HCV. New approaches to peer based models: Perspectives from across the blood borne virus sector seminar, Australian Research Centre in Sex, Health and Society, La Trobe University. Melbourne, May.

40. Brown, G. (2015). Understanding what works and why in peer and community based programs for HIV and HCV. Presentation, Members meeting, Australian Federation of AIDS Organisations. Sydney, April.

41. Brown, G. (2015). Using a complex systems approach to understand peer and community based health promotion programs. Presentation at the Developing and Evaluating Complex Interventions workshop, Public Health Insight, University of Melbourne and deCIPHER, University of Cardiff. Cardiff, 9-13 November.

42. Brown, G., & Reeders, D. (2015). Using a systems approach in evaluation research with peer and community based health promotion programs. Seminar series, Centre for Excellence in Intervention and Prevention Science. Melbourne, 17 March.

43. Graham Brown, Kylie Johnston, Marina Carman, Jeanne Ellard (2014) *Combination prevention with confidence? Development of a monitoring, evaluation and learning (MEL) and quality improvement (QI) framework for combination prevention*, Paper presented at the Promises & Limitations: biomedical treatment and prevention in the real world, 13th Social Research Conference on HIV, Viral Hepatitis and Related Diseases, Centre for Social Research in Health, UNSW, Sydney, February 20-21, 2014

44. Graham Brown (2014) Combination not Parallel - A systems view of partnerships to get beyond the rhetoric, Invited Plenary at National Gay Men's HIV Health Promotion Conference 2014, 7-10 April 2014 in Manly, Sydney.

45. Graham Brown and Daniel Reeders (2014) What Works and Why Workshop, Full day invited workshop at the National Gay Men's HIV Health Promotion Conference 2014, 7-10 April 2014 in Manly, Sydney.

46. Graham Brown and Daniel Reeders (2014) What Works and Why Project, Invited paper at the National Association of People Living with HIV Annual General Meeting and Workshop, November 15, 2014, Sydney

4.0 Selected Copies of Tools

This appendix provides copies of the piloted tools that are currently available public documents.

Table 3: Selected tools in appendix

Peer Activity Focus	Case study	Purpose	Tools in Appendix	Page
Peer Service Delivery	HRV	Monitor the roll-out of a peer distribution project with a coalition of partners in a new area	1. Learning meetings 2. Indicator matrix	
	WASUA	Increase capture of insights across projects in an outreach program	3. Learning meetings 4. Indicator matrix	
	PRONTO	Understand the strengths, weaknesses and opportunities of the peer model in point of care HIV testing for gay men	5. Focus group schedule (peer staff)	
Peer Health Promotion	SAM project	Evaluate the project's reach among discrete networks of sexually adventurous men	6. Interview schedule	
Peer Leadership	PLDI	Evaluate the strength of the functions of a partnership among PLDI member organisations	7. Survey tool	
	PAG/PLNSW	Improve capture of real-time insights from peer programs about the experience of community prescribing rolling out in NSW, Queensland and Victoria	8. Survey tool 9. Indicator matrix	

LEARNING MEETING TEMPLATE

Health Promotion Program Meeting Agenda

31st February 2016

Item	Description	Actions/decisions
1	Apologies and staff whereabouts this month	
	• New staff member Jane	
2	Review actions from last meeting's minutes	
	• Manager to speak to AOD treatment service about changing profile of clients (emerging: impact of amphetamine use)	
4	Review of emerging issues (top five) • (All) share any new insights into each • Do theories/plans need revision?	Review previous minutes Minute this discussion
	1. <u>Impact of amphetamine use</u> ENG (clients unfamiliar with NSP via PNP outreach) → L&A (development of safe injecting resource for 'ice' injection initiators) → INF (more people aware of NSP) → ENG (more new users).	
5	Identify any new emerging issues • Discuss the initial insights into them • Develop a quick theory statement • Identify actions to firm up understanding	Minute the insights Minute the theory Minute the actions
	2. <u>Switching to amphetamines</u> ENG (peer networkers) report friends who previously used heroin are switching to 'ice'; L&A (peer insight) we think that's because the heroin quality is low and they want to feel *something* at least.	
3	Meetings and reportbacks	
	• Manager met with AOD service – their forms and processes don't capture people who switched from heroin to ice.	• Team: watch for insights into different needs in 'switchers'.

LEARNING MEETING TEMPLATE

Health Promotion Program Meeting Minutes

31st February 2016

Item	Description and discussion	Actions/decisions
1	Apologies and staff whereabouts this month	
	• Welcomed Jane	Issued with learning diary
2	Review actions from last meeting's minutes	
	• Team: watch for insights into different needs of 'switchers' from heroin to 'ice'	
4	Review of emerging issues (top five) • (All) share any new insights into each • Do theories/plans need revision?	Review previous minutes Minute this discussion
	1. <u>Impact of amphetamine use</u> Rather than developing new resources, branding the local NSP was seen as a way to /\ the INF of existing resources. This can be piloted (L&A) via the PNP roll-out in Frankston in partnership (INP) with the local NSP services.	Jane to meet with NSPs.
5	Identify any new emerging issues • Discuss the initial insights into them • Develop a quick theory statement • Identify actions to firm up understanding	Minute the insights Minute the theory Minute the actions
	2. <u>Switching to amphetamines</u> Manager will collate insights from team into needs of switchers for discussion with funders about possible responses.	Jo Bloggs accepts insights by e-mail by 31st March.
3	Meetings and reportbacks	
	• New working group created with AOD service to develop a new intake process for clients with complex histories.	• Nominate a service user to sit as a consumer rep.

Collating Insights and Rating Confidence in our Mental Models of Emerging Issues			
Function	Indicators – what would be happening if this function were being fulfilled in our work around this emerging issue?	Confidence – that this is actually happening?	Markers – what cues or signals have you observed that justify your confidence?
Engagement with the diversity and dynamism of community	Reaching a diverse range of networks among PWUD including people not connected to other services	-2 -1 0 +1 +2	Networkers don't all know each other Contacts have long-unmet needs met
	PWUD are aware of the PN project	-2 -1 0 +1 +2	PWUD seeking to become PN Shifting reasons for joining and continuing
	Hearing new things and knowing what myths are circulating in the target area	-2 -1 0 +1 +2	E.g. hearing about hospitalisations for endocarditis and osteomyelitis
Alignment picking up signals from the policy system including partner agencies	Balance of competing voices and agendas locally	-2 -1 0 +1 +2	PWUD and PNs are seen as contributing to reduced impact of drug use on local area
	Impact on other services in the right direction	-2 -1 0 +1 +2	
	Willingness to partner with HRV and support the PNP	-2 -1 0 +1 +2	
	PNP is seen as helping services meet their strategic goals	-2 -1 0 +1 +2	E.g. demand for PNs to reach areas not well-served by existing NSP investment
Learning & adaptation the program changing its approach based on insights	Forming mental maps of networks for strategic outreach	-2 -1 0 +1 +2	
	PNs get involved in training contacts (informal distributors) and other PNs over the life of the project	-2 -1 0 +1 +2	
	The approach is adapted to new demands and opportunities that appear in the local context	-2 -1 0 +1 +2	E.g. trialing the ex-users as PNs
	Sector level: insights acquired through PNP work like 'early warning radar' system for the BBV and AOD sectors	-2 -1 0 +1 +2	Shared insights are more timely than research findings

Influence on community signals and insights about having an influence on the community system	Resourcing enhances existing capacities rather than replacing them	-2 -1 0 +1 +2	
	Demonstrating the value of PN project via success stories	-2 -1 0 +1 +2	
	Reducing the rate of sharing and the time between initiating drug use and education on safe injection	-2 -1 0 +1 +2	
Influence on policy system signals and insights about having an influence on the policy system	HRV is seen in the BBV and AOD sectors as credible and reliable in part due to insights obtained via PNP	-2 -1 0 +1 +2	Acknowledgment, co-ownership of outputs, outcomes that reflect the input of HRV/PNP.
	Funders and stakeholders seek out insights from HRV and PNP	-2 -1 0 +1 +2	Feed-in via HRV management.
	PNs are invited to participate in consultation and leadership opportunities within the local policy environment	-2 -1 0 +1 +2	Committee invites.

LEARNING MEETING

W3 PROJECT - Questions for Staff Meetings and Supervision

Key Questions	Every few meetings
Engagement Are there any new or emerging issues or trends? Do we understand why?	Are we hearing enough new things or diversity to be confident we have broad enough engagement? Are we seeing changes as a result of our past influence
Alignment What changes are occurring in the sector that we need to consider? How can WASUA best respond to these new trends or issues? How are other Agencies responding?	Are we seeing the impact of our advocacy / influence to policy system getting through? Do we know what the enablers/barriers are?
Learning & Adaptation Are these new trends or issues immediately altering the way we provide service? What do we need to investigate further to take action/adapt?	What are we hearing through engagement or alignment about changes we have made?
Influence on Community How are the services we deliver influencing our target communities?	Are we seeing changes as a result of our past influence (cross referenced to engagement above)
Influence on policy system How could the insights we have gained inform or change the larger policy or political environment.	Are we seeing increased or more relevant requests for our insights from the policy system?

Collating Insights and Rating Confidence in our Mental Models of Emerging Issues			
Function	Indicators – what would be happening if this function were being fulfilled in our work	Confidence - that this is actually happening	Example Markers –cues or signals that justify confidence (+) or lack of confidence (-)
Engagement with the diversity and dynamism of community	Reaching a diverse range of networks among PWUD including people not connected to other services	-2 -1 0 +1 +2	+ Outreach workers do not all know each other + New OPAM peer educators every 6 months + Contacts have long-unmet needs met + Geographic coverage of known areas of need + Demographic client data + Number of word of mouth referrals - Lack of capacity to visit known areas of need
	PWUD are aware of WASUA outreach services	-2 -1 0 +1 +2	+ PWUD seeking to become OPAM peer educators + ACE worker put in touch with a significant contacts - Only have access to PWUD who use WASUA services – we do not know about other PWUD
	Hearing new things and knowing what myths are circulating in the target area	-2 -1 0 +1 +2	+ data received about hospitalisations for endocarditis and osteomyelitis + clients make disclosures they would not make to other agencies + ACE worker invited into homes of PWUD + ACE worker able to ask dealer for data on injecting practices in community e.g. sharing
Alignment picking up signals from the policy system including partner agencies	Impact on other services in the right direction	-2 -1 0 +1 +2	+ Agencies allocate budget to fund WASUA outreach services to visit remote communities
	Willingness to partner with WASUA	-2 -1 0 +1 +2	+ Parents Drug Information Service (PDIS) refers parents and family members to WASUA + Chem Centre shares information on new drugs with WASUA and discusses implications of their availability for local PWUD community - Key person reliance on expertise and credibility of outreach team leader - limits capacity, risks sustainability of service - Access to ED data on soft tissue or vein injuries related to drug use
	WASUA is seen as helping services meet their strategic goals	-2 -1 0 +1 +2	+ Requests for advice from AOD sector + Requests for information from BBV sector + Requests for advice from mental health sector + Demand for outreach to areas not well-served by existing NSP investment + Referrals from other agencies

Learning & adaptation the program changing its approach based on insights	Outreach workers train contacts (informal distributors) and other outreach workers over the life of the project	-2 -1 0 +1 +2	+ OPAM diaries record training opportunities
	Services are adapted to new demands and opportunities that appear in the local context	-2 -1 0 +1 +2	+ E.g. response to knowledge that oxycontin pills were being reformulated and would no longer have same effects if injected. Potential for injury. Accessed contacts in US and Eastern states. Resource produced for outreach workers to share with consumers; also shared resource with WAAC and HepWA NSP sites + Information shared at fortnightly staff meetings and feedback sought from staff on what changes to services are needed
	Insights acquired through outreach services work like 'early warning radar' system for the BBV and AOD sectors	-2 -1 0 +1 +2	+ Feedback from sectors that WASUA insights are more timely than research findings
Influence on community signals and insights about having an influence on the community system	Outreach services enhance existing capacities rather than replace them	-2 -1 0 +1 +2	+ Contact tells ACE worker he feels 'useful' to the community in helping to reduce drug-related harms + Aboriginal Council talking to WASUA + 'Intensity' or 'escalation' of interaction with ACE worker increases over time + Annual snapshot consumer satisfaction survey (100-150 clients) + WASUA able to advocate successfully for NSP and disposal boxes in communities
	Success stories which demonstrate the value of outreach services	-2 -1 0 +1 +2	+ OPAM diaries report PWUD feeling able to assist peers/save friends' lives (empowered) e.g. awareness of risk reduction actions to take when someone is in 'pre-overdose' state + OPAM diaries continue to be completed and submitted after 6 months when peer educators no longer paid to collect this data + PWUD enrol in WASUA training through word of mouth referrals
	Changes in harm reduction behaviour amongst PWUD	-2 -1 0 +1 +2	+ OPAM diaries show reduced incidence of poly drug use - people are still using but more safely + Youth outreach worker can record evidence of youth changing behaviour to reduce risk e.g. vein care, clean water, not sharing
Influence on policy system signals and insights about having an influence on the policy system	Funders and stakeholders seek out insights from WASUA	-2 -1 0 +1 +2	+ Requests for information received by WASUA management from a range of sectors including child protection, mental health, BBV, AOD + Training and education delivered to other agencies
	WASUA is seen in the BBV and AOD sectors as credible and reliable in part due to 'on the ground' insights obtained via outreach services	-2 -1 0 +1 +2	+ Requests for advice from AOD sector + Requests for information from BBV sector + Requests for ministerial briefings
	WASUA invited to participate in consultation and leadership opportunities within the local policy environment	-2 -1 0 +1 +2	+ Invitations to strategic planning committees + Invitations to inter-agency forums + Consultancy requests + Paid guest lecture requests from universities - addiction, medicine, pharmacy

PRONTO! Staff Focus Group Guide

Adapted from:

- Peer service provision and policy participation
- Peer network targeted health promotion

Domain	Draft indicators	Notes
Engagement *refers to quality engagement with the diversity and dynamism of the community system the program is working with.*	Test facilitators 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	
	Test facilitators and colleagues include relevant diversity of cultural literacies and has the skills to draw on these to work with the different networks and cultures targeted for health promotion	
	The team identifies emerging practices within the client group and implications for prevention across the community	
	The program builds and updates a mental map of the networks and cultures that constitute the community it engages with and works to extend its reach within them	
	Members of the target community recognise PRONTO! as a participant within community and cultures and feel a sense of ownership around its work	
	PRONTO! gains insight of the reach and recall of health promotion resources among members of the targeted networks and cultures	
	Strategic opportunities to create new relationships with people and networks in the community are identified (during service provision or through staff own networks)	
Learning and adaptation *refers to adapting the program based on practitioner and organisational learning and sector integration.*	Peer insights are incorporated into the mix of types and sources of knowledge used in health promotion planning and activities	
	PRONTO! turns information acquired through peer service provision into organisational knowledge and uses it to adapt the service in order to improve its influence	
	PRONTO! team is constantly refining its mental models and collective perspective through discussion of peer insights, drawing on peer insights from other programs, and using new research insights	
	The program's culture and leadership support continual practitioner learning and facilitate the capture of knowledge as an organisational and strategic asset	
	Packaging strategically relevant knowledge for influence on diverse stakeholders	

Influence *refers to the ongoing impact upon and interplay with both the community and the policy systems.* *The **community system** includes the diverse and dynamic networks and cultures that emerge from patterns of interaction among people who use drugs and the pressures placed on them by their environment.* *The **policy system** includes other organisations in relevant sectors (AOD, mental health, primary health, crimino-legal and social welfare) and funders, media, policy-makers and legislators*	**Influence within the community system –**	
	Reinforce an ongoing culture of testing and safe sex options among PRONTO! clients	
	Influence of peer interactions on consumers' mental models of sexual practice or testing expereinces	
	Reducing the gap between risk experiences and testing	
	PRONTO! Supports the circulation, consumption, translation and incorporation of health promotion materials by members of target networks	
	Pronto clients encourage their friends to test / to come to Pronto	
	Influence within the policy / sector system –	
	Knowledge produced from peer insights is shared and used in the broader sector and policy environment to improve quality or effectiveness of other services	
	VAC and/or other organisations seek out the insights from PRONTO! for strategic use	
	Indirect influence in the sector results in changes that support the role of PRONTO! or peer testing generally	
	PRONTO! Strengthens policy support for a peer and community based approach in HIV services / prevention	
Alignment *refers to the extent to which different programs in the organisation or sector support and reinforce each other to achieve 'value add' from a coordinated approach.*	The program actively seeks out and uses knowledge from different perspectives and disciplines within the sector	
	Organisational leadership supports a peer approach in workplace culture and organisational strategy	
	There are enough flexible resources to support learning and adaptation	
	The broader sector and policy system includes and values the peer approach and insights it generates	
	The program contributes to sector learning to help program managers and policy makers understand and contextualise emerging issues from multiple perspectives	
	The program adapts its approach to support the effectiveness of other programs and the HIV response as a whole	
	The organisation has strategic and supportive relationships with key players within its sector, policy and funding environment	

Thank you for your support for the Positive Leadership Development Institute (PLDI).

In preparation for a PLDI planning day in October we are conducting a survey to collect information and insights from members of the partnership to then summarise and present at the PLDI planning meeting.

This survey is being conducted by Dr Graham Brown from the Australian Research Centre in Sex, Health and Society (ARCSHS) as part of their sponsorship of the Positive Leadership Development Institute (PLDI).

This survey will ask for your insights on how the Positive Leadership Development Institute (PLDI) and the partnership is functioning.

PLDI has a broad range of partners who may have different perspectives and insights into what PLDI is (or is not) achieving, beyond its impact on the resilience and wellbeing of individual participants. Some partners are closely involved, while others are supporting from a distance.

We are interested in how confident you are that four main functions are being met. The four key functions come from the W3 framework (w3project.org.au). They are things that need to be happening for a peer led program like PLDI to be effective and sustainable. The functions are: engagement with the HIV positive community, learning and adaptation , influence on community and policy-making, and alignment with policy and sector changes.

There are 2-3 questions for each function that have been developed in consultation with the PLDI program. For each one, we ask how confident you are that something is happening. We also ask for brief details of things you have seen or heard that inform your confidence rating. You may not yet have seen or heard things for all items. We plan to conduct this survey every 4-6 months to track changes and themes emerging over time and to feed this back to the partnership.

BRIEF ANSWERS ARE WELCOMED!

The first time you do this survey, it might feel unfamiliar. Feel free to call or e-mail us if you are not sure how to answer.

The overall confidence ratings and the list of things participants have seen/heard will be tabled at the next PLDI partnership meeting. The results are intended to inform the ongoing adaptation of the PLDI program.

The survey is not anonymous -- your name, position title and organisation will be linked to the answers you provide. Taking part in the survey is the same as taking part in a face-to-face meeting and sharing what you have seen/heard about the program and how well it is working. Including your name and organisation will help us understand where your 'things I've seen and heard' feedback is coming from. This will allow us to have a collated summary to present at the PLDI partnership meeting, rather than collecting the information at the meeting.

However, any identifying details will not be included when the results are shared outside of the PLDI partnership.

The survey is voluntary. Your decision to participate or not will not prejudice your relationship with PLDI or any of the partner organisations, the W3 Project or La Trobe University.

If you have any questions about the survey please feel free to contact W3 Project Lead, Dr Graham Brown, by e-mail at graham.brown@latrobe.edu.au

If you have any complaints or concerns about your participation in the study that the researcher has not been able to answer to your satisfaction, you may contact the Senior Human Ethics Officer, Ethics and Integrity, Research Office, La Trobe University, Victoria, 3086 (P: 03 9479 1443, E: humanethics@latrobe.edu.au) . Please quote the application reference number FHEC14/155.

Your details

1. Consent to participate

☐ I have read the participant information sheet (previous page), I understand that participation is voluntary and I agree to continue.

2. Name

3. Position title

4. Organisation

5. Role in organisation

6. I am the key contact for the PLDI program within my organisation

7. Involvement with PLDI

	Strongly disagree	Disagree	Not sure	Agree	Strongly agree
My organisation is closely involved with the PLDI partnership	○	○	○	○	○
I have a good understanding of the PLDI initiative	○	○	○	○	○

Engagement

The questions on this page help us gauge how well the PLDI partnership is engaging with the diversity and dynamism of the positive community.

8. Engagement indicators

	Very confident this is **not** happening	Confident this is **not** happening	Confident this **is** happening	Very confident this **is** happening	No opinion at this time
The mix of PLDI participants broadly reflects the positive community in my state/territory.	○	○	○	○	○

Please give brief details of what you've seen/heard that inform your rating.

	Very confident this is **not** happening	Confident this is **not** happening	Confident this **is** happening	Very confident this **is** happening	No opinion at this time
Through PLDI, knowledge flows in both directions between the HIV sector and the positive community.	○	○	○	○	○

Please give brief details of what you've seen/heard that inform your rating.

	Very confident this is **not** happening	Confident this is **not** happening	Confident this **is** happening	Very confident this **is** happening	No opinion at this time
My organisation uses PLDI to learn more about changes in the positive community.	○	○	○	○	○

Please give brief details of what you've seen/heard that inform your rating.

Learning & Adaptation

The questions on this page help us gauge how well the PLDI partnership adapts its approach according to insights obtained through peer practice.

9. Learning & Adaptation indicators

	Very confident this is **not** happening	Confident this is **not** happening	Confident this **is** happening	Very confident this **is** happening	No opinion at this time
Program content and approach are revised when new insights become available about changes in the HIV sector and positive community.	○	○	○	○	○

Please give brief details of what you've seen/heard that inform your rating.

	Very confident this is **not** happening	Confident this is **not** happening	Confident this **is** happening	Very confident this **is** happening	No opinion at this time
Members of the PLDI partnership regularly suggest ways to adapt the PLDI program.	○	○	○	○	○

Please give brief details of what you've seen/heard that inform your rating.

Alignment

The questions on this page help us gauge how well the PLDI partnership is picking up signals about what's happening in the HIV sector and policy environment.

10. Alignment indicators

	Very confident this is **not** happening	Confident this is **not** happening	Confident this **is** happening	Very confident this **is** happening	No opinion at this time
As part of our involvement in PLDI, my program/organisation shares information about changes in the sector and policy landscape.	○	○	○	○	○
Through our involvement in PLDI, my program/organisation learns about changes in the sector and policy landscape.	○	○	○	○	○

Please give brief details of what you've seen/heard that inform your rating.

Please give brief details of what you've seen/heard that inform your rating.

Influence

The questions on this page help us gauge how well the PLDI partnership is able to mobilise influence within the community and policy/sector environment.

11. Influence indicators

	Very confident this is **not** happening	Confident this is **not** happening	Confident this **is** happening	Very confident this **is** happening	No opinion at this time
My organisation and other partners are finding roles/opportunities for PLDI graduates to practice and demonstrate positive leadership.	○	○	○	○	○
As positive leaders, PLDI graduates demonstrate awareness of needs and experiences that are **different from their own**.	○	○	○	○	○
As positive leaders, PLDI graduates demonstrate awareness of the priorities of **other organisations** in the HIV sector.	○	○	○	○	○
PLDI delivers value to my program/organisation and the sector beyond the benefit it may have for individual positive people.	○	○	○	○	○

Please give brief details of what you've seen/heard that inform your rating.

Please give brief details of what you've seen/heard that inform your rating.

Please give brief details of what you've seen/heard that inform your rating.

Please give brief details of what you've seen/heard that inform your rating.

Final remarks

12. Is there anything else you'd like to tell us about the PLDI partnership?

PAG Community Pharmacy Initiative – Access to HIV Treatments Advisory Group Evaluation Matrix

Function	How strongly do you agree or disagree with these statements, based on what you have seen or experienced through the your participation in the Access to HIV Treatments Advisory Group	Scale 1=Strongly disagree to 5= strongly agree	Any comments – such as what key event or experience (or lack of) has given you this impression
Engagement	PLNSW is receiving feedback from a **diverse range** of PLHIV about their experiences with the community pharmacy roll out	1 2 3 4 5	
	PLNSW is receiving **timely** feedback from PLHIV about their experiences with the community pharmacy roll out	1 2 3 4 5	
	PLNSW is receiving feedback from PLHIV through a **diverse range of sources and strategies**	1 2 3 4 5	
Alignment	Organisational partners or stakeholders (eg pharmacies, clinicians, health Dept) are **providing PLNSW with timely insights** and feedback about the community pharmacy roll out	1 2 3 4 5	
	PLNSW is **responding appropriately to feedback** from organisational partners and stakeholders about the community pharmacy roll out	1 2 3 4 5	
	PLNSW has made it clear they are **keen to hear feedback** from organisational partners and stakeholders about PLNSW strategies to support the community pharmacy roll out	1 2 3 4 5	
Learning & adaptation	PLNSW has been **using feedback and insights** to refine their approaches and priorities regarding the community pharmacy roll out	1 2 3 4 5	
	PLNSW has been **flexible and responsive** in its work to support the community pharmacy roll out	1 2 3 4 5	
	PLNSW has **quickly synthesised feedback from PLHIV and identified key issues** or insights to share with their partners/stakeholders	1 2 3 4 5	

Function	How strongly do you agree or disagree with these statements, based on what you have seen or experienced through the your participation in the Access to HIV Treatments Advisory Group	Scale 1=Strongly disagree to 5= strongly agree	Any comments – such as what key event or experience has given you this impression
Influence – Sector/policy	The range of members on the **Advisory group reflects key stakeholders** in implementing the community pharmacy roll out	1 2 3 4 5	
	PLNSW syntheses insights and feedback from PLHIV in a way that is **useful for the reference group** to use or act on needed	1 2 3 4 5	
	I found the reference group process to be a **useful way to share and receive timely feedback**	1 2 3 4 5	
	The reference group process has **influenced my practice, decisions or advice** to others regarding the community pharmacy roll out	1 2 3 4 5	
	I have found the reference group process a **good use of my time**	1 2 3 4 5	
	I look forward to the insights from PLNSW with interest as I know they will be **accurate and useful**	1 2 3 4 5	
Influence - community	I believe PLNSW communication to the PLHIV community about the community pharmacy roll out has been **timely and effective**	1 2 3 4 5	
	I believe PLNSW has been able to **keep PLHIV community up to speed** about the community pharmacy roll out	1 2 3 4 5	
	PLNSW has **communicated widely with PLHIV** in NSW about the community pharmacy roll out	1 2 3 4 5	

Open ended questions at end

- What have you found to be the most useful and/or least useful about your participation in the Access to HIV Treatments Advisory Group process
- Have you seen or experienced anything that challenged your confidence in the insights contributed by PLNSW?
- What actions have you taken (or intend to take) due to your participation in discussions connected to the Access to HIV Treatments Advisory Group process

Which full committee meetings did you attend (list dates)

PAG Community Pharmacy Initiative – Partnership Indicator Matrix			
Function	Indicators – what would be happening if this function were being fulfilled?	Confidence – that this is actually happening?	Markers – what cues/signals have you observed that increase **and/or** decrease your confidence?
Engagement	PAG members are receiving feedback on the impact of the changes from a diverse range of positive people.	-2 -1 0 +1 +2	Cues are expected from: • Poz Events (planet positive, workshops) • Online Anonymous feedback (diversity may be unable to track) • Mystery Shopper feedback (online or other) • October Survey • TIM
	PAG members are thinking about people whose experience is not currently represented in the feedback received and coming up with ways to reach them for consultation.	-2 -1 0 +1 +2	Gaps in above Particular attention to online anonymous
	Positive people are aware of and give feedback to PAG about the effectiveness of local advocacy initiatives.	-2 -1 0 +1 +2	Poz Events and mystery shopper - Reach and recall of community pharmacy option - Proportion tried / acted (barrier/enabler) - Experience of acting/requesting - Word of mouth assessment of PozLife initiatives and experiences at pharmacy October Survey – same points as above
Alignment	PAG members receive feedback from a range of sources about emerging issues and problems via 'back channels' with policy stakeholders.	-2 -1 0 +1 +2	- Comm Pharm reference group - poz action members - ASHM - commonwealth - local/ ally pharmacist - pharmacy guild - futures (2016) questions
	PAG members have an ongoing and up-to-date sense about how their own and other messages and initiatives are 'playing' in the policy and funding environment.	-2 -1 0 +1 +2	- e.g. how well pharmacy guild are reaching pharmacy owners - tracking of refinements in implementation / resistance to PAG messages

Learning & adaptation	PAG members are recording every possible cue/signal about the impact of the changes (regardless of format).	-2 -1 0 +1 +2	- staff and volunteers pass on word of mouth to be collated - internal meetings and information systems
	The cues/signals collected are regularly collated and used to support advocacy efforts and shared within PAG's networks.	-2 -1 0 +1 +2	- the collated findings are regularly shared and considered by the PAG reference group
	Different kinds of stories and data are chosen to support messages tailored to the situation to different advocacy initiatives.	-2 -1 0 +1 +2	
	PAG members are engaging in local advocacy and recording and sharing their reflections on what's working, where, and why (not).	-2 -1 0 +1 +2	
	PAG observes the results of its initiatives (via E & A) and uses them to verify and adapt its mental models of the emerging issues and refine its plan of action over time.	-2 -1 0 +1 +2	- discussion at meetings - action items - follow up on action items
	PAG changes its approach as needed and beds any changes down in policy and practice.	-2 -1 0 +1 +2	- timeliness
Influence	PAG members are able to work with and through other players/voices where it helps to achieve good outcomes.	-2 -1 0 +1 +2	- partnerships - training delivery
	Where possible PAG targets its advocacy to upstream drivers of the practices it wants to change.	-2 -1 0 +1 +2	- use of insights to find leverage points - provides timely feedback on insights received to people who can do something about it
	PAG collects and shares its stories of success in local advocacy initiatives to sustain the broader momentum.	-2 -1 0 +1 +2	- strategic use of positive and negative situations to motivate pharmacists to adopt best practices - sharing findings with positive community to demonstrate their feedback has been heard