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Australian Research Centre in Sex, Health and Society

W3 Project

The impact of peer-led work in Australia's HIV and hepatitis C response — executive summary

https://w3framework.org

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About this report

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

This report provides an overview of work undertaken during Stage 3 of the W3 Project with Australian organisations led by people living with HIV (PLHIV) and people who use drugs (PWUD). It is the final in a series of three reports describing this work, the first two being:

1. W3 Project: Creating a set of evaluation indicators for peer-led work[1]
2. W3 Project: Locating evidence against the W3 Indicators for peer-led work[2]

The purpose of this report is to provide a clear snapshot of the:

- Steps taken in the effort to evaluate and demonstrate the full impact of peer work
- Evidence found and what it tells us about the role of peer-led organisations in the HIV and hepatitis C response
- Barriers and enablers that we encountered in demonstrating the system-level impact of peer work

Funding

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Acknowledgements

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

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

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

Terminology and acronyms

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

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

AOD: Alcohol and other drugs.

BBV: Blood-borne virus.

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

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

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

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

MOU: Memorandum of understanding.

PLHIV: People living with HIV.

PWUD: People who use drugs.

STI: Sexually transmissible infections.

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

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

Executive summary

The Australian National HIV[3] and Hepatitis C[4] Strategies emphasise the importance of community and peer-led approaches in the partnership response. Peer-led approaches, developed, led, and implemented by individuals from affected communities, play a crucial role in Australia's public health response to HIV and hepatitis C due to their positive influence both within their communities and within the health system and policy environment[5].

The What Works and Why (W3) Project has collaborated with peer-led organisations since 2014 to strengthen our understanding of the system-level role and impacts of their work within the national HIV and hepatitis C response. The current (third) stage of the W3 Project aimed to consolidate evidence demonstrating this role and impact.

The W3 Framework served as the theoretical basis for evidence collation and analysis, focusing on engagement, alignment, adaptation, and influence. Six partner peer organisations participated in the study, three led by people living with HIV and three by people who use drugs. Over 1,100 documents and data sources were collected, summarised, and analysed.

The findings demonstrated that investing in peer-led organisations yields significant positive and system-strengthening effects on both community and health system levels, as well as in the policy environment. These organisations exhibited a strong ongoing commitment to long-term community engagement, cultivating meaningful relationships, and adapting their work to address emerging community needs. Peer-led organisations placed a strong emphasis on building relationships with diverse stakeholders and actively contributed peer expertise to policy and strategy discussions. The evidence further demonstrated that actors within the health sector and policy environment valued and sought out contributions from these peer-led organisations.

However, there is a need for strong support to build the capacity of peer-led organisations to comprehensively evaluate their full role and impact. Enablers and barriers affecting the ability of peer-led organisations to collect evidence and demonstrate their system-level role were identified. Recommendations to leverage enablers and mitigate barriers were developed.

Table 1: Enablers, barriers, and recommendations

Enablers and barriers	Recommendations
Enablers	
A policy and sector environment that enables meaningful community participation and values peer insights	Maintain the commitments in the national and state strategies to meaningful participation, as well as strengthen the recognition of the system-strengthening role of investing in peer-led and community-led organisations
Funding partnerships that value and enable the community engagement, sector partnership, and system-strengthening role of peer organisations	Resourcing arrangements that recognise and enable peer organisations to fulfill their system-strengthening roles within community engagement, sector partnerships, and policy participation
Barriers	
Limited resources to monitor and evaluate the system level impact of investing in peer led organisations	Ensure that monitoring and evaluation in peer organisations include resources to assess both their service-level and system-level roles, as well as assess the quality of the policy and sector environment to enable peer organisations to fulfill these roles
Stigma and criminalisation	Ensure that responses to stigma and criminalisation include the impact of stigma and criminalisation on achieving meaningful community participation in the HIV and Hepatitis C responses

Summary

Background

The Australian National HIV[3] and Hepatitis C[4] Strategies affirm the importance of community-based and peer-led approaches within the partnership response. This partnership with communities is even more critical as the partnership responds to significant developments in prevention and treatment, shifts in epidemiology, policy and practice, and the impact of system-level shocks such as COVID-19.

Peer-led approaches in HIV and hepatitis C are led and implemented by people from the communities most affected by HIV and hepatitis C. They operate through organisations established and governed by these communities. These programs include a variety of peer activities, including[5]:

- Peer service delivery (such as PLHIV peer navigators, peer-led rapid HIV testing, or peer-led needle and syringe programs)
- Peer health promotion (such as peer-developed and peer-implemented campaigns or community development)
- Peer leadership (such as peers taking leadership roles in their community or the health sector, or participating in policy or service reform)

The effectiveness of these approaches stems from the strong, positive influence that peer work has in communities and in the health systems and policies that affect communities' health.

Since 2014, the What Works and Why (W3) Project has worked closely with staff from peer-led organisations and programs in the HIV and hepatitis C sectors. The project has explored the broader system-level role that investing in peer-led organisations plays in strengthening the HIV and hepatitis C response.

This stage of the W3 Project aimed to create a consolidated evidence base showing the scope, quality, and impact of peer-led HIV and hepatitis C programs, and to guide investment in targeted peer-led health promotion programs. This aimed to support peer-led responses to demonstrate the range of ways they strive to achieve their full impact and value.

We worked with partner organisations to pool and analyse their monitoring and evaluation data and other information about their work to:

- Create a consolidated evidence base that illustrated their scope, quality, and impact at a system level
- Provide guidance for funding, monitoring, and evaluating peer-led responses

Method

The W3 Framework (page 16) provided the theoretical framework for the evidence collation and analysis. The W3 Framework describes four key system-level functions through which peer-led responses create positive change: engagement, alignment, adaptation, and influence within the community and within the health sector and policy environment.

For the third stage of the W3 Project, we invited six partner peer organisations to participate, including:

- Three organisations led by people living with HIV:
  - Queensland Positive People
  - Positive Life NSW
  - Living Positive Victoria
- Three organisations led by people who use drugs:
  - NSW Users and AIDS Association (NUAA)
  - Harm Reduction Victoria
  - Peer Based Harm Reduction WA

All activities throughout the project development and implementation were conducted collaboratively with our partner organisations.

Due to the COVID-19 pandemic, the original planned methodology needed to be significantly adapted. The capacity of peer organisations to collate data and collect additional data during this period was significantly reduced or not possible, and so the emphasis in locating evidence was on existing and accessible evidence within and outside the peer organisations.

In collaboration with peer organisations and other stakeholders, we developed agreed indicators to assess if each function was being achieved. The W3 Project located and collated over 1,100 documents and data sources, including direct contributions from the partner organisations, as well as web-based searches for public information, academic literature, and grey literature (such as policy documents, sector reports, and external organisation links to referrals to peer organisations). Documents were systematically organised into project databases and analysed for their contribution to assessing if the W3 functions were being achieved.

Findings

The scope, quality, and impact of peer work at a system level

We found good evidence that investing in peer organisations can achieve system-level influence in communities and in policy and health systems to strengthen the response to HIV and hepatitis C.

Overall we found that peer-led organisations demonstrated, through their actions, a clear commitment to long-term and sustained community engagement. They invested significantly in cultivating relationships and partnerships across the health and other sectors. They also demonstrated the outcomes of drawing on community insights and sector relationships to constantly adapt and refine their work. Furthermore, they brought influential peer expertise and insights to policy and strategy discourse.

We identified enablers and barriers that impacted on the capacity of peer organisations to achieve and demonstrate their system-level influence.

We found that, for these organisations to fulfil their potential, it was essential to have both a policy environment that enabled meaningful community participation and valued peer insights, and funding partnerships that valued and enabled the community engagement, sector partnership, and system-strengthening role of peer organisations. However, we found that the limited resources available to monitor and evaluate the system-level impact of peer-led organisations reduced the capacity to prioritise this essential work in strengthening the HIV and hepatitis C response. We also found that the impact of stigma and criminalisation hindered not only the peer organisations' ability to reach priority communities but also limited their capacity to demonstrate the impact of their community engagement.

Summary of evidence

Table 2 provides an overview of the strength and scope of the evidence that was available for assessment against each function and its indicators. This represents the collation and analysis of 1,161 documents, interviews, workshops, and online data searches.

Table 2: Evidence ranking system

1. Strong evidence available across **all** organisations	There is evidence corroborated by multiple sources and across **all** organisations that the peer organisations have been achieving the indicator.
2. Strong evidence available across most organisations	There is evidence corroborated by multiple sources and across most organisations that the peer organisations have been achieving the indicator. There is no evidence to the contrary.
3. Good evidence available across most or all organisations	There is evidence across most or all organisations that the peer organisations have been achieving the indicator. Evidence may be strong for a minority of organisations. There is no evidence to the contrary.
4. Limited evidence available across most organisations	There is limited or indicative evidence from most organisations that the peer organisations have been achieving the indicator. Evidence may be strong or good for a minority of organisations. There is no evidence to the contrary.
5. Available evidence shows mixed results	There is evidence that the peer organisations have been achieving the indicator alongside evidence of the peer organisations not achieving the indicator.
6. Contrary evidence	There is corroborated evidence across most organisations that the peer organisations have NOT been achieving the indicator.
7. Insufficient evidence	There is insufficient evidence available to assess if the organisations have been achieving the indicator.

Engagement

Engagement is how the peer organisation or program interacts with, participates in, and learns from its communities. Interaction is not just about the peer programs and services. It is also about how the peer organisation or program participates within its community on a deeper level.

Peer-led organisations demonstrated clear commitment to community engagement, valuing meaningful participation and recognising the importance of diverse perspectives. Our findings suggested peer organisations held a broad perspective on engagement as a quality of all the combined activities of an organisation or program, rather than as a specific type of activity.

Peer-led organisations demonstrated peer-to-peer learning, thereby fostering a current understanding of their communities and enabling proactive responses to emerging issues. Their diverse peer workforce and initiatives were instrumental in creating avenues for the representation of community perspectives, particularly those of marginalised populations. Long-standing community relationships resulted in an enriching feedback culture, fostering trust and promoting a sense of ownership within the organisation. These organisations strengthened community relationships, extended their reach, and formed partnerships, promoting inclusion and sustainability.

However, these organisations faced barriers in fully demonstrating their engagement. Stigmatisation and criminalisation of community members created privacy concerns that posed challenges in data collection. The informal nature of many engagement processes also made documentation challenging. Additionally, resource limitations hindered regular evaluation of their practices, affecting their capacity to effectively capture and utilise community knowledge.

'We have a solid connection with people from a range of communities and subcultures that many other services find "hard to reach." For us these are our friends and peers.'

—Harm Reduction Victoria CEO, 2017-2018 annual report[6(p. 10)]

Despite these challenges, capacity to strengthen documentation, analysis, and decision-making processes could enhance their adaptability and responsiveness, ensuring the promotion of community wellbeing in the face of evolving dynamics.

Table 3: Engagement indicator achievement

Indicator	Evidence that indicator is being achieved
Process/quality	
ENQ1 The diversity of community members that access and/or engage with the peer organisation reflects the diversity within the peer organisation's target community group(s)	3. Good evidence available across most or all organisations
ENQ2 The peer organisation identifies, engages, and responds accordingly to community members who are less able to participate in consultation	1. Strong evidence available across all organisations
ENQ3 Structures, processes, and opportunities are in place to support peer workers to learn from each other's insights and maintain a current overall understanding of their diverse communities	1. Strong evidence available across all organisations
ENQ4 The peer organisation actively communicates with community members to improve each other's understanding of emerging issues and practices, how these might impact communities, and how best to respond	1. Strong evidence available across all organisations
Impact	
ENI1 Community members recognise the organisation as peer-led and as an important part of, and resource to, their community	1. Strong evidence available across all organisations
ENI2 Policy advice and peer leadership is based on current community needs and experience	3. Good evidence available across most or all organisations
ENI3 Relationships with different community members and networks are built or strengthened as a result of the peer organisation's activities	4. Limited evidence available across most organisations
ENI4 The peer organisation is informed about changes within their community and assesses how they might impact community wellbeing and/or the peer organisation's work	3. Good evidence available across most or all organisations

Alignment

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

Our findings revealed that, despite their limited resources, peer organisations invested significantly in cultivating relationships and partnerships with stakeholders across the health and other sectors. The peer organisations demonstrated a broad range of both formal and informal partnerships, displaying an expansive collaborative network across various sectors. Furthermore, they actively pursued new partnerships in response to emergent community needs, illustrating their adaptability and commitment to the wellbeing of their communities.

The NSW policy environment around alcohol and other drug use is notable for a lack of a cohesive strategy with the official policy of "just say no" — in sharp contrast to the evidence-based national policy of harm minimisation.

—NUAA CEO, 2018-2019 annual report[7(p. 3)]

'Partner with relevant Victorian agencies, community-based organisations and health services to develop specific and culturally sensitive policies and interventions to eliminate barriers to treatment in communities which evidence shows are at risk of falling short of the 95:95:95 targets.'

—Living Positive Victoria, 2018 strategic plan[8(p. 5)]

Evidence sourced from multiple internal and external parties indicated substantial recognition within the health sector and policy environment of the peer organisations' credibility, trustworthiness, and crucial role in the broader public health response. However, mirroring the scenario with community engagement, resources were limited for monitoring the progress and process of these collaborations. This scarcity of resources made it challenging to illustrate the iterative and responsive nature of their relationship management efforts and the work emerging from these partnerships.

Table 4: Alignment indicator achievement

Indicator	Evidence that indicator is being achieved
Process/quality	
ALQ1 The peer organisation actively seeks to create partnerships with stakeholders across the health sector and other relevant sectors, particularly at the senior management level	3. Good evidence available across most or all organisations
ALQ2 The peer organisation seeks out and collaborates with beneficial and relevant research and policy initiatives	1. Strong evidence available across all organisations
ALQ3 The peer organisation actively communicates with sector partners to improve each other's understanding of emerging issues and practices, how these might impact communities, and how best to respond	3. Good evidence available across most or all organisations
ALQ4 The peer organisation creates safe and effective ways for community members to participate in the health and policy sector's response	4. Limited evidence available across most organisations
Impact	
ALI1 The peer organisation is informed about changes within the health sector and policy environment and assesses how they might affect its communities and/or its work	4. Limited evidence available across most organisations
ALI2 Key players from the broader health sector and policy environment recognise the peer organisation as credible, trustworthy, and an essential partner in the overall public health response	1. Strong evidence available across all organisations
ALI3 Policy, media, and funding environments support (or do not impede) innovative and culturally relevant approaches to community health	5. Available evidence shows mixed results

Adaptation

Adaptation is about how the peer organisation or program changes the way it works to suit its changing environment. This encompasses the way they use knowledge gained through both engagement and alignment to understand when they need to adapt and how they should go about doing so. Central to strong adaptation is the extent to which it is informed and driven by peer insights and community knowledge.

While we found evidence of adaptation across the entire study period, the COVID-19 pandemic in particular represented a unique opportunity to understand the peer organisations' adaptability in response to rapidly changing community, health sector, and policy environment contexts.

We found significant evidence of the outcomes of adaptation to changing community needs and to changes in the health sector and policy environment. We found good evidence across all organisations that this adaptation was based on peer insight and community knowledge. Evidence also demonstrated the extent to which peer organisations support development of their peer staff in this role.

'We exist for our communities, to identify and serve their needs. We have a commitment to constantly review ways to enhance representation and ownership by the community.'

–Peer Based Harm Reduction WA, 2022-2027 strategic plan[9]

While the outcomes of adaptation were evident, the inherent nature of adaptation often limited the tangible evidence available to demonstrate the process itself. This was primarily due to the intrinsic way in which organisations worked, prioritising service delivery and community engagement over formal documentation. Additionally, when adaptation occurred rapidly, it did not necessarily involve extensive consultation, needs analysis, or the creation of referenced reports, strategic plans, or program plans. However, this agile approach was essential as it allowed organisations to take prompt action. It is worth noting that while 'evidence-based best practice' guided the peer organisations to enable rapid adaptation with their communities, the organisations had to balance this rigorous evidence-based approach with other forms of emerging evidence and knowledge, such as peer insights.

Table 5: Adaptation indicator achievement

Indicator	Evidence that indicator is being achieved
Process/quality	
ADQ1 The peer organisation combines and uses information and insights from engagement and alignment to identify and to guide reorientations and responses to emerging priorities	4. Limited evidence available across most organisations
ADQ2 The peer organisation's practices are guided by peer knowledge and insights	2. Strong evidence available across most organisations
ADQ3 The peer organisation draws on engagement with membership and partnerships with the sector to develop evidence-based positions	2. Strong evidence available across most organisations
ADQ4 The peer organisation supports staff to acquire skills in peer leadership, evaluation, and policy participation	3. Good evidence available across most or all organisations
Impact	
ADI1 The peer organisation adapts its work, priorities, and strategies to the changing needs of its community	1. Strong evidence available across all organisations
ADI2 The peer organisation translates insights from engagement and alignment into accessible language and practical advice for their community and the health sector and policy environment	1. Strong evidence available across all organisations
ADI3 The peer organisation assesses and synthesises diverse views of the community and leads advocacy on key priorities for the broader public health response	3. Good evidence available across most or all organisations

Influence in communities

Community influence is about how well the peer organisation or program is able to affect their community's health, behaviour, knowledge, or attitudes – for example, through health education, harm reduction, or support services. It also encompasses community-level impacts, such as strengthening community networks, influencing community norms and trends, or enhancing a positive sense of community agency. Peer programs and organisations derive their influence from their deep integration and participation within the communities they serve, operating within them rather than intervening from outside.

We found good evidence that the peer organisations successfully achieved their funded service goals within their respective communities. This evidence came primarily from evaluations conducted by the peer organisations themselves or, in some circumstances, pilot projects undertaken in collaboration with research partnerships. However, as the resources allocated for these evaluations emphasised reporting on service delivery outputs to meet contractual requirements, they focused on short-term individual-level outcomes. As a result, most of the peer organisations lacked the necessary resources to evaluate community-level outcomes.

'We were successful in reaching a geographically dispersed cohort, including a large proportion of people who had never tested for HIV.'

—Queensland Positive People, 2017-2018 annual report[10(p. 18)]

Nevertheless, there was indicative evidence that suggested community-level influence. For example, the long-term strong engagement with their communities inferred strong influence and credibility within their communities, despite the limited availability of direct evidence to demonstrate the strength of their profile in their communities, the nature of word-of-mouth referrals, or the direct impact of their work on building a strong collective community voice.

Despite these limitations, all the organisations in our study demonstrated a strategic commitment to evaluation and recognised the importance of demonstrating and understanding their impact. They valued the ability to showcase their effectiveness beyond their contractual requirements and aligned to their respective strategies and core values. However, all organisations in the study experienced constraints that impacted their capacity to conduct comprehensive evaluations of their work within their communities.

Table 6: Community influence indicator achievement

Indicator	Evidence that indicator is being achieved
Process/quality	
CIQ1 The peer organisation has a strong profile within its community and is endorsed by peer networks	3. Good evidence available across most or all organisations
CIQ2 The peer organisation receives referrals from community members (including those who are not current or former clients)	4. Limited evidence available across most organisations
CIQ3 The organisation supports peer leaders to build their confidence, skill, and experience in community and personal advocacy	3. Good evidence available across most or all organisations
Impact	
CII1 Coordinated peer leadership results in a strong collective community voice	3. Good evidence available across most or all organisations
CII2 The peer organisation's engagement activities are achieving its stated impact goals	3. Good evidence available across most or all organisations

Influence in health sector and policy environment

Health sector and policy environment influence is about how the peer organisation or program achieves or mobilises change within the health sector and policy environment to strengthen public health and community outcomes. Peer-led organisations are instrumental in shaping the health sector and policy environment. They bring peer expertise and perspectives that contribute a unique dimension to discourses on processes and outcomes; for example, changes to the way health services are run or changes to government or organisational policies.

The evidence reviewed demonstrated significant involvement in submitting informed policy advice, participating in working groups, and advocating and presenting solutions for improved access and outcomes for their communities. These activities suggested a significant role for these organisations in policymaking, health sector advocacy, and service delivery.

Despite the clear achievements of peer-led organisations, they continued to face challenges. Changes in policy and health sector contexts were often slow, demanding considerable resources from small organisations. Support from partners, while crucial, did not always translate into effective changes in the health sector and policy environment. Even with consistent advocacy and significant buy-in, some legislation with detrimental community health outcomes remained unchanged.

'Of the ten submissions representing the interests of PLHIV, eight were made at the federal level on issues which stand to significantly impact the largest group of PLHIV in Australia. These were matters that impinged upon our human rights, law reform, income support, national census data, the retirement income system, homelessness, ageing and the Aged Care system.'

—Positive Life NSW, 2019-2020 annual report[11(p. 10)]

Table 7: Health sector and policy environment influence indicator achievement

Indicator	Evidence that indicator is being achieved
Process/quality	
PIQ1 Key players from the broader health sector and policy environment seek advice and contributions from the peer organisation	1. Strong evidence available across all organisations
PIQ2 Policy advice is ready when needed and peer leadership is responsive to opportunities for policy participation	2. Strong evidence available across most organisations
PIQ3 The peer organisation maintains control over the use and interpretation of the information they share with external stakeholders, and advocates for appropriate privacy and data usage policies to protect their communities (data sovereignty)	4. Limited evidence available across most organisations
Impact	
PII1 The peer organisation achieves buy-in from stakeholders regarding policy advice to advance community needs	2. Strong evidence available across most organisations
PII2 The peer organisation's partnerships and policy advice have influenced positive change in the health sector and policy environment	3. Good evidence available across most or all organisations

Enablers and barriers to demonstrating the system-level impact of peer work

Enabler: A policy and sector environment that enables meaningful community participation and values peer insights

We found that peer organisations individually and collectively have built significant levels of trust and credibility within their communities and across the BBV and STI response.

We found clear evidence that knowledge generated through high-quality engagement could flow, through effective practices of peer leadership, to other policy actors and stakeholders in the prevention sector. These real-time insights, the capacity to identify emerging trends and issues within a community, being early adopters of innovations in models of care and biomedical advancements, and advocating equitable health promotion, were critical to peer organisations being relevant and persuasive in both the community and policy systems. This has enabled them to gain timely insights, translate these into policy and practice, and provide strong leadership to enhance and strengthen the HIV and hepatitis C response.

We found that peer organisations had to demonstrate not only the authenticity of their community connection to advocate on behalf of their community – but also that this authenticity needed to be recognised and supported by the sector.

The embedding of a commitment to meaningful community participation in key government policy documents and in organisational strategy documents across the sector provided a framework for peer organisations to advocate for and maintain this system-strengthening role.

Enabler: Funding partnerships that value and enable the community engagement, sector partnership, and system-strengthening role of peer organisations

In addition to direct community services, we found that the peer organisations played an important system-level role in informing and strengthening the HIV and hepatitis C response, including ensuring diverse community voices and experiences were present within the response.

Peer organisations capacity to fulfil this role was enabled not only by the quality of their engagement with their communities, but also the ability and resources to translate their community knowledge into quality advice as well as maintain strong connections across the health sector and policy environment.

While we found evidence of strong working relationships and partnership between peer organisations and most funders, we also found that peer organisations resources were stretched to maintain engagement with diverse communities, evolving epidemiology, and a broad range of partnerships and relationships required across the sector.

Community engagement and sector partnership are roles the HIV and hepatitis C sector relies on the peer organisations to fulfil and need to be resourced to be sustainable in an evolving epidemic.

Barrier: Limited resources to monitor and evaluate the system-level impact indicators of investing in peer-led organisations

We found, for most peer organisations, a focus on contractual reporting on occasions of service and numbers of clients. As service delivery and community advocacy organisations, the peer organisations were often tied to contracts that purchased discrete services rather than organisations being funded as a whole to deliver an integrated set of synergistic programs. This tied organisations to occasions of services and numbers of clients while also needing to respond to expanding and diversifying community needs within their current resources. While the system-strengthening role of peer organisations was valued by the policy and service sector, current monitoring and evaluation only occasionally acknowledged the significance of this role and its impact.

We also found that it was a challenge for peer organisations to prioritise evaluation and the demonstration of their system-level impact over the resources needed to achieve this impact. When significant community crises occur, such as the impact of COVID19, the limited resources need to be prioritised to implementing rapid adaptation to support communities and the sector response, and reporting on outputs and services, rather than system-level evaluation.

The limited resources available within peer organisations to demonstrate the impact of their investment in sector partnership and policy participation work can potentially deprioritise this essential work to strengthening the HIV and hepatitis C response.

Barrier: Stigma and criminalisation

We found that the impact of stigma and criminalisation permeated throughout the work of the peer organisations. We also found that the legislative system could present a complex mix of both enablers and barriers that impact the capacity of a peer-led program to participate and maintain influence within communities.

The impact on communities continued to provide a barrier to not only the peer organisations' work but also their capacity to demonstrate their engagement and impact within their communities. This included peer organisations needing to find innovative ways to achieve meaningful community participation or service evaluation that provided anonymity.

Recommendations

- Maintain the commitments in the national and state strategies to meaningful participation, as well as strengthen the recognition of the system-strengthening role of investing in peer-led and community-led organisations
- Resourcing arrangements that recognise and enable peer organisations to fulfil their system-strengthening roles within community engagement, sector partnerships, and policy participation
- Ensure that monitoring and evaluation in peer organisations include resources to assess the quality and impact of both their service-level and system-level roles, as well as assess the quality of the health sector and policy environment to enable peer organisations to fulfil these roles
- Ensure that responses to stigma and criminalisation include the impact of stigma and criminalisation on achieving meaningful community participation in the HIV and hepatitis C responses

References

1. Hilton, P. M., Brown, G., & Bourne, A. (2021). *W3 Project: Creating a set of evaluation indicators for peer-led work* (p. 2992962 Bytes). La Trobe. https://opal.latrobe.edu.au/articles/report/W3_Project_Creating_a_set_of_evaluation_indicators_for_peer-led_work/16455933/4
2. Hilton, P. M., Brown, G., & Bourne, A. (2022). *W3 Project: Locating evidence against the W3 Indicators for peer-led work* (p. 2894971 Bytes). La Trobe. https://opal.latrobe.edu.au/articles/report/W3_Project_Locating_evidence_against_the_W3_Indicators_for_peer-led_work/20188772
3. Australian Government Department of Health. (2018). *Eighth National HIV Strategy 2018-2022*. Commonwealth of Australia. https://www.health.gov.au/sites/default/files/documents/2022/06/eighth-national-hiv-strategy-2018-2022.pdf
4. Australian Government Department of Health. (2018). *Fifth National Hepatitis C Strategy 2018-2022*. Commonwealth of Australia. https://www.health.gov.au/sites/default/files/documents/2022/06/fifth-national-hepatitis-c-strategy-2018-2022.pdf
5. Brown, G., Reeders, D., Cogle, A., Madden, A., Kim, J., & O'Donnell, D. (2018). A systems thinking approach to understanding and demonstrating the role of peer-led programs and leadership in the response to HIV and hepatitis C: findings from the W3 Project. *Frontiers in Public Health*, *6*, 231–231. https://doi.org/10.3389/fpubh.2018.00231
6. Harm Reduction Victoria. (2018). *Annual report. 2017-2018*. https://www.hrvic.org.au/_files/ugd/ebb8bf_c0f24e0e0fff4c8c9ee1949b96962062.pdf
7. NSW Users and AIDS Association. (2019). *Annual report 2019*. https://static1.squarespace.com/static/61bc083a85af43143a2eb69a/t/620ddee23232620472680bf3/1645076224598/NUAA%2BAnnual%2BReport%2B2018%2B-%2B19.pdf
8. Living Positive Victoria. (2017). *Strategic plan: 2018 and beyond*. https://livingpositivevictoria.org.au/wp-content/uploads/2017/10/Strategic-Plan_Final.pdf
9. Peer Based Harm Reduction WA. (n.d.). *Strategic plan 2022 – 2027*. Retrieved 15 October 2022, from https://harmreductionwa.org/strategic-plan/
10. Queensland Positive People. (2018). *Annual report 2017—2018*. https://www.qpp.org.au/wp-content/uploads/2022/06/QPP_Annual_Report_2017-2018.pdf
11. Positive Life NSW. (2020). *Annual report 2019–20*. https://www.positivelife.org.au/wp-content/uploads/2021/03/plnsw-2019-20-annualreport.pdf.pdf

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

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

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

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

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

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