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Australian Research Centre
in Sex, Health and Society

W3 Project

Creating a set of evaluation indicators for peer-led work

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W3 Framework

Australian Research Centre
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W3 Project: Creating a set of evaluation indicators for peer-led work

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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 role in the public health response and to support their ability to evaluate and demonstrate the full impact of their work.

This report details work undertaken with seven Australian organisations led by people living with HIV (PLHIV) and people who use drugs (PWUD) to develop a comprehensive set of quality/process and impact indicators for use by peer-led organisations and programs to support them to demonstrate the full extent of their impact and value.

Funding

The W3 Project receives funding support through a grant from the Australian Government Department of Health (From Knowledge to Action: A social research program to inform implementation of the National BBV and STI Strategies).

Acknowledgements

We thank everyone who has supported and worked with the W3 Project.

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

Since its inception in 2013, the W3 Project has worked with peer-led organisations and programs across Australia, including (in alphabetical order):

- ACON
- Australian Federation of AIDS Organisations (AFAO)
- Australian Injecting & Illicit Drug Users League (AIVL)
- Harm Reduction Victoria
- Living Positive Victoria
- National Association of People with HIV Australia (NAPWHA)
- New South Wales Users and AIDS Association (NUAA)
- Peer Based Harm Reduction Western Australia
- Positive Life New South Wales
- Queensland Positive People
- Scarlet Alliance, Australian Sex Workers Association
- Thorne Harbour Health
- Western Australian AIDS Council

Dedication

We dedicate this report to our friend and colleague Jude Byrne, who passed away during this project's work in 2021. Jude was an internationally recognised, powerful peer advocate who – through her deep insights, formidable intelligence, persuasive approach and capacity to create change – fought to advance the health and human rights of people who use drugs. Jude was a long-time supporter of the W3 Project and its aims, and she played a significant role from the beginning. The national and international influence of Jude's work and advocacy is a vital demonstration of the role and impact of peer-based leadership.

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.

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 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.

PLHIV: People living with HIV.

PWUD: People who use drugs.

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

W3 Functions: The four roles or purposes that peer-led work must fulfil to maximise its impact.

Background

Why develop new evaluation indicators for peer-led work

Peer-led responses are a vital part of the overall health response to blood-borne viruses (BBVs) such as HIV and hepatitis C. The unique role that peer-led organisations and programs play in positively influencing their communities is well documented (1-4). Less well recognised is the role that they play in improving the health sector and policy environment that affect the wellbeing of their communities (5).

Despite their importance, peer-led organisations and programs often find it difficult to demonstrate the full impact and value of their work. Partly, this can be due to the limited resources and scale of many peer-led organisations impacting on their capacity both to carry out rigorous evaluation and to generate enough data from which to draw statistically significant conclusions. Limited resources also mean that the scope of evaluations is often limited to indicators that focus on outputs and service funding acquittal. However, these indicators often fail to measure the full extent and impact of peer work (6).

In order to address these challenges, the W3 Project developed the W3 Framework, a new program theory that positions peer-led work within both their community and the health sector and policy environment. The W3 Framework can help improve understanding of the influence of peer work on communities and policy, and it can guide evaluation and investment decisions in peer-based and peer-led programs in HIV and hepatitis C.

W3 Project, Stage 3

The current stage (Stage 3) of the W3 Project is a national study of how well peer-led responses achieve and sustain the four W3 Functions in their work. This stage will pool resources and data from selected peer-led responses in multiple states across Australia.

We will work with peer-based programs to refine their data collection and collect and collate data from organisations and program staff interviews. Data will be analysed with the aim of generating a stronger and clearer evidence base that will support peer-led responses to:

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

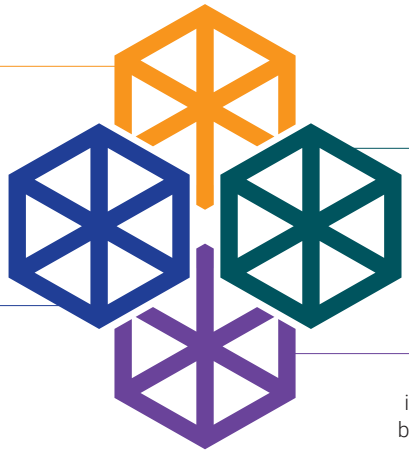
We also hope this work will provide insights and guidance for the investment and scale-up of peer programs in priority populations and for policymakers.

THE W3 FRAMEWORK

Using a systems-thinking approach, the W3 Project worked with more than 90 peer workers across Australia to develop the W3 Framework (7)**.** The Framework defines four W3 Functions, which are the core roles or purposes fulfilled by effective peer work:

Engagement:

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



Adaptation:

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

Alignment:

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

Influence:

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

Further information about the W3 Framework is available at http://www.w3project.org.au/.

Creating a set of evaluation indicators for peer-led work

Through working with peer-led organisations and programs in the design of this project, it became evident that, beyond their usefulness for this project, a set of consistent and agreed-upon indicators against each of the W3 Functions would be a significant asset to the peer-work sector. We set out to produce two lists of indicators against each of the W3 Functions, one for use at an organisational level by peer-led organisations and one for use at a programmatic level by peer-led programs.

Indicators against each W3 Function included:

- **Quality and process indicators** that measure if the program or organisation is undertaking the necessary actions to achieve strong results under each function, for example, 'The organisation supports peer leaders to build their confidence, skill, and experience in community and personal advocacy'.
- **Impact indicators** that measure if the program's actions are leading to the achievement of strong results (achieving impact) within each function, for example, 'Coordinated peer leadership results in a strong collective community voice that contributes to policy recognition of diverse needs and experiences within the community'.

Method

The following provides a short summary of the method used to develop the indicators. The Appendix provides a more detailed description of the methods and data analysis.

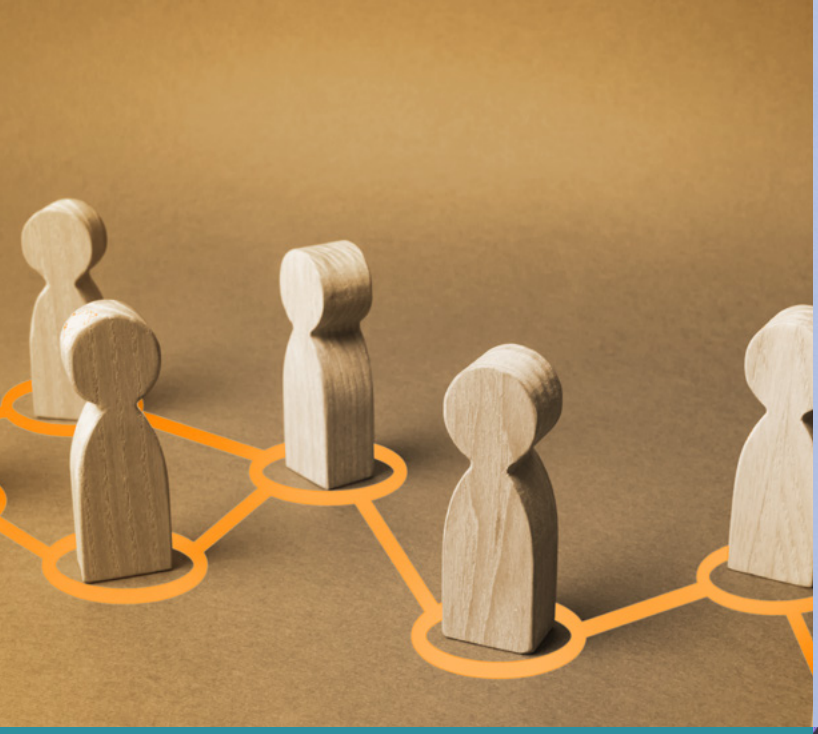
We initially envisaged conducting consultation workshops with peer workers from across our partner organisations to develop these lists. However, lockdowns and travel restrictions throughout 2020 due to COVID-19 prevented us from pursuing this course of action. It was decided, therefore, to develop the indicator list using a modified Delphi method (8). The Delphi method was devised in the 1950s as a way of obtaining consensus among a group of experts through the collection of their feedback in series of iterative questionnaires. As well as being able to be conducted remotely, this method had the additional benefit of facilitating the creation of a list of robust indicators by using a validated method of arriving at a group consensus.

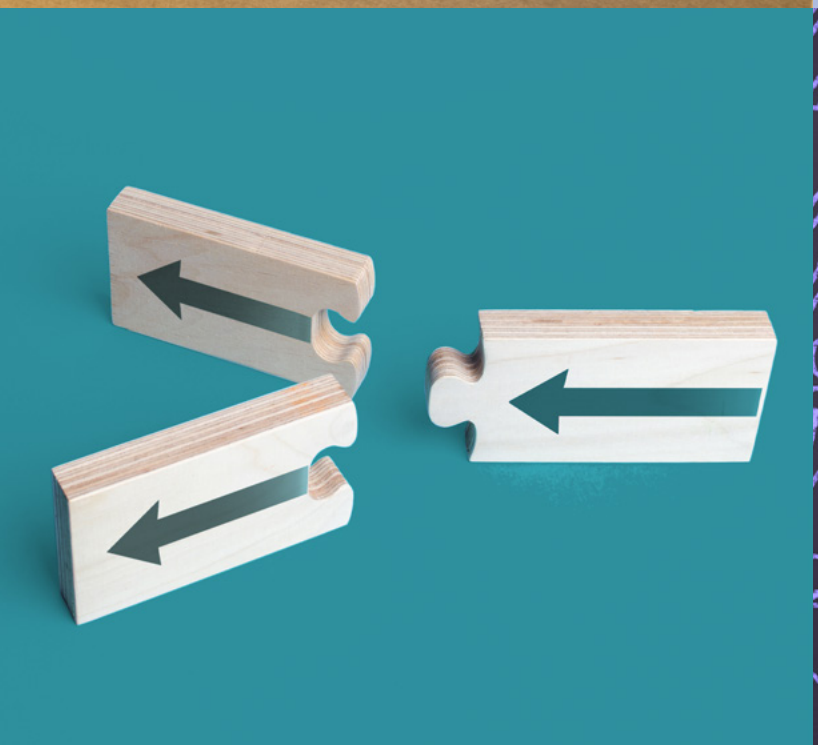
The method we used involved three consultation rounds: two via online questionnaires and one via online conference calls. In each round, lists of draft organisation- and program-level indicators were prepared and respondents asked to provide their feedback on the lists. The feedback from each round was analysed and used to refine the draft indicators for the next round. Separate online consultation questionnaires were developed for the organisation- and program-level indicators to allow staff to choose whether they wanted to provide feedback on one or both indicator types. The consultation interviews discussed both the organisation- and program-level indicator lists.

Participants

Participating peer-led organisations included organisations led by people living with HIV (PLHIV) and people who use drugs (PWUD). Respondents included staff from two peer-led national peak organisations (one PLHIV and one PWUD) and five state-based peer-led organisations (three PLHIV and two PWUD). Additionally, to ensure that the indicators would be relevant and useful from the perspective of funders, representatives working in BBV and alcohol and other drugs (AOD) policy from a state government health department were also invited to participate.

It is difficult to accurately ascertain the number of individual staff who provided feedback due to the anonymity of the online survey responses and the fact that, for each survey, organisations were encouraged to invite any interested staff to participate, including staff who had not been involved in previous surveys. Some staff provided responses to all surveys, while others provided responses to only one survey or some surveys. Additionally, we are aware that in in some instances, more than one person contributed to a single survey response. The maximum number of responses received for a single survey was 10 for the program-level survey and 15 for an organisation-level survey. The staff who participated in the process came from across diverse levels of the participating organisations, including staff working in program delivery, management and executive leadership.

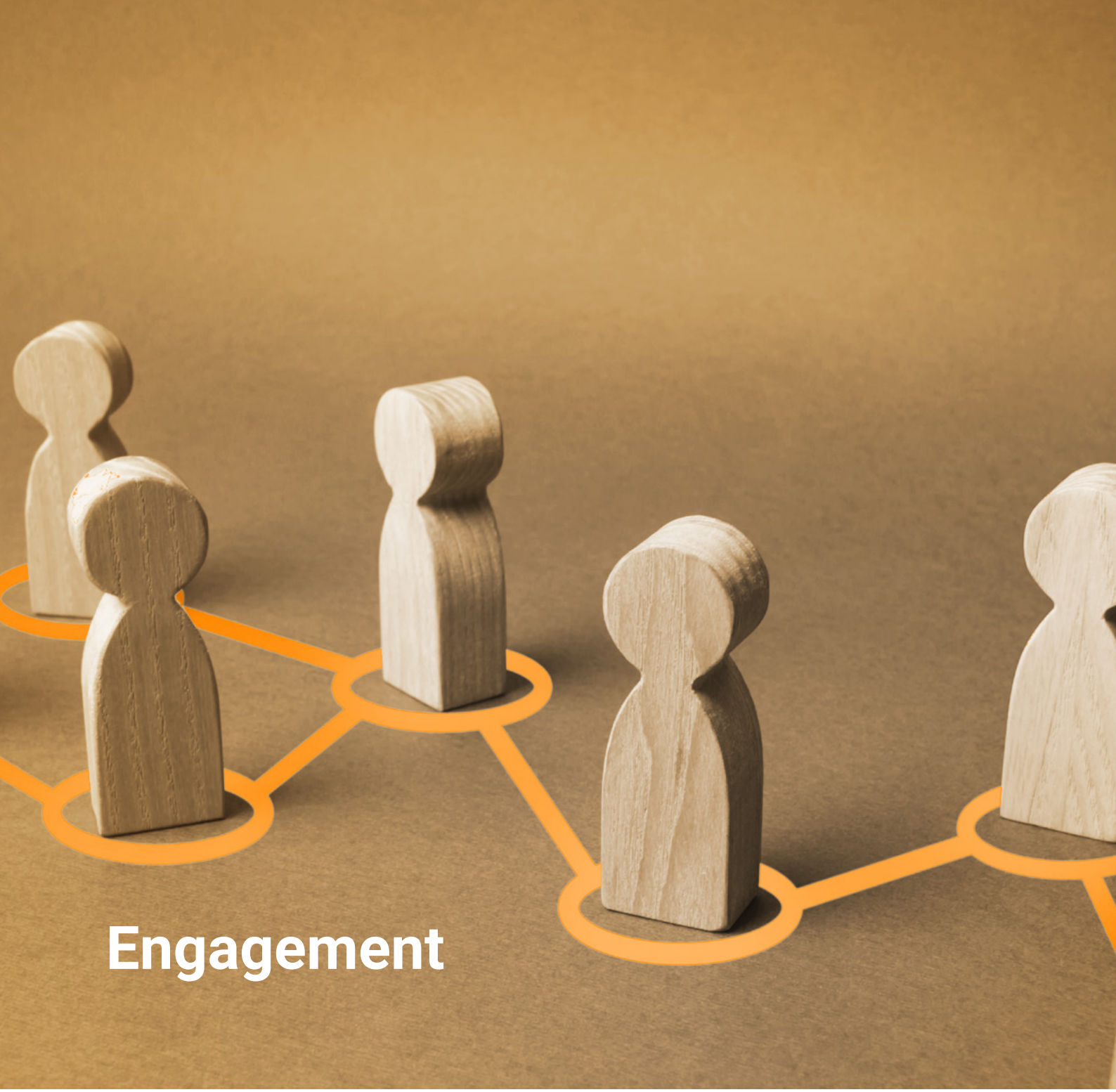




The W3 Indicators

The W3 Indicators developed through the modified Delphi method are listed in the following tables.

Included is a list of examples of potential metrics or sources of evidence that peer-led organisations or programs may be able to use to demonstrate each indicator. The example metrics are not an exhaustive list. They are included to help clarify and contextualise the indicators and to give organisations and programs an idea of the kinds of metrics they may be able to use to demonstrate their effectiveness against the indicators. Organisations and programs are welcome to use any or none of these examples. Each organisation and program should decide what metrics best suit their specific context.



Engagement

Engagement is how the peer organisation or program interacts with 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 programs and organisations are part of the communities they work in. They feel the same tensions and the same challenges. They also play a role in community debate. Their communities trust that they are authentic and credible because of this long-term relationship.

Peer-to-peer interactions are central to effective engagement. Each interaction – whether it is part of their work or in their day-to-day lives – improves a peer worker's skills. This, in turn, leads to deeper and more authentic engagement.

Peer workers – and, by extension, peer programs and organisations – maintain a strong and up-to-date understanding of their communities. They are finely attuned to their community's diverse and changing needs.

Organisation-level indicators

Indicator	Examples of potential metrics and sources of evidence[1]
Quality/process indicators	
The diversity of clients that access and/or engage with the peer organisation reflects the diversity within the peer organisation's target community group(s).	• Client service/intake data (# of clients and demographic markers) • Peer worker notes about ad hoc interactions with clients
The peer organisation identifies, engages and responds accordingly to community members who are less able to participate in consultation.	• Notes from/records of outreach, engagement and responses • Demographic profile of organisation's board, advisory committees and other consultation groups • Materials and engagement are culturally responsive and adapted (e.g. languages, cultural considerations) • Access to opportunities for consultation is facilitated for people with different needs (disability access, translation services)
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.	• Examples of policies, meeting schedules, professional development sessions etc. • Staff feedback indicates that they feel well-resourced and supported • Group supervision and reflective practice discussions for peer staff • Accreditation standards • Internal or externally delivered professional development for peer staff • Clinical supervision for peer staff • Board evaluations
Impact indicators	
Community members recognise the organisation as peer-led and as an important part of and resource to their community.	• # of pieces of community feedback received (including expectations, complaints, endorsements and suggestions) • # of requests by community members, networks, organisations etc. for information, support etc. • Social media metrics • # of self-referrals or self-referred on recommendation from other peers/ community members
Policy advice and peer leadership is based on current community needs and experience.	• Consolidated reports of peer insights from across the organisation are referenced in background information and justification for policy advice and peer leadership decisions
Relationships with different community members and networks are built or strengthened as a result of the peer organisation's activities.	• # of relationships, # new relationships, # relationships lost • # of former clients who engage with other activities or programs • % of staff or volunteers who are former clients/users of organisation's programs • Community feedback about quality of relationships • Partnerships and MOUs within community • Sustained community involvement in development and implementation of initiatives to address the needs of specific communities

Program-level indicators

Indicator	Examples of potential metrics and sources of evidence[1]
Quality/process indicators	
Peers are consulted/involved in designing and developing the program.	• Evidence of peer consultation in documentation of program development • Program has an advisory committee that includes peers
The peer program is delivered by a diverse group of well-trained peer staff/peer staff with connection to diverse peer communities.	• Staff demographics • Peer program staff are hearing diverse views and/or changing experiences from within the community • Evaluations from training and professional development sessions
The peer program is accessed by diverse community members across the geographic span of the program.	• Number of clients accessing the service • Client service/intake data by gender, sexuality, cultural background, age, socioeconomic background, rural/regional populations, geographic distribution, and any other service-specific priority groups
Peer clients and staff report high levels of satisfaction with the peer-to-peer interactions within the program.	• Client feedback forms • Peer worker feedback forms • Staff performance evaluations and self-reflections • Staff-manager supervision sessions
Impact indicators	
The program builds and maintains strong networks and relationships with community members.	• # of word-of-mouth referrals/referrals from community members • Formation and continuation of MOUs and partnerships with individuals and communities • Sustained community involvement in development and implementation of initiatives to address the needs of specific communities
Participants share their experiences and insights because they feel their contribution adds value to the program.	• Program evaluation survey data • Client interviews and focus groups • Peer worker notes about interactions with clients
The peer program's understanding of its community is kept up to date and strengthened through its on-the-ground work.	• Program staff/volunteers have regular meetings to discuss emerging community issues from within communities (evidence = meeting minutes). Learnings from these discussions are incorporated into program strategies and materials. • Systems are in place that allow program-level insights filter up to senior staff and board (staff, volunteers, supervisor, board meet to communicate insights) Alignment

[1] *Examples of potential metrics and sources of evidence are intended to help clarify the indicators and to provide a starting point for thinking of ways to demonstrate achievement of the indicator. They are not intended to be comprehensive. Not all examples will be appropriate or relevant to all organisations or programs. Organisations and programs are responsible for developing metrics and evidence sources that are relevant to and appropriate for their own context.*

Alignment

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

Peer programs and organisations pick up insights from the broader sector. This might come from, for example, changes to:

- Laws, policies or policing strategies
- Organisational partnerships within the sector
- Epidemiology
- Available treatments
- Partner organisation services
- Access to health services

Peer programs and organisations draw on these insights to identify implications for their own community and/or work. In particular, they identify whether changes within the sector might support or undermine the needs of their community or their work. Peer programs and organisations can then draw on peer insight to identify what they need to adapt or advocate.

Strong alignment creates an environment in which peer and non-peer responses enhance each other's work because:

- The peer organisation or program gains real-time insights into changes occurring in the health sector and policy environment
- The health sector and policy environment respects and values the input and expertise of the peer organisation or program
- There is consistency between the health sector and policy environment and the peer organisation or program

Organisation-level indicators

Indicator	Examples of potential metrics and sources of evidence[1]
Quality/process indicators	
The peer organisation actively seeks to create partnerships with stakeholders across the health sector and other relevant sectors, particularly at the senior management level.	• # of MOUs between the peer organisation and other stakeholders • # of advisory committees attended by senior management
The peer organisation collaborates with beneficial and relevant research and policy initiatives.	• # of research partnerships/collaborations • # of policy initiatives
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.	• # of contributions made to external working groups, advisory committees, interagency groups etc. • Records of new insights gained from participation in external working groups, advisory committees, interagency groups etc.
The peer organisation actively seeks out opportunities for policy contributions and advocates for creating safer and effective ways for community members to participate in the health and policy sector's response.	• Examples of advocacy • Nominations of peer leaders to sit on external advisory committees and boards • # of peers meaningfully contributing to external advisory committees or boards
Impact indicators	
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.	• Discussion about new learnings from the health sector and policy environment (e.g. from interagency committees, communities of practice etc.) – including learnings coming from peer program staff – is a standing agenda item for executive team meetings • Records in executive team meeting minutes of discussions about new learnings from the health sector and policy environment
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.	• # of collaborative partnerships with external/mainstream organisations that the organisation participates in • # of collaborative partnerships with external/mainstream organisations that the organisation leads • # of client referrals from external/mainstream organisations • Examples of resources or policies produced by external/mainstream organisations that use/reference materials and policy statements put out by the peer organisation • Examples of contributions to research • Examples of policy or other submissions
Key players from the broader health sector and policy environment seek advice and contributions from the peer organisation.	• # of requests for advice or other contributions from external/mainstream organisations • # of invitations from external/mainstream organisations for peer staff to contribute to advisory groups • Peer organisation is asked to engage in research • Peer organisation is drawn on as a resource/educator about its community

Program-level indicators

Indicator	Examples of potential metrics and sources of evidence[1]
Quality/process indicators	
The peer program actively seeks out and uses knowledge from different parts of the health sector and policy environment.	• New learnings from the health sector and policy environment (e.g. from interagency committees, communities of practice etc.) is a standing agenda item for team meetings/discussions recorded in minutes
The peer program team is aware of emerging practices and changes within broader health sector and policy environment and how they may affect its communities or program.	• Discussion about new learnings from the health sector and policy environment (e.g. from interagency committees, communities of practice, research, legal and legislation, other areas of the sector etc.) is a standing agenda item for team meetings/discussions recorded in minutes
Other organisations and services recognise the peer program as useful and valuable.	• Stakeholder interviews and focus groups • # of other organisations that contact the peer program for advice • # of client referrals from other organisations and services
The peer program's priorities align with/ contribute to the achievement of key high-level sector goals and strategies (e.g. National HIV or Hepatitis C Strategy).	• Examples of instances where program priorities draw from or align with key documents/strategies
The peer program and other partner services strive to complement each other.	• Evidence of collaborations and partnerships between peer program and other services • Stakeholder interviews and focus groups • Evidence of cross-referrals between peer program and partner services • Evaluations processes – external stakeholders are involved in evaluation processes
Impact indicators	
The peer program is included within the broader health service system and culture.	• Referral data indicates steady or increasing referrals from mainstream services • Stakeholder interviews and focus groups
Other organisations and services within the health sector recognise the peer program as helping them meet their own strategic goals and engagement with community, and they look to the peer program for information and advice.	• Stakeholder interviews and focus groups • # of referrals to program from non-peer services • Program staff invited to contribute to interagency networks, advisory committees etc. • # of requests from other services for information and advice • Outcomes of program are used to inform policies and practice
The peer program creates, supports, strengthens or streamlines referral pathways and service linkages.	• Client intake/referral information • Information from stakeholders informing program of cross-referrals • Peer workers refer clients to other relevant services

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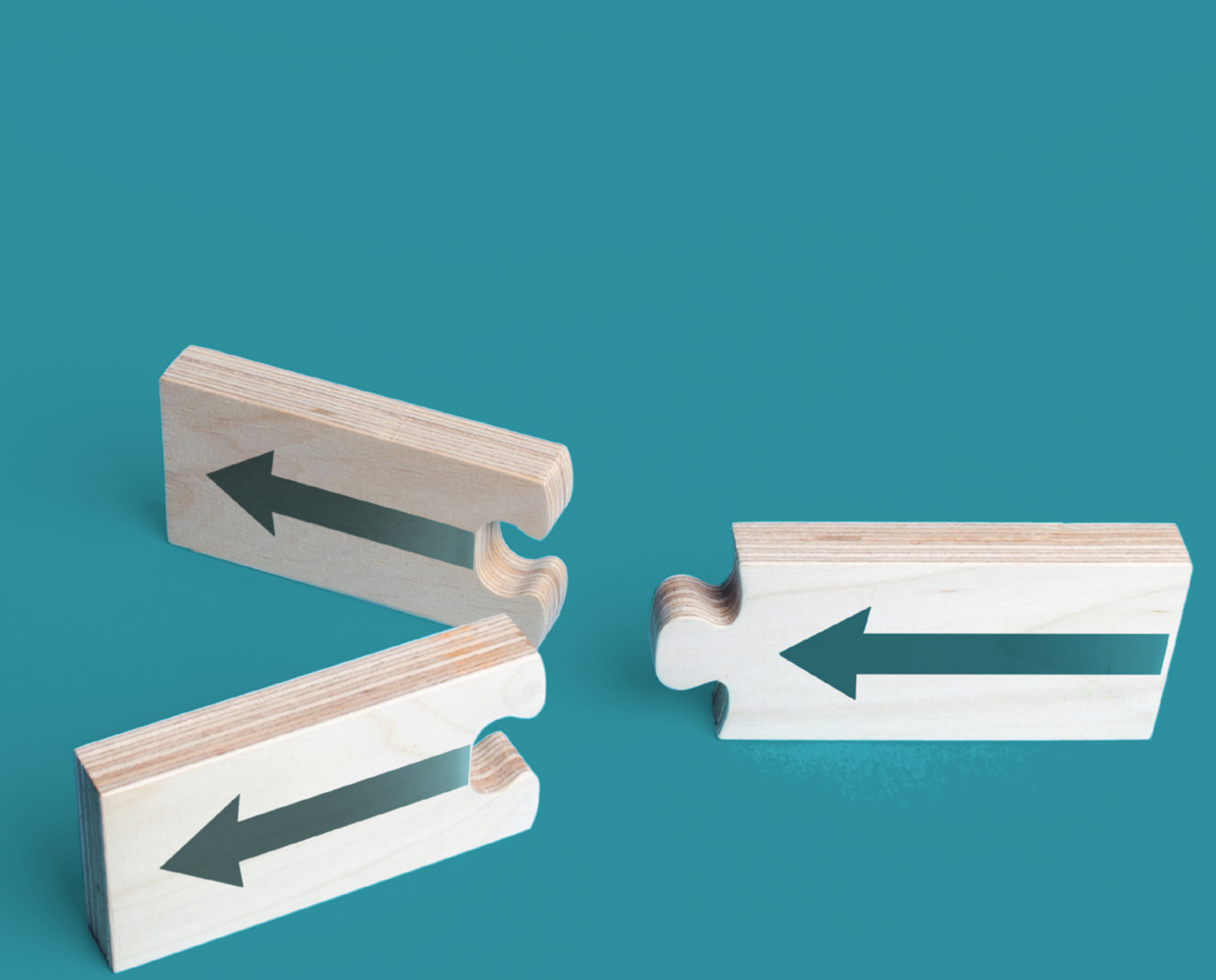

Adaptation

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

Individual peer workers are constantly leaning from their interactions with their communities – both in their work and in their personal lives. Peer programs and organisations learn and adapt, both from their experiences delivering services and from the lived experiences of their peer staff.

Peer programs and organisations have strong connections to and understanding of their communities and the health sector and policy environment.

They pick up signals about changes in their communities through engagement. Likewise, they pick up on changes in the health sector and policy environment through alignment.

They understand how these changes might impact their communities. They can also pre-empt how their communities might react or respond.

Effective adaptation ensures that peer programs and organisations:

- Don't become outdated or obsolete
- Maintain or increase their effectiveness
- Take advantage of positive changes
- Minimise harmful effects that changes might have on their communities

Organisation-level indicators

Indicator	Examples of potential metrics and sources of evidence[1]
Quality/process indicators	
The peer organisation regularly gathers feedback and evaluation results from peer service participants and insights from community (engagement) and insights from social research, epidemiology, health service usage data, and other sector knowledge (alignment).	• Examples of collated information • Sharing new insights from community, social research, epidemiology etc. are standard meeting agenda items across all levels of the organisation, and insights from across multiple meeting minutes are collated into a single document
The peer organisation uses information and insights from engagement and alignment (indicator #OADQ1) to identify and to guide reorientations and responses to emerging priorities.	• Discussion of insights and information is a standing agenda item for executive team meetings • Records in executive team meeting minutes of discussions and decisions made in response to collated information • Examples of the use of this information in strategic planning documents • Examples of the use of collated information in policy briefings, advocacy materials etc. • Organisational strategy documents, position papers and policy advice briefings refer to insights from peer team meetings
The peer organisation's practices are guided by peer knowledge and insights.	• Policies, procedures and guideline documents state that strategic planning and program design be informed by peer knowledge • Records of peer consultation in documentation about changes to practices relating to service delivery
The peer organisation draws on engagement with membership and partnerships with the sector to develop evidence-based positions.	• Position papers include references to information drawn from community and sector partnerships
The peer organisation supports staff to acquire skills in peer leadership, evaluation and policy participation.	• Professional development (PD) is offered to peer staff interested in taking on peer leadership roles and policy participation. (Evidence = records of PD, staff participation in PD, # of staff who participate in PD going on to take on peer leadership or policy participation.)
Impact indicators	
The peer organisation adapts priorities and strategies to the changing needs of its community.	• The background information, justifications, 'reference lists' etc. for strategic planning include reference to data from community engagement, client feedback and peer staff insights
The peer organisation draws on community and sector insights to improve future work.	• Reports of consolidated data from program evaluations, peer staff feedback and program planning sessions from across the organisation • Strategic planning documentation demonstrates that reports of consolidated data (that include data from client feedback and peer staff insights as well as evidence-based research) are used in planning process
The peer organisation draws on community and sector insights to improve (update and refine) policy advice.	• The background information, justifications, 'reference lists' etc. for policy advice decisions include reference to a range of evidence sources (that include data from client feedback and peer staff insights as well as evidence-based research)
The peer organisation translates research and community insights into accessible language and practical policy and program advice.	• Examples of resources produced
The peer organisation assesses and synthesises diverse views of the community and leads advocates on key priorities for the broader public health response.	• Position papers and policy advice

Program-level indicators

Indicator	Examples of potential metrics and sources of evidence[1]
Quality/process indicators	
Peer insights over time are collated, summarised and shared within and beyond the peer program.	• Meeting minutes from internal and external meetings • Copies of correspondence with external partners • Range or nature of community and peer insights shared within the peer program and within the organisation that the program sits in
The peer program draws on peer insights, research and epidemiology, and program evaluations to refine programs.	• Documentation outlining the different sources of information that are used in program planning cycles • Team meeting minutes outlining actions in response to peer insights
The peer program adapts its approach in response to changes within the community, health sector and/or policy environment that impact upon the community or upon how the program is delivered.	• Program staff have regular meetings to discuss emerging community issues from within communities and the health/policy environment (evidence = meeting minutes). Learnings from these discussions are incorporated into program strategies and materials.
Impact indicators	
Knowledge acquired through engagement and alignment improves the relevance and influence of future work.	• Positive feedback from client and stakeholder interviews, evaluation surveys, focus groups etc. demonstrates high level of relevance and influence
The peer program learns from peer insights and evaluation and adapts accordingly.	• Data from program evaluations, peer staff feedback, and program planning sessions demonstrate that learnings from engagement and alignment are integrated into programs and evaluations report on the success of these integrations
The peer program has adapted to the needs of its clients and community.	• Client and community feedback endorses changes or remains positive through times of change Influence – Community

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Influence

Influence is about how well the peer organisation or program is able to affect its community as well as the broader health sector and policy environment.

Because this influence flows in two directions, we created two sets of indicators for this function:

- Community influence
- Health sector and policy environment influence

Community influence

Community influence is about how well the peer organisation or program is able to affect their community's health, behaviour, knowledge or attitudes (e.g., through health promotion, harm reduction or support services).

Peer programs and organisations derive their influence from the fact that they are part of their communities. In other words, they operate within communities instead of intervening on them.

Community influence is a strong reflection of a peer program's or organisation's engagement and cultural authenticity. This is particularly demonstrated by:

- The level of trust communities have in the peer organisation or program
- Whether communities see the peer organisation or program as culturally credible and authentic
- Whether communities feel that the peer organisation or program is based on the reality of their shared experiences

Organisation-level indicators

Indicator	Examples of potential metrics and sources of evidence[1]
Quality/process indicators	
The peer organisation has a strong profile within its community and is endorsed by peer networks (including both online and offline).	• Membership records • Examples of endorsements by peer networks • Social media engagement metrics • Positive feedback from clients and community members
The community is aware of and supports the policy advice and participation of the peer organisation.	• Positive feedback from clients and community members about peer organisation's visible participation in policy process
The peer organisation receives increasing referrals from community members (including those who are not current or former clients).	• Client intake and referral information • 'Where did you hear about this service/organisation?' on intake form • Self-referrals who found out about the service from other community members
The organisation supports peer leaders to build their confidence, skill and experience in community and personal advocacy.	• # of professional development sessions delivered to peer leaders (e.g. public speaking) • Resources allocated to peer leaders travelling and delivering workshops, speeches, presentations etc. • Participation at leadership or management meetings (invitation to participate/observe) • Mentoring people for growth/providing people with meaningful opportunity to lead, manage, engage at higher levels

Indicator	Examples of potential metrics and sources of evidence[1]
Impact indicators	
Coordinated peer leadership results in a strong collective community voice that contributes to policy recognition of diverse needs and experiences within the community.	• # of joint statements released by community organisations/networks (should be high) • # of opposing statements released by community organisations/networks (should be low)
The peer organisation's engagement activities are achieving its stated impact goals (e.g. increased client knowledge; informed health management, treatment or harm reduction decisions; improved client quality of life).	• Collated/aggregated/consolidated evaluation data from across the peer organisation's programs and activities
Community-level research indicates a trend of improvements in priority health-related outcomes (e.g. quality of life, resilience, health behaviours, knowledge, behaviour etc.).	• National survey results • Academic research papers

Program-level indicators

Quality/process indicators	
The peer program has broad, deep reach across and within its community.	• Service delivery records (# services delivered) • Resource distribution records (# resources distributed to # of different people/places) • Workshop attendance records (# of people attending workshops/ demographics)
The peer program has a strong profile and is endorsed by online and offline peer networks.	• Examples of endorsements by peer networks • Social media engagement metrics • Client intake and referral information includes referrals from peer networks • Reach of print advertising
The peer program receives increasing referrals from community members (including those who have not previously accessed the program).	• Client intake and referral information • Self-referrals who found out about the service from other community members • Attendance at events, programs and services
Impact indicators	
Peer program delivery addresses community needs or gaps.	• Needs assessments • Client surveys and feedback
Peer program materials are adapted and incorporated by members of target networks and cultures.	• Examples (e.g. photos or physical copies) of adapted materials • Citations of peer program materials in reference lists • Sharing of peer program materials through online networks
Participants report increases in the outcome goals of the program (e.g. quality of life, resilience, health behaviours, knowledge, behaviour etc.).	• Client health and wellbeing surveys • Pre- and post-workshop or service evaluation surveys

[1] *Examples of potential metrics and sources of evidence are intended to help clarify the indicators and to provide a starting point for thinking of ways to demonstrate achievement of the indicator. They are not intended to be comprehensive. Not all examples will be appropriate or relevant to all organisations or programs. Organisations and programs are responsible for developing metrics and evidence sources that are relevant to and appropriate for their own context.*

Health sector and policy environment influence

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.

This includes influence on processes and outcomes; for example, changes to the way health services are run or changes to specific health department policies.

Insights from peer workers may be the broader sector's only source of real-time knowledge about emerging issues. This places peer programs and organisations in a strong position to provide valuable strategic insights and guidance to funders, policymakers, health services and researchers.

Policy influence is a strong reflection of a peer program's or organisation's alignment. It is particularly demonstrated by:

- The strength of the peer program's or organisation's sector-wide partnerships
- The peer program's or organisation's level of participation in the health sector and policy
- The peer program's or organisation's ability to produce meaningful recommendations and strategic advice to the broader sector

On the other hand, influence is undermined by weak alignment and stigma within the health sector and policy environment.

Organisation-level indicators

Indicator	Examples of potential metrics and sources of evidence[1]
Quality/process indicators	
The peer organisation can demonstrate outcomes of policy advice and participation and achieve buy-in from stakeholders to advance community needs.	• Existence of a policy officer or other staff member with this duty in their job description/work plan • Existence of sector partnerships, relationships or lines of communication between the peer organisation and policymakers or other sector partners and stakeholders • Minutes from external meetings • Emails between peer organisation and partners/policymakers • Representation on advisory boards and steering committees • Engagement in sector consultations
Policy advice is ready when needed and peer leadership is responsive to opportunities for policy participation.	• % of arising policy participation opportunities that were strategically important and taken/not missed
The peer-led organisation translates the needs/ experiences from the community into different languages used in policymaking.	• # of peer organisation's messages that have been adapted by policymakers
The peer organisation maintains control over the use and interpretation of the information they share with external stakeholders (data sovereignty).	• Policies that reflect the peer organisation's respectful management of community and peer insights on behalf of its community (e.g. data sovereignty policies)

Indicator	Examples of potential metrics and sources of evidence[1]
Impact indicators	
The contribution of peer leadership in consumer representation and policy advocacy is recognised and sought out.	• # invitations from external organisations to sit on advisory committees
Insights from the peer organisation are recognised as current and useful.	• Repeat requests from sector partners for advice • Advice cited in policy/briefing documents
Policy, media and funding environments support (or do not impede) innovative and culturally relevant approaches to community health.	• % campaign ideas that were possible/that were not shelved due to policy, media, funding environments

Program-level indicators

Quality/process indicators	
The peer program and health service partners are collaborating to meet the needs of the peer community.	• Meeting minutes from collaborations • Correspondence records • Peer community feedback
Policy participation activities and messages draw on community experience and insights and use them to contextualise research.	• Records of communication between mainstream and peer staff that include examples of advocacy using diverse peer stories to humanise, explain and back up research-based evidence
Impact indicators	
Peer insights and knowledge from program implementation are shared and used by the broader sector.	• Stakeholder interviews and focus groups • Photos, screenshots or physical examples of this happening within mainstream health/policy settings
Insights from the peer program are recognised as current, beneficial and relevant.	• Repeat requests from sector partners for advice • Advice cited in policy/briefing documents
Other programs and sector stakeholders adapt their approach to support the effectiveness of the peer program.	• Stakeholder interviews and focus groups/peer staff evaluations of program partnerships and relationships indicates improvement over time

[1] *Examples of potential metrics and sources of evidence are intended to help clarify the indicators and to provide a starting point for thinking of ways to demonstrate achievement of the indicator. They are not intended to be comprehensive. Not all examples will be appropriate or relevant to all organisations or programs. Organisations and programs are responsible for developing metrics and evidence sources that are relevant to and appropriate for their own context.*

Next steps

These indicators will be used as the basis for the collection and consolidation of evaluation data across Australian peer-led organisations and programs working in HIV and hepatitis C.

The W3 Project will work with our partner organisations to evaluate:

- Peer navigation programs for people with new HIV diagnoses
- Peer networker and outreach programs for people who use drugs
- Peer-led testing programs for HIV and hepatitis C

References

1. He J, Wang Y, Du Z, Liao J, He N, Hao Y. Peer education for HIV prevention among high-risk groups: A systematic review and meta-analysis. BMC Infectious Diseases. 2020;20:338.
2. Bajis S, Dore GJ, Hajarizadeh B, Cunningham EB, Maher L, Grebely J. Interventions to enhance testing, linkage to care and treatment uptake for hepatitis C virus infection among people who inject drugs: A systematic review. International Journal of Drug Policy. 2017;47:34-46.
3. Henderson C, Madden A, Kelsall J. 'Beyond the willing & the waiting' - The role of peer-based approaches in hepatitis C diagnosis & treatment. International Journal of Drug Policy. 2017;50:111-5.
4. Brown G, O'Donnell D, Crooks L, Lake R. Mobilisation, politics, investment and constant adaptation: lessons from the Australian health-promotion response to HIV. Health Promotion Journal of Australia. 2014;25(1):35-41.
5. Brown G, Perry G-E, Byrne J, Crawford S, Henderson C, Madden A, et al. Characterising the policy influence of peer-based drug user organisations in the context of hepatitis C elimination. International Journal of Drug Policy. 2019;72:24-32.
6. Brown G, Reeders D, Dowsett GW, Ellare J, Carman M, Hendry N, et al. Investigating combination HIV prevention: Isolated interventions or complex system. Journal of the International AIDS Society (JIAS). 2015;18(1):20499.
7. Brown G, Reeders D, Cogle A, Madden A, Kim J, O'Donnell D. 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. 2018;6:231.
8. Dalkey N, Helmer O. An experimental application of the DELPHI Method to the use of experts. Management Science. 1963;9(3):458-67.

Appendix

Modified Delphi method and detailed results

It was vital that development of the indicators be conducted with the full participation of peer workers from as many of our partner organisations as possible. To ensure this, we needed to navigate the capacity of our partners to participate and provide feedback while managing the challenges they were facing in meeting the rapidly changing needs of their communities. This included changes in staff across three partner organisations and the withdrawal of another partner organisation due to capacity challenges.

In order to facilitate the participation of as many of our partners as possible, we used a modified Delphi method. The method we used involved three rounds: two via anonymous online questionnaires and one via online conference calls. In the questionnaires, respondents had the option to disclose the type and name of the organisation where they worked and the type of role they held.

In each round, lists of draft organisation- and program-level indicators were prepared, and respondents were asked to provide their feedback on the lists. The feedback from each round was analysed and used to refine the draft indicators for the next round. Separate online questionnaires were developed for the organisation- and program-level indicators to allow staff to choose whether they wanted to provide feedback on one or both indicator types. The interviews discussed both the organisation- and program-level indicator lists.

Round 1

Indicator lists

The initial list of indicators was compiled from our previous work:

- Developing indicators with our partner organisations during Stage 1 of the W3 Project
- Piloting the W3 Framework with Living Positive Victoria and Harm Reduction Victoria in Stage 2 of the W3 Project
- Conducting an evaluation of National Peak Organisations in the second half of 2020

This first list of indicators had a total of 82 indicators, including 41 organisation-level and 41 program-level indicators. Table 1 provides a breakdown of the number of indicators in each category.

Table 1: Number of indicators in initial draft indicator list used in the first round of the Delphi method

	EN	AL	AD	IC	IP	Total
Organisation	**8**	**8**	**13**	**5**	**7**	**41**
Quality/process	4	4	7	3	3	**21**
Impact	4	4	6	2	4	**20**
Program	**11**	**11**	**7**	**7**	**5**	**41**
Quality/process	6	6	4	3	2	**21**
Impact	5	5	3	4	3	**20**
Total	**19**	**19**	**20**	**12**	**12**	**82**

Key: EN = Engagement, AL = Alignment, AD = Adaptation, IC = Community influence, IP = Health sector and policy environment influence

Feedback collection

Two surveys were developed using QuestionPro: one for organisation-level indicators and one for program-level indicators. Surveys were distributed to partner organisations via email. Organisations were invited to circulate the surveys internally to any staff member who was interested in participating. Organisations were encouraged to distribute surveys to staff from across diverse levels of the organisation in order to obtain feedback from peer staff working across program delivery, program management and organisational/executive leadership.

The survey presented each of the draft indicators with examples of potential metrics/evidence against each indicator. The indicators were presented in groups according to function and indicator type (quality/process or impact indicators).

For each indicator, participants were asked to select one of the following options:

1. **Yes:**
   - This indicator works, and we will be able to collect information to measure it.
2. **Maybe**:
   - This indicator might work but the wording is not quite right.
   - This indicator works but collecting information to measure it would be a problem.
   - I don't understand what this indicator is getting at.
3. **No:**
   - This indicator does not work.
   - There is no way we could collect information to measure this.

Respondents were also given the opportunity to provide further open-ended comments or feedback on each group of indicators.

Participants

A total of 15 responses were received in the first round of surveys, including seven responses to the survey about organisation-level indicators and eight responses to the survey about program-level indicators.

The demographic profile of respondents to both surveys is shown in Table 2 and Table 3.

Response analysis

The emphasis of the analysis in the first round was to review the responses and comments for indicators that:

- Were unclear (to refine wording)
- Would be difficult or impossible to measure (to refine wording or remove)
- Were not core to that W3 Function (to remove)

Feedback was also reviewed to check for any clear differences between staff responses from PLHIV-led organisations, PWUD-led organisations and government.

Feedback was generally consistent across respondents from different organisation types. A theme that came through strongly in the responses was concern about or interest in how some of the indicators could be measured or achieved.

> *These are great indicators. We would need to reorient the way we do things to capture the evidence here (that's a good thing).*
> *— Respondent from a PLHIV-led organisation*

> *The easier the information is to collect, the better for sustainability of continuous improvement activities.*
> *— Respondent from a state government health department*

In particular, staff from both PLHIV-led and PWUD-led organisations expressed concern about being able to achieve the alignment indicators. While they felt that the indicators did represent what alignment should look like, they doubted whether the health sector and policy environment would enable their achievement.

> *I nearly selected the unsure option for all of these indicators because I worry often that external orgs still don't understand the value of peer workers – especially a drug-using peer.*
> *— Respondent from a PWUD-led organisation*

> *Not sure on how to re-word these. We would require a willingness for policy makers to listen.*
> *— Respondent from a PLHIV-led organisation*

Table 2: Demographic profile by organisation type of respondents for the first round of surveys

	PLHIV	PWUD	Government	Not disclosed	Total
Organisation-level indicator survey	4	2	1	0	**7**
Program-level indicator survey	5	1	1	1	**8**
TOTAL	**9**	**3**	**2**	**1**	**15**

Table 3: Demographic profile by role of respondents for the first round of surveys

	Executive leadership	Management	Program delivery	Other	Not disclosed	Total
Organisation-level indicator survey	3	3	0	0	1	**7**
Program-level indicator survey	2	3	0	0	3	**8**
TOTAL	**5**	**6**	**0**	**0**	**4**	**15**

Indicator refinement

Analysis of responses facilitated the reduction of the length of the list of indicators from 82 to 67, including:

- 50 unchanged indicators
  (24 organisation level, 26 program level)
- 14 modified indicators
  (10 organisation level, four program level)
- Three new indicators
  (one organisation level, two program level)

The 14 modified indicators were reworded to improve clarity and readability. This included making it easier to interpret the what the indicator was intended to measure or capture. In some cases, modifications incorporated other indicators that had strong overlap.

Eighteen (seven organisation-level, 11 program-level) indicators were removed. These were the indicators for which all or most respondents answered, 'No, this indicator does not work or there is no way we could collect information to measure this'.

Several of the removed indicators could be measured or captured effectively by the remaining indicators. Where appropriate (and particularly where the responses were split between 'No', 'Maybe' and 'Yes'), these indicators were rolled into other (modified) indicators. In some cases, the indicator was removed from the indicator list but retained as an example of how one of the remaining indicators could be measured or demonstrated.

Round 2

Indicator lists

The second list of indicators comprised a total of 67 indicators, including 35 organisation-level and 32 program-level indicators. Table 4 provides a breakdown of the number of indicators in each category.

Table 4: Number of indicators in initial draft indicator list used in the second round of the Delphi method

	EN	AL	AD	IC	IP	Total
Organisation	**7**	**6**	**11**	**5**	**6**	**35**
Quality/process	3	3	5	3	3	**17**
Impact	4	3	6	2	3	**18**
Program	**6**	**9**	**6**	**6**	**5**	**32**
Quality/process	3	6	3	3	2	**17**
Impact	3	3	3	3	3	**15**
Total	**13**	**15**	**17**	**11**	**11**	**67**

Key: EN = Engagement, AL = Alignment, AD = Adaptation, IC = Community influence, IP = Health sector and policy environment influence)

Feedback collection

As in the first round, two surveys were developed using QuestionPro: one for organisation-level indicators and one for program-level indicators. Surveys were distributed to partner organisations via email. Organisations were once again invited to circulate the surveys internally to any staff member who was interested in participating and to encourage contribution from a range of staff from across diverse levels of the organisation.

Indicators were grouped by function. Respondents were asked to look at all of the quality/process and impact indicators under each function and indicate whether they felt that anything was missing that is important to demonstrating what they did in their own work relating to that function. For each indicator, respondents were then given the opportunity to choose whether they would:

- Keep the indicator without changing it
- Suggest changes to the indicator
- Remove the indicator

Respondents were again given the opportunity to provide further open-ended comments or feedback on each group of indicators.

Participants

A total of 25 responses were received in the second survey round, including 10 responses to the survey about organisation-level indicators and 15 responses to the survey about program-level indicators.

The demographic profile of respondents to both surveys is shown in Table 5 and Table 6.

Response analysis

The emphasis of the analysis in the second round was to refine the wording of the indicators, to remove any further indicators, and to add anything identified as missing.

The feedback was highly positive. For 97% (n = 65) of the indicators, at least two-thirds of respondents said to 'Keep the indicator without changing it'. There were 31 indicators for which all participants selected 'Keep the indicator without changing it'.

> *[I] was truly impressed with the quality of the work presented in the surveys. It's clear that a lot of thought and consideration has gone into the indicators and I genuinely found it hard to identify gaps. Whilst reading through I could instantly appreciate how relevant and useful this work will be to both [our organisation] and its members.*
> *— Respondent from a PWUD-led organisation*

Only two indicators received a response, in each case from a single respondent, indicating that they should be removed. In one case, this echoed concerns from the first round regarding the (un)willingness of mainstream sector to collaborate effectively with peer-led organisations. In the other case, the indicator was in the program-level list but was more appropriate as an organisation-level indicator.

Two gaps were identified: peer involvement in program development and data sovereignty.

Indicator refinement

Analysis of responses facilitated the creation of a new list of 69 indicators that included:

- 37 unchanged indicators
  (24 organisation level, 13 program level)
- 30 modified indicators
  (12 organisation level, 18 program level)
- Two new indicators
  (one organisation level, one program level)

The majority of the modified indicators underwent only minor alterations that simplified and clarified wording.

One exception to this was among the organisation-level adaptation indicators. Respondents reported both that indicators had significant overlap and could be combined, and that they were too complicated and should be separated. This was due to the nature of 'adaptation' being a process. In response, we modified two existing indicators and added a new indicator with the purpose of creating indicators that described a three-step process and eliminated overlap without generating a single long and complicated indicator.

Two of the modified indicators were unchanged in terms of their wording, but they were moved to more appropriate positions within the indicator lists. One of these indicators was moved from engagement impact to community influence impact and another from program-level alignment to organisation-level alignment.

Table 5: Demographic profile by organisation type of respondents for the second round of surveys

	PLHIV	PWUD	Government	Not disclosed	Total
Organisation-level indicator survey	3	2	1	4	**10**
Program-level indicator survey	5	4	0	6	**15**
TOTAL	**8**	**6**	**1**	**8**	**25**

Table 6: Demographic profile by role of respondents for the second round of surveys

	Executive leadership	Management	Program delivery	Other	Not disclosed	Total
Organisation-level indicator survey	3	1	1	1	4	**10**
Program-level indicator survey	2	3	3	1	6	**15**
TOTAL	**5**	**4**	**4**	**2**	**10**	**25**

Round 3

Indicator lists

The third list of indicators comprised a total of 69 indicators, including 37 organisation-level and 32 program-level indicators. Table 7 provides a breakdown of the number of indicators in each category.

Table 7: Number of indicators in initial draft indicator list used in the second round of the Delphi method

	EN	AL	AD	IC	IP	Total
Organisation	**6**	**7**	**12**	**6**	**6**	**37**
Quality/process	3	4	6	3	3	**19**
Impact	3	3	6	3	3	**18**
Program	**7**	**8**	**6**	**6**	**5**	**32**
Quality/process	4	5	3	3	2	**17**
Impact	3	3	3	3	3	**15**
Total	**13**	**15**	**18**	**12**	**11**	**69**

Key: EN = Engagement, AL = Alignment, AD = Adaptation, IC = Community influence, IP = Health sector and policy environment influence)

Feedback collection

Due to the fact that relatively few changes were made to the indicator lists after the second round, and these were predominantly minor, it was decided to invite organisations to participate in consultation interviews to gather nuanced feedback rather than conducting a third round of online surveys.

Feedback about the third indicator lists was collected during interviews conducted through conference calls. The purpose of the interviews was to provide respondents the opportunity to provide more context to their feedback than was allowed for by the online questionnaire format. It also gave the facilitator an opportunity to ask questions and gain deeper insight into the respondents' feedback.

Each organisation was invited, via email, to participate in a conference call to discuss the third-round indicator lists. As in the previous two rounds, organisations were encouraged to invite any staff member who was interested in participating from a range of staff from across diverse levels of the organisation. It was not necessary for staff to have provided feedback in the previous rounds.

During interviews, staff were briefed about the purpose of the interviews and invited to lead the conversations, providing feedback and comments where they thought most important. The interviewer also asked specific questions about indicators that had been added during the previous round.

Participants

Seven 1- to 2-hour interviews were conducted with one to three staff from four PLHIV-led organisations and two PWUD-led organisations. A total of 14 staff participated in the interviews, including 10 from PLHIV-led organisations and four from PWUD-led organisations. Participants held a variety of roles within their organisations, including three executive leadership, five management, four program delivery and two other roles (including roles specific to evaluation).

Response analysis

The emphasis of the analysis in the third round was to finalise the wording of the indicators and ensure that there were no gaps. Additionally, the example metrics and evidence sources were refined to ensure that they helped to clarify how the indicators might be applied to a diverse range of organisations and programs.

The feedback was highly positive with the vast majority (94%) of indicators undergoing no significant change. No changes (n = 57, 84%) or only minor changes (n = 7, 10%) were suggested for 64 (94%) of the indicators. Suggestions were made to add or refine examples of potential metrics and sources of evidence for 26 (38%) of the indicators.

The majority of the interviews tended to focus on clarifying the indicators by adding or refining example metrics and evidence sources. Particularly in the case of some of the less familiar indicators, having a range of easy-to-understand potential metrics and evidence sources that could be applicable to diverse organisation and program types proved important to staff feeling confident that they would be able to use the indicator in practice.

Two gaps were identified, relating to data sovereignty and accountability of peer-led organisations to communicate with their communities about their policy advice and participation.

> *It's about having control and feeling like you have control [of your data].*
> *— Respondent from a PLHIV-led organisation*

Indicator refinement

Analysis of responses facilitated the creation of a final list of 69 indicators that included:

- 39 unchanged indicators or examples (17 organisation level, 22 program level)
- 18 unchanged indicators with modified examples (11 organisation level, seven program level)
- 10 modified indicators, six of which also had modified examples (one organisation level, one program level)
- two new indicators

Table 8 provides a breakdown of the final number of indicators in each category.

The majority of the changes were minor refinement to wording that removed unnecessary words (e.g. changing 'The peer program receives increasing word-of-mouth referrals from community members' to 'The peer program receives increasing referrals from community members'), simplified wording (e.g. changing 'has the ability to' to 'can') or clarified the indicator (e.g. changing 'The peer program is accessed by diverse community members' to 'The peer program is accessed by diverse community members across the geographic span of the program').

Participants were specifically asked to provide feedback to help clarify the three indicators that were developed during the second round to represent a three-step adaptation process. Staff from three organisations suggested changes, and the indicators were subsequently modified and reduced from three to two.

Two new indicators were developed to address the gaps raised regarding data sovereignty and accountability to community with regard to policy participation and advice. Feedback was sought from the staff members who had originally identified these gaps to ensure that their concerns were accurately understood and appropriately addressed by the new indicators.

Table 8: Number of indicators in initial draft indicator list used in the second round of the Delphi method

	EN	AL	AD	IC	IP	Total
Organisation	**6**	**7**	**10**	**7**	**7**	**37**
Quality/process	3	4	5	4	4	**20**
Impact	3	3	5	3	3	**17**
Program	**7**	**8**	**6**	**6**	**5**	**32**
Quality/process	4	5	3	3	2	**17**
Impact	3	3	3	3	3	**15**
Total	**13**	**15**	**16**	**13**	**12**	**69**

Key: EN = Engagement, AL = Alignment, AD = Adaptation, IC = Community influence, IP = Health sector and policy environment influence)

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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