Sydney Local Health District Peer Educator Program: Waterloo Pilot Program Evaluation Report

Developed by the Health Equity Research and Development Unit (HERDU)

2024

NSW GOVERNMENT Sydney Local Health District

UNSW SYDNEY

Sydney Local Health District acknowledges the Gadigal and Wangal Peoples of the Eora Nation as the traditional owners of the land on which the District is located and works.

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About this document
This report presents a summary of the methods and key findings of the evaluation of the Waterloo Peer Educator Program.

About the Health Equity Research and Development Unit (HERDU): HERDU is a partnership between SLHD and UNSW Sydney. HERDU's mission is to work in partnership with health services, organisations and communities to identify and reduce existing inequities in health and to prevent inequities in health from arising in the future.

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Abbreviations

AOD Alcohol and Other Drugs
DV Domestic violence
HL Health literacy
PE Peer educator

1 Executive Summary

The Waterloo Peer Educator Program is a community-based peer education initiative for improving health and wellbeing outcomes among social housing residents. The program was conceived and designed collaboratively by a group comprised of housing tenants, Sydney Local Health District (SLHD) staff, social workers, local NGO Counterpoint Community Services, and academic advisers from the Health Equity Research and Development Unit (HERDU). An evaluation was conducted to investigate the impact of the program and how it can reduce health inequities. This report presents a summary of key findings of the evaluation pilot program.

What is the Waterloo Peer Educator Program?
The program trains and supports community members to become peer educators, delivering tailored health information and providing assistance to other community members in Waterloo.

The suburb of Waterloo

The pilot program was based in the Waterloo social housing estate, a multi-ethnic social housing precinct in inner city Sydney. Waterloo has undergone gentrification in recent years and in 2016 had an Index of Relative Socio-economic Advantage and Disadvantage in the top 40% in Australia. Poor health and persistent health inequities for social housing residents in Waterloo are linked to complex issues in people's lives and everyday challenges like poverty, stigma, caring responsibilities, social isolation, and chronic conditions that require tailored responses.

What have we done?

The District established a pilot Adult Peer Educator Program and conducted an evaluation to explore the impact of community-based peer education on enhancing community health and wellbeing. The evaluation aimed to determine how this initiative could enhance existing health promotion and navigation strategies in the District while promoting equity.

Program goals

Improved knowledge about health and wellbeing.

Empower residents with information to manage their own health and wellbeing.

Reduce social isolation and build supportive networks.

Expand and illuminate pathways to health services.

Does it work?

Yes! The evaluation highlighted the effectiveness of the Peer Educator Program as a strength-based approach with positive health and wellbeing impacts on the Waterloo community.

Key findings

Community-based peer education fosters enhanced social connections, mental health, and overall well-being for participants. Ongoing support is crucial for individuals to build the skills and confidence needed to initiate change, reflect on issues, and take actionable steps. Maintaining consistent involvement with health services necessitates a flexible strategy that prioritises trust-building, acknowledges evolving circumstances, strengths, and needs, and adjusts accordingly. This approach values contextual understanding, experiential knowledge, and problem-solving, over conventional recommendations and service access pathways.

Impacts: Peer and Community

The program evaluation examines how health literacy, social connectedness, access to services, and overall well-being of Peers and Community were affected. It demonstrated what results emerged from these impacts, and that they met the program goals. For the full impact listing, please refer to the evaluation report.

Increased active engagement in health and improved knowledge. • Activities reached more residents than standard health education workshops.
Developed knowledge and personal skills. • Residents stated that peer-led workshops were relevant and appropriate and increased their understanding of health.
Empowerment of Peers and Community. • Developed individual capabilities, motivation, confidence. Increased participation, and social support, community connectedness. Increased engagement in social action for health (advocacy), and community cohesion.
Change in attitudes and levels of health behaviours. • Activities reached residents who had been very disengaged and previously did not attend outreach or community events. It was observed that residents experienced more positive attitudes and a sense of optimism.
Appropriate trusted and accessible health services • There was a reported increase in uptake of health services.
Improved health outcomes • Demonstrated increased wellbeing, quality of life, and improved emotional health. • Positive social outcomes such as employment opportunities

Impacts: Health system

Findings show signs of positive change within health and other services engaged with the program despite its early stages. For the full impact listing, please refer to the evaluation report.

Incorporating collaborative and strength-based approaches
Tapping into community knowledge and patient experiences to enhance services
Building relationships and trust to optimise services reach and uptake
Activating collaboration and forming new cross-sectoral partnerships

How does it work?

Right Peers – Right Program – Supportive Environment

The program demonstrated its effectiveness through a blend of three essential components: the right peers, the right program, and a supportive environment. Having the right peers involved applying selection criteria and having a skilled and trusted facilitator, crucial for steering the program and integrating it into the community.

The right program entailed dedicating time, space, and resources, offering continuous support in carrying out activities and enhancing the skills of participants, and collaborating with community organisations. Having a health worker based one day a week delivering health navigation at Counterpoint Community Services enhanced the opportunities for collaboration.

The program was planned and delivered as a model of community empowerment and based at Counterpoint Community Services which has shared values with Sydney Local Health District. Creating the right environment for the program to succeed involved securing strong support and access to staff time and program funding, fostering a culture of collaboration and empowerment among staff delivering and planning for the program, promoting a mindset of optimism and hope for change, and leading by example. It was essential to encourage health promotion strategies that extend beyond standard information provision, emphasising a targeted approach for optimal outcomes.

This model of community empowerment was designed to strengthen and empower peers and communities to support health equity and reduce inequities. By using empowerment frameworks, the program demonstrated how individuals can improve their ability to assert control collectively and individually. The frameworks considered three dimensions of power to measure the program impacts and outcomes for participants as well as the health service. They were:

- "Power within" which emphasises individual self-esteem, confidence, and efficacy.
- "Power with" focusing on collective identity and action.
- "Power over" addressing resources and advocacy.

This exploration highlights empowerment as both an outcome and a process to improve health and wellbeing.

Conclusion

The pilot program has demonstrated that adopting a strength based approach to collaborating with communities can lead to improved health and wellbeing outcomes. By embracing innovative methods, we have witnessed positive results that indicate a sustainable and effective program.

This program aims to empower communities by sharing decision-making power, enhancing their capabilities and knowledge, and creating a supportive environment with the necessary resources and guidance. Peer educator programs can foster culture of support and growth within the community. The findings of this pilot program can be transferred across community programs that aim to support health equity and reduce potential health inequities.

2 Introduction

This report presents an evaluation of the Waterloo Peer Educator Program, a community-based peer education initiative for improving health and wellbeing outcomes among social housing residents. The evaluation aimed to investigate the Waterloo program itself as well as understanding how and why community-based peer education and support can help tackle health inequities.

2.1 Background

Social housing residents face significant health inequities compared to the wider community due to factors including social isolation, intergenerational disadvantage, poverty, stigma, limited health literacy, and barriers to accessing resources (1–3). In the suburb of Waterloo, in inner city Sydney, there is substantial socioeconomic disadvantage that is concentrated in the Waterloo public housing estate – a densely populated area and one of the largest social housing estates in NSW. There is evidence of ongoing and persistent issues with physical and mental health among social housing residents in Waterloo (4,5). There are also significant changes on the horizon with the proposed redevelopment of the Waterloo Estate, which has created uncertainty and some psychological distress among residents (6).

Through the Waterloo Human Services Collaborative Group, residents have expressed concerns about gaps in health care, vulnerable transition points, and general barriers when accessing the right services, at the right time and for a cost they can afford. Improved service integration and service accessibility was also one of the priorities of the Waterloo Human Services Plan (priority 5) (7). In a health system context that is becoming increasingly complex, this is not surprising.

What is the Waterloo Peer Educator Program?
The program trains and supports community members to become peer educators, delivering tailored health information and providing assistance to other community members in Waterloo.

We are surrounded by health information, but it can be difficult to appraise and use this information to achieve better health outcomes. Peer education involves the provision of information and assistance or support by people who share similar characteristics as the target population. There is evidence that peer education can enable people to make better use of information and services; inspire healthier behaviours; and support self-management and community support networks; therefore potentially contributing to decreased health disparities in the long term (8). However and despite growing policy support, the evidence base for the effectiveness of peer education among adult populations and marginalised groups is still developing and it has also been described as a "method in search of theory" (9). There is a need for deeper investigation of the underlying mechanisms generating impacts. The evaluation therefore focuses on the role of community-based peer support and education in Waterloo using the following considerations as starting points:

- **There are persisting health burden and health inequities in Waterloo**
  Poor health among residents in social housing and in Waterloo is an ongoing issue. Disparities in health outcomes experienced by social housing residents are also avoidable and unfair. In a recent survey of 320 social housing residents in Waterloo 48% of all respondents rated their health as fair or poor (4). Other measures of health and wellbeing like life satisfaction was also

lower than Sydney region NSW averages (ibid). The SLHD has made it a priority to provide high quality health care and improve the living and working conditions of people in the area (10).

- **Building on successful place-based initiatives is a good idea**
  Recent service and community developments in Waterloo like the SLHD Health Living Link Manager, the Waterloo Collaborative Group, and Human Service Plan, that focus on improving communication and integration between services and residents and on empowering community members have shown early positive results (11,12). These initiatives show that acknowledging people's underlying social and economic constraints as well as building on community strengths and motivation to make changes are important ingredients in tackling complex, entrenched problems like health inequities. Community-based peer education may similarly offer a contextual, sensitive and more holistic approach to health promotion.

2.2 Purpose of the evaluation

The study aimed to investigate the possible role of community-based peer education in improving health and wellbeing in the Waterloo community and evaluate to what extent this initiative can inform and complement existing health promotion and navigation approaches in SLHD in ways that bolster equity.

Our study aimed to:

1. Assess the impacts of the program on peer educators, and health system and community services
2. Explore how, why and under what circumstances the program contributes to meeting the health and wellbeing needs of Waterloo residents; and contributes to influencing service practices
3. Inform the SLHD future policy and program developments in community-based and/or peer-led approaches to better achieve health outcomes and reduce health inequities.

3 Methodology

The study used a **concurrent evaluation approach** (evaluating the intervention as it happens) and **realist methodology**. The evaluation was informed by a realist synthesis of evidence (8) and a rapid review of more recently published literature on community-based peer education.

Realist evaluations are a theory-driven methodology that seeks to explain **how and why** programs like peer education work to generate particular outcomes.

This is different from standard outcome evaluations that focus on the question of effectiveness (did this work?) and health-related immediate or intermediate behavioural outcomes alone. As noted earlier, evidence for peer education interventions remains relatively weak and recent evaluations have not consistently shown health or service benefits (13). This is likely due in part to the use of research methods that are poorly suited to capture the complexity of interactions and range of impacts of health interventions in complex social settings. In contrast, we decided to apply a realist inspired evaluation approach in order to:

- capture **the full range of impacts** on all the stakeholders (see Figure 1).
- **understand** what it is about the program that makes it work (or not work) and generates impact on communities and health systems.
- **inform the future and potential transferability** of the program by identifying the specific resources that condition impacts in different circumstances, demonstrating where and how it is worth investing in this type peer initiatives.

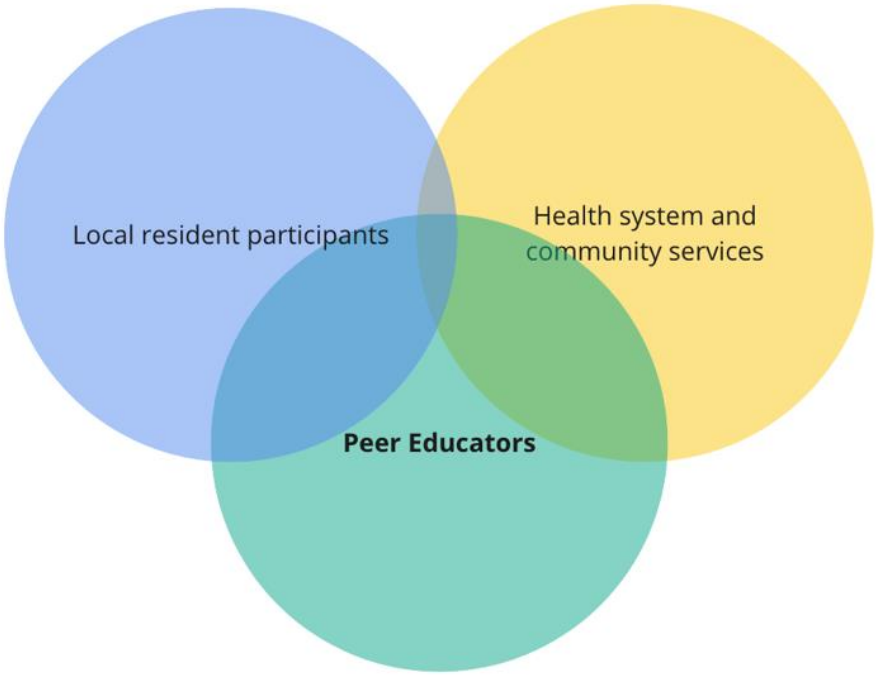


Figure 1 Capturing impact across the different stakeholders

What is a realist evaluation?

Realist evaluations focus on causal narratives and explanations to produce a deeper understanding of how complex interventions work under different circumstances, and for whom. Realist evaluations pay particular attention to ***context,*** that is, the social, environmental and other circumstances that surround the program and may lead or influence people to make certain decisions (14). There are different contextual layers in an intervention including individual, interpersonal, organisational, and policy levels (15). Context is particularly important for non-medicalised programs that focus on social change and social determinants because they mostly involve the interplay of human reasoning and decisions with resources provided by the program, a process known as ***mechanisms*** of change.

Realist evaluations aim to get to the bottom of causal explanations by understanding the action of underlying mechanisms within specific contexts – how resources influence and shape the nature and potential impacts of complex interventions (16). These explanations are known as ***program theories*** or context-mechanism-outcome (CMO) configurations and they are continuously refined and tested during the evaluation.

The study followed a realist evaluation process (see Figure 2) that also sought to embed realist thinking through ongoing collaboration and learning with the implementation team (14).

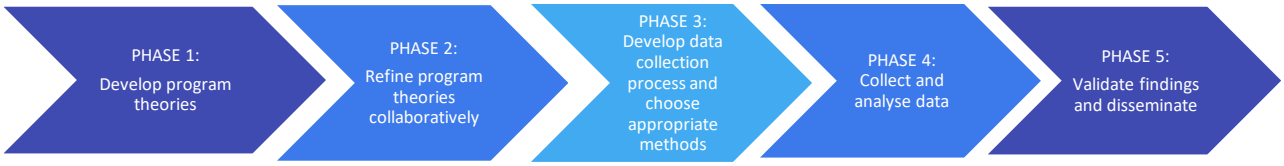


Figure 2 Realist evaluation process

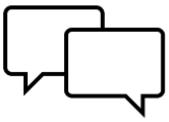
We first developed initial program theories building on existing published literature regarding how and why the peer educator program was meant to work to achieve its stated goals (Phase 1 – see Appendix 1: initial program theories). We organised collaborative sessions with people involved in the program design and leadership (implementation team and steering group) to further unpack their assumptions and beliefs in how and why community members would be able to use the resources from the program to effect intended change (Phase 2) (see Appendix 2 – Program Logic). These initial steps were essential because they allowed us to:

- Identify elements of the program to focus on for the evaluation
- Support the planning and refining of implementation activities along the way, highlighting potential gaps in logic or unsupported assumptions that needed addressing
- Create buy-in for the evaluation by engaging people early, showing there is value in evaluation to learn, inform and improve the program design. This also nurtures a culture that says evaluation is everybody's business (14).

We then developed a range of data collection tools to best answer evaluation questions and explain how the model worked to improve health and wellbeing.

3.1 Data collection methods

The study design was based on mixed methods (see Table 1).



We primarily collected qualitative data through **semi-structured interviews** with peer educators and service providers to capture impacts, process, and test program theories (see Appendix 3 – Characteristics of participants). Interviews were recorded and conducted face to face (with one exception due to the participant being overseas).

We conducted **ethnographic observation** of training sessions and community-based activities. We participated in staff debrief sessions after these activities.

Documents about the peer educator program including initial program design, training material and feedback forms post training, and activity reports were also used to inform our analysis.

Ethics approval for the study was granted by the SLHD Human Research Ethics Committee on 12 December 2022 (protocol number X22-0328 2022/ETH01687).

Quantitative data was collected through a **survey** to assess the impact of the training on peer educators as well as recording participation rate and reach for community-based activities.

Table 1 Overview of data sources and analysis

Mixed-methods study	**Qualitative data**	**Semi-structured interviews**	14 peer educators (including 2 who exited the program) 5 service providers See Appendix 3 – Characteristics of participants	Analysis - deductive and inductive approach
		Observations	Training modules for peer educators (13 x 3hr) Reflection session with peer educators (2hr, May 2023) Community-based activities led by peer educators (10 x 1.5hr) Staff debrief sessions (8 instances; 20-30min each) Findings validation session with peer educators (1hr, Dec 2023)	
		Documents	Promotion material Training material Activity reports Correspondence from implementation team members, partner services and organisations	
		Feedback forms	Feedback forms completed by peer educators post training sessions (n= 29)	
	Quantitative data	**Survey post-training**	n = 11 Results shown in Table 3 (findings section)	Analysis -Descriptive analysis
		Participation rate and reach for community-based activities	Results shown in Appendix 5 - Peer Education activities delivered to community	

Data: Every peer educator was offered the opportunity to be interviewed, including people who had dropped off the program. Observations captured a range of different trainers and topics as well as different types of community activities, from the more formal and traditional kind such as group presentations to the more innovative including trivia nights and art sessions, until we reached saturation. Interview transcripts, observation fieldnotes and documents were analysed using Nvivo 12 software.

3.2 Analysis

In this process we combined a **deductive analytic** approach to test and refine our initial program theories with a more **inductive approach** attentive to new or unexpected findings specific to the context and setting of the program. We cross analysed a sample of interview transcripts to test validity. We also looked for alternate explanation and cases and triangulated information where possible. Abductive and retroductive analysis, involving examining the findings and taking a step back to develop new ideas and theories, was used to develop explanations about the causal powers and mechanisms that make the program work (15).

4 Study setting and program description

The study is based in the Waterloo social housing estate, a multi-ethnic social housing precinct in inner city Sydney. As a suburb, Waterloo counts approximately 16,400 people, of which:

2.8% are Indigenous

63% of residents were born outside Australia

of households use a language other than English at home

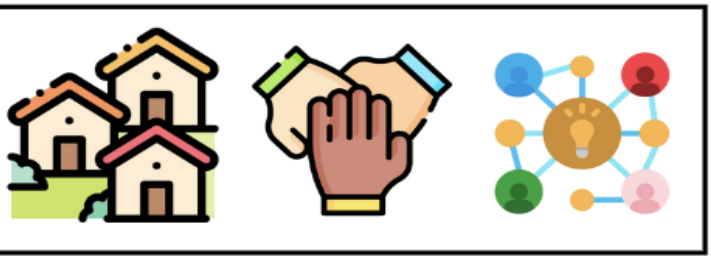
Social housing makes up **17%** of homes in the suburb

Waterloo has undergone gentrification in recent years and in 2016 had an Index of Relative Socio-economic Advantage and Disadvantage in the **top 40%** in Australia.

However, significant pockets of disadvantage remain, and:

its Index of Relative Socio-economic Disadvantage in 2016 was in the **bottom 20%** nationally

At the same time Waterloo also has a **rich history of being at the forefront of community and union organising**



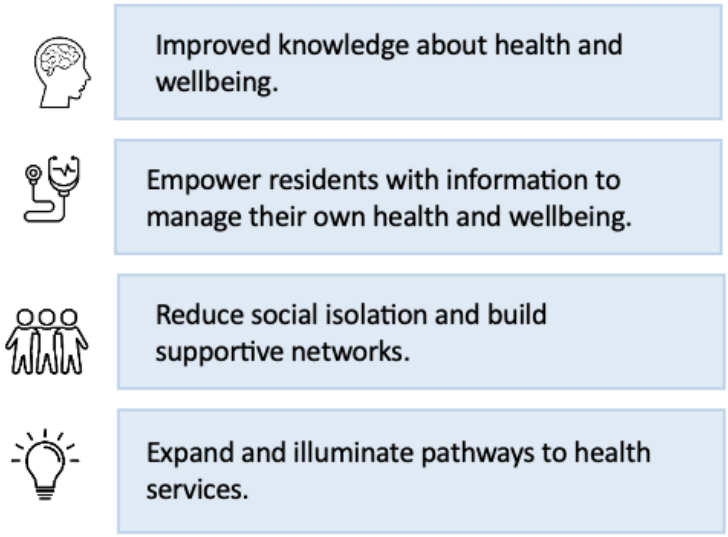
There is a long standing and well-established community service sector in the area and organisations committed to empower residents (7). Efforts to improve service integration and collaboration to better serve the Waterloo community have increased in recent years ahead of the planned redevelopment of the estate (10–12).

The Waterloo Peer Educator Program was developed collaboratively as part of the SLHD's participation in the International Foundation for Integrated Care (IFIC) Autumn School in 2021. The program was conceived and designed by a group comprised of social housing tenants, the SLHD Healthy Living Program Manager Waterloo, social workers, local NGO Counterpoint Community Service, and academic advisers from HERDU. Using a needs assessment exercise and the IFIC Integrated Care Initiative Tool (19), the group identified both opportunities and barriers for improving health and wellbeing among social housing residents (Table 2).

Table 2 Co-design phase: opportunities and barriers for the Peer Educator Program

Opportunities	Barriers
Interest for more relevant and targeted health information.	Red tape in accessing services Poor communication between services and residents.
Motivation to support neighbours and community members.	Navigation issues.
Interest from residents in being more in control of their health and develop capacity to help each other. SLHD committed to place-based working and collaboration with residents in Waterloo.	Rising levels of social vulnerability. Rising levels of complex care needs among residents, particularly around mental health management and AOD. Increased social isolation post pandemic – some community services have not resumed their f2f programs.

The program therefore aimed to use opportunities and community resources to achieve the following goals:



The tag line of the program also captures **the dual objective of health promotion and community development** at the heart of the program:

Making it easier for Waterloo residents to **live a healthier, more engaged, and fulfilled life**.

How: through a community led project training local people to be health educators and information gatherers using a peer support model.

Lesson learnt: collaborate early, at the design phase; understand the culture, norms, social issues, and health seeking behaviours of the community; leverage existing assets and opportunities and build on good will.

The Peer Educator Program consists of four stages (project plan and timeline are available in Appendix 4 – Peer Wellbeing Educators Project Plan).

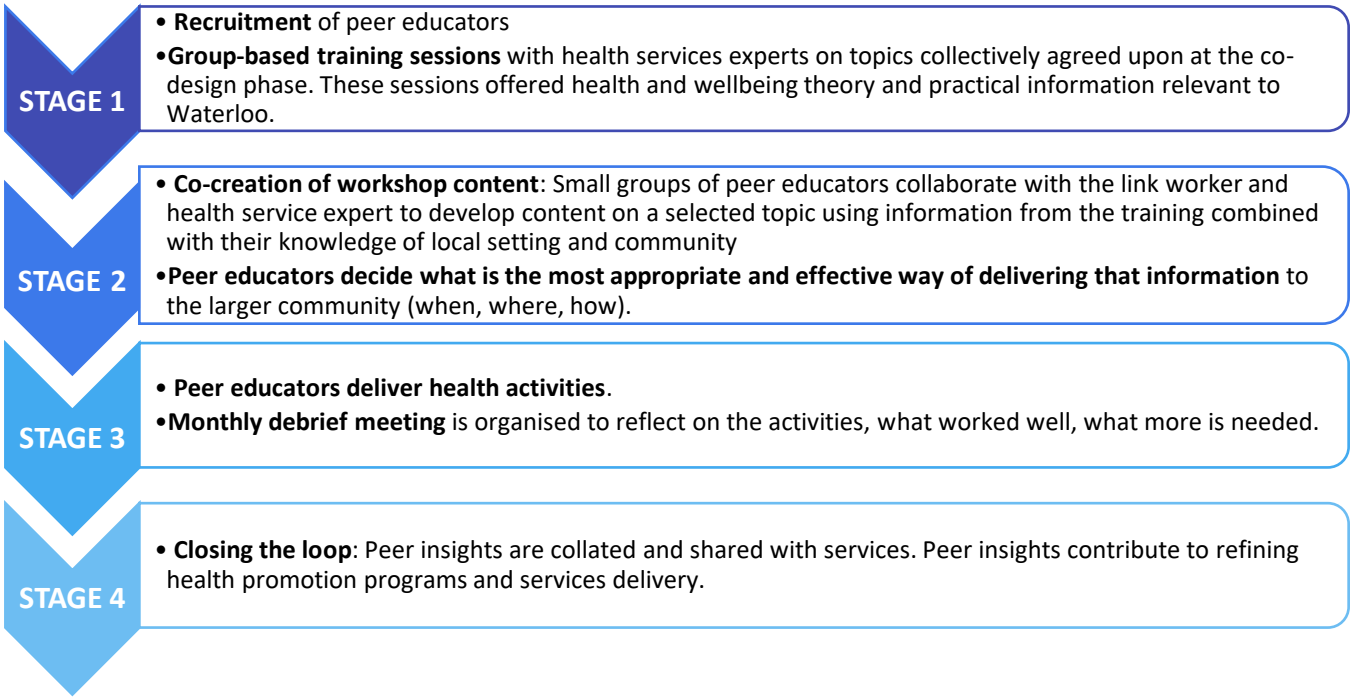


Figure 3 Stages of the peer educator program

4.1 Understanding the program and interpreting how it works

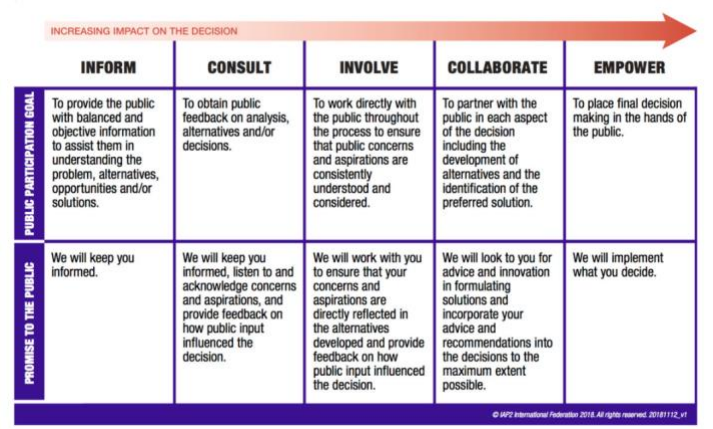
We identified appropriate conceptual models in our review of relevant literature to guide our understanding of how the program was meant to work in achieving its goals in Waterloo specifically, and to explore how peer education in the community could help address health inequities more generally.

First, we drew on **critical health literacy** models. Historically, health literacy (HL) focused on the capacity of patients to read and understand health information; navigate health services and referrals; and to adhere to health instructions. Many interventions frame low health literacy as a **problem of information deficit** remediated by giving information that match levels or skills of patients so that they can use health messages and health services to maintain or improve health (20,21). In this perspective, education is about transmitting the right information and persuading people to follow it.

Critical health literacy models show that health literacy is more than the individual ability to read health information or to make appointments. It is about **improving people's access to information and their capacity to use it** (22). HL therefore encompasses a much wider scope. It comprises health education and promotion methods that go beyond information diffusion **and increase people's agency to make decisions** in the context they are in. As such, HL is important for empowerment. The *process* that supports people's learning and skill development matters. In other words, HL is not only about individual skills and competencies and requires a more participative collective approach to health education. In a critical HL model, the role of **context, networks and**

psychosocial factors is foregrounded – they are understood *as enabling or inhibiting factor*s because they all shape people's ability to engage in and act on health information (23,24). Lastly, desired health-related goals are set by people themselves, not medical or outside experts. These considerations helped us focus the evaluation.

What is community development?
"*A way of working directly with communities to build community connectedness, community capacity and empowerment, and enable communities to realise and develop their assets and take action on needs they have prioritised*" (35) Community development recognises that community are heterogenous and involves types of engagement at the collaborate or empowerment level of the IAP* spectrum.



Source: https://organizingengagement.org/models/spectrum-of-public-participation/
*IAP: The International Association for Public Participation's Spectrum of Public Participation

Second, to think about community development and its relation to influencing health systems and tackling health inequities, we used **models of community empowerment** developed in the literature (25,26). It is well established that strengthening and empowering people and communities is an important strategy to tackle health inequities (27), including in the WHO Integrated Care Framework (28). The WHO recognises that "providing the opportunity, skills and resources that people need to be … empowered users of health services and advocates", is a key lever of action to reform health systems (p.5). Such strategy therefore requires health system's willingness to invest in people and communities.

We used empowerment frameworks (Figure 4) outlining how people develop capabilities to exercise greater collective and individual control across three levels (**"**power within"; "power with" and "power over") to explore the pathways between empowerment both as an outcome and as part of the process to enhance health and wellbeing.

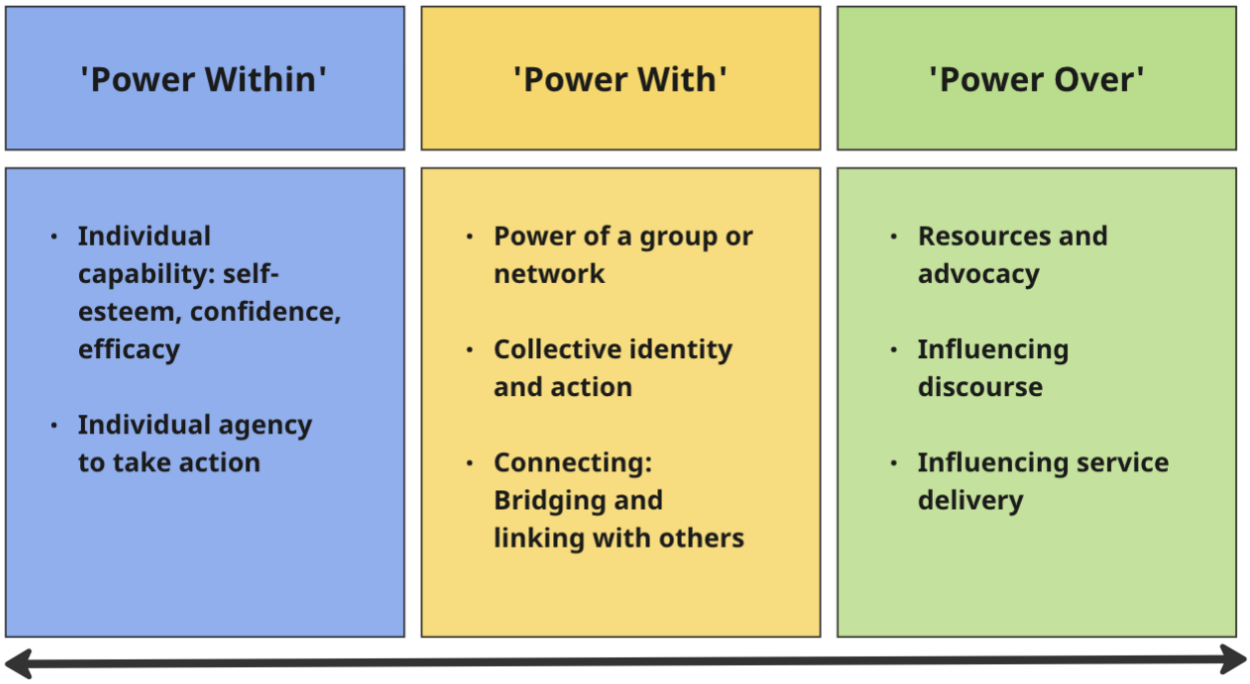


Figure 4 Empowerment framework (Adapted from Popay et al. 2021 and Power Up 2023)

Importantly, these models recognise that **it will take more than the health sector** to narrow the health gap and to improve health and wellbeing for marginalised communities. Collaboration and action across sectors are needed to achieve this ambition and so we also looked for evidence of cooperation and alignment with other stakeholders. In addition, for sustainable change to occur tackling structural inequalities is also crucial according to this literature (8,23,25,29) – hence we remained alert to efforts at influencing system change by embedding different ways of working in the broader system.

5 Findings

Our findings section is divided into two parts.

First, we outline **the impacts of the program** on peers and community in relation to its objectives of improving health literacy, social connectedness, pathways to services and general health and wellbeing for residents. We also looked for impacts on health system and other services that indicate alignment and influence of the peer educator program. Impacts are understood broadly as events, actions and decisions that contribute to short-, medium-, or longer-term outcomes.

Second, we dig deeper into the findings to **explore how and why impacts and outcomes emerged** (combination of contexts and mechanisms in realist terminology) and what can be learned from the program more widely.

5.1 Impacts

KEY FINDINGS: Peer and Community Impacts

Increased active engagement in health and improved knowledge.

- Activities reached more residents than standard health education workshops.

Developed knowledge and personal skills.

- Residents stated that peer-led workshops were relevant and appropriate and increased their understanding of health.

Empowerment of Peers and Community.

- Developed individual capabilities, motivation, confidence. Increased participation, and social support, community connectedness. Increased engagement in social action for health (advocacy), and community cohesion.

Change in attitudes and levels of health behaviours.

- Activities reached residents who had been very disengaged and previously did not attend outreach or community events. It was observed that residents experienced more positive attitudes and a sense of optimism.

Appropriate trusted and accessible health services

- There was a reported increase in uptake of health services.

Improved health outcomes

- Demonstrated increased wellbeing, quality of life, and improved emotional health.

KEY FINDINGS: Health Services Impacts

- **Changing culture:** adopting **collaborative and strength-based approaches.**
- **Service optimisation:** tapping into **community knowledge and patient experiences to enhance services.**
- Building **relationships and trust** to optimise **services reach and uptake.**
- **Activating collaboration across sectors** and forming partnerships at program scale.

Impacts: Peer Educators

In mapping the different impacts for peer educators, we identify how active engagement in health and building knowledge and skills can lead to improved capabilities for health literacy and action, potentially contributing to change in behaviours needed to achieve better health outcomes. Table 3 summarises the impacts for peer educators across 8 outcome categories with supporting data and examples. Relevant findings from the Peer Educator Survey are also presented.

Table 3 Impacts for peer educators

Outcome category	Examples	Supporting data
Active engagement in health	Peer educators enabled to draw on range of information and experiences to learn about health. Promoting active engagement in health in the wider community (e.g. opportunistic and incidental conversation with other residents).	**Personal Engagement** - Training workshops consistently very well attended over 18-month period (av. 17 peer educators). - High retention rate in the program: initial cohort of 20 peer educators, with two exiting because of work/study early on, and two more exiting later in the program because of pre-existing health issues. - All remaining peer educators delivered at least one community-based activity. **Community Engagement** "When **I have chance conversations** with other people, with families and friends…I do recommend, I do tell them, you can go here [health service]" (PE7). "Mission Australia and OzHarvest run the outreach on a Thursday […] I **did talk to them and gave them things to help them** [with hoarding issues]" (PE10). "There was some catchphrases that are always good to remember and **then pass on**. If they're impactful for you, they'll be impactful for someone else" (PE3).
Peer educators surveyed said their understanding of how to keep healthy has improved (>90%) [1]		

[1] Survey conducted with peer educators (n=11).

Outcome category	Examples	Supporting data
Knowledge and personal skills	Increased awareness about health topics. Increased knowledge and understanding of health issues and support/services available. Acquired new skills and developed existing skills including: communication; public speaking; leadership; group work; facilitation; project management; research .	**Awareness, knowledge and understanding** "I learnt a lot" (PE11) "It told me what's available for people through the medical system" (PE4) "I've learned so much from the training.. I've got a better understanding of the problems other people are facing" (PE6). "There was things like domestic violence and family violence […] **I had lived experience, but I really didn't know how to get really the supports.** So … that was really educational for me" (PE1). "I do hear a lot about **antisocial behaviour**. But mostly in those, they would be just call the police. So **I've learned a bit more about that**, I guess, and the other options other than calling the police" (PE2). **Skills** "it's impacted in a positive way, where **I've got those skills** from the training to be able to now get a job" (PE1). **"…gaining the knowledge, the skills** to be able to then bring it to the people" (PE4). "it harnessed the **research skills** that I had: my nurturing skills, **my ability to talk to people**, **presentation skills** and communication, interpersonal skills, because you relate to different levels of people and different levels of understanding. Yeah, a lot of skills" (PE7).
Peer educators reported gaining communication skills (100%) and public speaking skills (>63%) Peer educators reported having good knowledge about the health topics covered in training (>72%) Peer educators all agreed that their knowledge of health information and health services has improved (100%) Peer educators reported having knowledge about the health services available to residents, and how to access them (100%)		

Outcome category	Examples	Supporting data
Power within: individual capabilities, motivation, confidence	Increased confidence and increased sense of self efficacy. This translated, for example, in feeling confident and qualified to talk to others about health and health services. Greater ability to define what health and wellbeing means for each individual and greater motivation for healthier lifestyle. Greater ability to reach out for help and support.	"I **feel better qualified**. If I ran into someone with issues that they brought to my attention, I feel better qualified now to help them…I would feel **more confident** to help them" (PE6). "if I have the **correct information** for me, I can stick to that and **stay focused.** But whereas **before this I was very anxious and nervou**s, so I would just do the opposite, or not know" (PE1). "I participated in the event…I **was confident that I had the knowledge"** (PE11). **"I feel more confident** answering [questions] or saying, no, I don't know, but here's where you can find out…my self-confidence has improved" (PE2). "…**hearing about different programs** and what's out there is **always a benefit**. Because then you can say to people, "Well, you could try this. Have you contacted them?" (PE3). "[the program] stimulated me. **It gave me a life** because it allowed me to do research… that's really important for me probably for my own **sense of fulfillment, for my sense of achievement"** (PE7). "[The program was good] for **confidence, for connection, for self-esteem... To add something worthwhile to your day.** All those benefits and all of those **contribute to your overall health**." (PE3). **"I know how to support somebody… I can actually confidently be of assistance**… being through the peer education program, you've got that confidence, you've got that reassurance that there is support out there, and we're giving you the correct [info]" (PE1). "where the peer educators are involved in designing the workshops…I could see it too – just observing **how each person just really shines"** (PE1). **"you can actually let people in the community know [when you are struggling**], then they support you and they know. And that's a good feedback for you that they actually know that you're actually getting somewhere and doing some stuff like that" (PE10).

Outcome category	Examples	Supporting data
Peer educators reported feeling confident starting conversations about health topics covered in training (81% to 90% for the priority issues identified at the start of the program) Peer educators reported being able to ask for help or advice (100%) Peer educators reported increased Confidence in talking to a doctor or health professional (>81%)		
Power with: Increased participation, and social support, community connectedness	Reduced social isolation: improved engagement with society, social support/wellbeing. Developed networks, connection and support (informational, emotional, instrumental support).	"I got to know some peers better…so in a way where we have a very quite **good social connection**. the peer education programs, **it allows us to keep connecting** with each other, feel safe with each other, and then we can also catch up outside of these workshops" (PE1). "it's when you're **talking to people who you've never met before and they're interested and even appreciate what you're telling them,** that's good too" (PE2). "I came to know more people in the community…**I'm going out more often and being a part of the world** (PE7)". I'm nursing a community. I'm bringing up the community... That's what the Peer Education's done for me. It's given me fulfillment. **It gave me a sense of belonging. It made me useful**. (PE7). "I feel so compassionate and joyous in this group…**I feel alive in the group"** (PE8). "I knew that this was a good thing because, you know, it stirs that part of your brain again. **It stirs your connection with other people**…I'm more open to it [being part of community groups]" (PE3). **"I was able to go back into society, and social way of life"** (PE1). "…creating situations **where people can meet other people and socialise in a meaningful way**, and build self-esteem in doing something" (S5).
Peer educators reported being more connected to other residents and networks of support (>90%)		

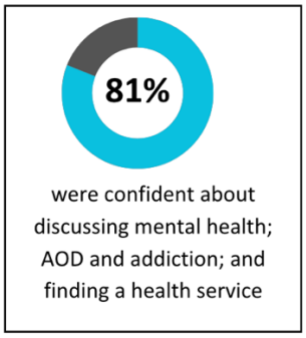
Power over: Engagement in social action for health (advocacy)	Working together to challenge negative perceptions and discourse. Working together to change norms and social status. Acting together to effect change in the Waterloo environment so it can enable health.	**"even though I'm not working, doesn't mean I can't be useful**….. what you think isn't always necessarily true about yourself" (PE3). "realis[ing] that no matter what your age group, no matter your social standing, we all have issues. All of us. And these are our particular ones to our neighbourhood and that's **what we're going to focus on: us"** (PE3). "We have had ….people who always stood up and wanted to be on committee or go to meetings and advocate represent the constituents. So we, here, are reflecting that too I believe. **There is a strong powerful force, people who are prepared to speak out"** (PE Reflection session, May 2023). **"we are trying to do something for ourselves to improve our health**, to make diabetes a thing that we can take control of or manage. And so that's something to be proud of. And now **I'm proud of my community.** For me, that is a big affirmation **that people in social housing aren't this dependent, do nothing or know nothing people."** (PE7). "We're coming from **a grassroots level**…people power is going **to make a huge difference**" (PE8). "I realised that there was big issues in the community, and that there wasn't anyone talking about it, and how to support. These were steps to report it to your DCJs [Department of Communities and Justice], FACS [Family and Community Services]. And so I didn't want to do it in a way that it's bad. **I wanted to be able to support the community, by continuing to educate myself** (P1). "We talked to their bosses [of the building's concierge] and they're actually very interested. And it's to give them information about if they're worried about somebody who they can ring. Presently, all they can do is ring DCJ, who know nothing." (PE5). **Increased participation and more critical input** Community services and local agencies in Waterloo reported increased input and more critical thinking from peer educators in their meetings, both in terms of existing projects and providing new ideas: "you see that **coming from the peer educators rather than the traditional leaders** that are in the community. So that's good to see that that **growth**" (service provider, observation Sep 2023).

Outcome category	Examples	Supporting data
		Other examples include: influencing LAHC and training high-rise building concierge workforce Lobbying local chemists to stock overdose reversing drugs as well as other opioid medication.
Peer educators felt more confident to collectively speak up for their rights (>81%) Confidence in working together and supporting each other also increased (>90%)		
Change in attitudes and levels of health behaviours (Intermediate health outcomes)	More positive attitudes Realistic goal setting Changes in levels of health behaviours: (e.g. oral health, eating differently, following healthy plate guidelines, walking and getting out more).	"from my personal goals, I've set goals…**just trying to do healthier living sort of things** as well. So trying to do those small things and trying **to set realistic goals as well** rather than, oh, yes, I need to change everything and get everything sorted" (PE10). "the dental one. I now **clean my teeth f**irst thing in the morning, which took me a while" (PE2). "it gave me a **good feeling** for me personally, in the sense that I was being **another step in becoming more my old self that I had lost"** (PE4).
100% of peer educators reported doing at least one activity, or follow one tip discussed in the workshops, to improve their health		
Appropriate trusted and accessible health services (Intermediate health outcomes)	Reported increased uptake of health services.	Some peer educators undertook **Hep C testing** "there's definitely these things where you can go – there's a van, a Hep C van that you can go and get yourself tested as well. I've never had that done, but I did go" (PE1). -Peer educators started using **Counterpoint community services and referrals/case management** (Staff debrief Feb 2023). - Peer educators engaging with **mental health services more regularly** :"Try to get a bit more of a consistency in looking at the mental health issues for myself out (PE10).
55% of peer educators reported recommending health services to others		

Outcome category	Examples	Supporting data
Improved health outcomes	Increased wellbeing and quality of life. Improved emotional health and wellbeing. Positive social outcomes (e.g. employment as lived experience worker, consumer representative for dental hospital, opportunities for casual admin and reception work).	"previous to this, going to these workshops and engaging in community events, I had a lot of anxiety, depression, and chronic fatigue […]I **think that helped me to -it impacted my private life, my daily life"** (PE1). **"Physically, I feel better**. I think **my mind is clearer** in a way …we all **need to be useful to do something**, to be accomplished, to be acknowledged and recognized. That's an important psychosocial need or mental health need" (PE7). "…four of them **getting a job** in peer education or in other types of [work]" (S3). "obviously **some of the peers have been able to obtain work**, which is fantastic. And whether they didn't actually realise at the time that their stories, **their knowledge could actually enable them to do that** on that scale, which is just amazing" (S4). "Like it's taken me years to be able to find a job, because of my mental health issues" (PE1). **"I think I can do that job** [following employment offer]" (PE3).
After the training peer educators reported a more active and positive engagement in life (100%)		

Further evidence supporting outcomes for peer educators[2]

- After completing training in early 2023, peer educators agreed they had enough information to start a conversation about health topics they had identified as high priority for the community:



were confident about discussing mental health; AOD and addiction; and finding a health service

nutrition **(>81%)** and domestic violence **(>72%)** were other emerging topics that peer educators felt confident about

- Peer educators also reported that they felt:

a more active and positive engagement in life **(100%)**

more active in the management of their health **(>90%)**

more confident to collectively speak up for their rights (empowerment indicator) **(>81%)**

increased uptake of health directed behaviours: **100%** peer educators reported doing at least one activity, or follow one tip discussed in the workshops, to improve their health

more connected to other residents **(>90%)** and networks of support, and able to ask for help or advice **(100%)**

gained communication skills **(100%)**

55% of peer educators had recommended health services to others

[2] Survey conducted with peer educators (n=11).
The survey included questions taken from standard health literacy and heath education questionnaires (32,33) across the following scales: Having sufficient information to management my health ; Actively managing my health (HLQ scale) and health directed behaviour (heiQ scale); Positive and active engagement in Life (heiQ scale); Skill and technique acquisition (heiQ scale); Health service navigation (heiQ scale); Social integration and support (heiQ scale)

- **Positive changes reported also included:**
    - Knowledge base expanded (health information, health services)
    - Confidence increased
    - Reduced isolation
    - Social support and working together with flow-on benefits for sense of belonging, emotional wellbeing and mental health.

- **Areas that needed additional training and support** included public speaking; health navigation (appropriate and accessible services); training in relation to domestic violence and diabetes.

Impacts: Community

Primary data collection from community participants was outside the evaluation's main scope. Evidence for this group of participants comes from observations conducted at events led by peer educators and anecdotal reports from interviewees.

Appendix 5 - Peer Education activities delivered to community presents an overview of the activities led by peer educators (in Waterloo, Redfern and Surry Hills); participation rate and reach; as well as collaboration with other services and we present a summary below.

Table 4 Impacts for community

Outcome	
Active engagement in health	Peer educators led **health promotion activities** for communities in Waterloo, Redfern, Camperdown and Surry Hills, with **participation consistently high** - AOD presentation (65 people) - Mental health and wellbeing quiz (55 people) - Diabetes workshop and BBQ (45 people) - AOD quiz night trivia for Aboriginal residents (18 people) - Open art workshop series (6 x 10 people) - Healthy eating lunch (25 people) - Declutter workshop (70 people + 2 weeks of skip clean up) To note: numbers reported by implementation team. **Reach and engagement** - Activities are reaching **more residents than standard health education workshops** in this community(observation - staff debrief sessions). - Activities are reaching **residents who are otherwise very disengaged** and do not show up to outreach or community events (observation, staff debrief sessions; correspondence service provider). - Feedback from residents is that workshops are relevant and appropriate and increase their understanding (activity report). **Other example: Overdose awareness week program of activities** - 6 peer educators trained to administer Naxolone. - Peer educators did outreach with SLHD Harm Minimisation Team in multiple locations and interacted with >100 people.

Power within: Capabilities for health literacy and action developed	**Increased confidence** Ability to discuss sensitive issues like AOD, mental health and hoarding with their peers has improved: "Lots of discussion at the workshop with residents about mental health and them feeling more comfortable about their own mental health (S3). "[one woman] feeling less stigmatised about her mental illness" (S3). **Greater sense of hope and agency** "Gained a sense of hope and that **change is possible from hearing people's storie**s at workshop and events… giving people hope about health" (PE Reflection session, May 2023). "Especially **the housing culture**, **many people give up hope** of finding the right [help] 'oh there are no doctors and Medicare and they get into a rut…everything's bad' we are able to tell them **that you can go to this place to get help**" (PE Reflection session, May 2023).
Power with: Community participation and connectedness	**Increased opportunities for participation** Workshops that run regularly like the "Art and Affirmations" workshop series provide reliable, predicable environment that encourages community connection (activity report; correspondence from staff). **Increased community cohesion** Peer educator-led events are community led and provide opportunities for people to meet and talk to each other with positive effects for community cohesion: *People are less paranoid of each other and their neighbours* (observation, staff debrief Nov 2023) *"Rather than feeling like oh my God, I'm scared, I don't know what to do; I'm not going to do anything. I think that these workshops really helped me to overcome that kind of barrier" (PE1).*
Referrals to services and service uptake	**Evidence of referrals at different locations:** Cohort at Common Ground building is more engaged with health services (correspondence from staff). Some referrals post workshops to AOD services and hoarding team (activity report; S3).

Impacts: Health services

Findings show signs of positive change within health services engaged with the program even though the program is still in its early days. It is important to note that different parts of the health system have different levels of buy-in for the program, so these impacts vary (see more in the digging deeper section 5.2.).

Table 5 : Impacts for health services

What changed?	How?	Supporting evidence
Changing culture: changing perceptions and attitudes	By being exposed to their community in a different way, services reported considering a shift towards more **a strength-based and partnership approach** with consumers. This has potential to influence the system more broadly. This exposure challenged stigma regarding social housing tenants amongst health service staff.	"We need to **listen carefully** to what clients and patients and the community is saying" (S3). "**the peer educators teach me things**" (observation, staff debrief Oct 2023). "to see them stand up **doing their workshops and proud to tell their story and proud to help others, that's a huge impact**" (S4). "giving the health staff an understanding that **patients and clients have greater skills than you can imagine**. That's been one of the positives. I think that the patient-staff relationship is still a bit skewed and there's no sense of the value" (S3).
Service Optimisation: Tapping into community knowledge and patient experiences to enhance services.	Peer educators acted as i**ntermediaries** between community and services, highlighting vulnerabilities, barriers, and unmet needs. **Services saw the value of lived experience** input in optimising service delivery in practice. There is **trust and credibility in the program.**	"the manager for the [name redacted] **Mental Health.** I can't remember her title. she really enjoyed it and went, 'oh, that's amazing. **We could use that way of working** in some of the mental health work we're doing'" (S3). "[health service] is **thinking about how they can use those people in there. S**o drug health is using them within the Naloxone training. So they'll send them out with their staff (S3)". "**the way peers spoke to [consumers] with no pressure** gave them time to process the information and then decide to sign up" (activity report).
	Prioritising **prevention and early intervention** is also a strong demand that can help to reorient services. There is appetite for positive health	Problems are perceived as "not bad enough" so services cannot or will not intervene, this is an issue (observation, peer-led activity Mar 2023).

	(rather than treating illness) in the community.	"**preventing things from getting worse**" (PE Reflection session, May 2023). "you don't want to get the person at the emergency when they're in a diabetic coma or you don't want to get them after they've been boarding so long that they've got infection" (PE Reflection session, May 2023).
Building relationships and trust: optimising services' reach and uptake	Post-pandemic some members of the community felt very disengaged from (health and community) services. **The program created opportunities to rebuild connection** between services and community and a renewed sense of trust and collaboration, which over time, can **lead to greater service uptake.**	"there is **momentum, energy** and **positivity in the community**" (senior manager, observation, staff debrief Feb 2023). "**it does help me with my relationship with them in the community**. And it certainly has helped, doing that, training them…. They come to me a lot more readily. So since then I've actually had them, different peers approach me for different reasons, just for advice on certain things" (S1).
Activating collaboration across sectors: forming new partnerships	The program generated **partnerships between different services** that tended to work separately, enabling sharing of best practice and ongoing relationships.	"**to influence [other services] in the long run** for all the other things I do It's influential to bring people on board like that in collaborative ways because you begin to open up their understanding of what's possible" (S3).
	The program drew in collaboration from across the spectrum of institutions including **local government; DCJ and housing**; community service organisations and NGOs (see Appendix 4 for full list).	"Activating" these partnerships is important because these stakeholders have been reluctant to work together in the past (observation, staff debrief May 2023; Aug 2023). Some human and community services perceived as removed from the area have re-engaged with residents as well and started offering services more actively (observation, staff debrief Nov 2023).

5.2 How and why does it work? Digging deeper

We tested and refined the initial program theories that had been developed in collaboration with the implementation team through interviews and observations to understand how the program worked in practice.

We found that the program works through the interaction of **three essential components:**

We describe the learnings from the program at these **three levels: individual characteristics of peer educator**; **training and program coordination**; **organisational and policy factors**. We delve into the mechanisms of action in particular contexts that contribute to impacts.

The right peers

A core initial assumption was that people are more likely to engage with and listen to an educator who they consider a peer.

Peerness, as **perceived similarities**, in this program rests on the fact that participants are social housing residents who can talk to their neighbours.[3]

> I think people will talk to you. You're their neighbour, you've been kicking around there for ages, they know you (PE5)

However, we found that this common ground is **a necessary but not sufficient condition** to trigger mechanisms that produce emergent outcomes. There are additional characteristics that make it more likely for participants to become effective peer educators identified by service providers, including **knowledge of the community**, **lived experience**, and skills like the "**capacity to absorb insights from others**" (S2).

[3] One participant was not a social housing resident providing a good counter example: the university graduate interacted well with the rest of the group and did one health activity, however power dynamic with other residents did persist and their engagement was not sustained over time. This tends to suggest that peer educators who do not live in the community or do not have strong existing ties with the communities are likely to exit the program.

> It's *not* just lived experience, it's their skills…People think that people who are disadvantaged have no skill and it's the opposite. They're highly skilled because they have a lived experience of all of those things that come together to give them a very specific understanding of what's going on (S3)

Peer educators were not passive recipients of the program. What people bring to the table interacts with the context, group dynamic and training, contributing to (or inhibiting) outcomes. If peer educators have a positive attitude aligned with the goals of the program **(buy-in, positive attitude**), then it is more likely that they will collaborate with others and engage in the training in ways that produce holistic, encouraging approaches to health promotion, something with "**heart", "soul" and a sense of "genuine" care:**

> …really putting their soul into it… really get to the heart of what people are really going through and going from there…people are treated as human beings (PE10)

> … want to do more to improve their community, but also empower it and give it hope There's not only the compassion, there is love…like the genuineness (PE8)

> Everybody is keen for other people in the group to be successful in whatever they do. That's why we go to other people's presentations and things, to support the mental stuff because I think we're genuinely interested" (PE6)

Peer educators' levels of **motivation** will also influence their dedication to the program and its likelihood of producing quality peer education and interaction – motivation can be mixed: we found that extrinsic motivation (wanting to give back to the community and helping others) is needed for success but intrinsic motivation (gaining personal skills and knowledge; updating health information; gaining experience for employment; getting paid work; making new friends and connections) can encourage and sustain participation as well.

Life and work experiences also contribute and shape whether people are equipped with **skills, knowledge and capacities** to facilitate the delivery of peer education. There is no one-size fits all here. For instance, **lived experiences** of particular health, psychosocial, cultural or economic conditions was recognised as a key "strength" because it can help **create a common bond** with other peer educators and with community participants as a service provider observed: "*I think one of the strengths of it is that having people with lived experience"* (S5). These experiences can then be used as a foundation to start conversations that are based on **empathy and understanding o**f the circumstances that act as barriers to individual health. It is a foundation that gets built upon through interpersonal dynamic and the "sharing" described by this participant:

> peer educators …can deal with issues that resonate with the other person whose experience may have been the same as theirs or who has gone through the same journey with them. And then … you could empathise and relate, and that's very important…The sharing of their experiences. That's really something. It really opened your eyes. It put my feet on the ground in a way (PE7)

Some peer educators also have a **professional background** in health, welfare or counselling – their expertise and knowledge prompted informed discussions on specific topics with their peers and enriched these discussions (observations). Some also were building on previous experience being actively involved in various community groups and activities within Waterloo. This **diversity** in expertise, life experiences and capabilities were perceived as an asset that can contribute to widening the scope of the program and its potential reach so long as people recognise things they have in common and share a common goal (buy-in):

> the group is spread over the whole estate, it's not just one little bit. … it also helps to build up a bit of a network and allegiances across the areas so that that's necessary as well (PE10)

> we're diverse, our group. So everyone's got a different perspective, everyone has different life experience… maybe with different goals to get out. But we were supportive of each other nonetheless….So the more unique your group or broader your base is, I think the more powerful you're going to be (PE3)

> The group is representative of a plurality of views… But then what is important is that whatever you view is, there's respect amongst one another, there's understanding (PE7)

When peer educators were already aware of their own capacities and seeking support to deal with their health **(reflexivity and capabilities)**, they were more likely to complete the training and successfully deliver health activities to community participants. Importantly, while some aspirations and capacities were apparent at baseline (recruitment), others were more latent and *emerged. They* were realized over time through interaction with the group. Peer attributes and characteristics therefore should not be understood as static, something fixed and apparent from the onset – instead the **process of engaging and reflecting** as a group also brought these assets to the fore:

> just being in the group…It's just a little bit easier to think out loud, I guess, to process things, if you've got someone to sound off who's on the same level of knowledge as you (PE2)

Recruitment poster for the Waterloo Peer Educator Program

Being part of other community networks can also be an asset for a peer educator. This reflects they are visible/known in the community; able to engage with others; and can leverage networks to diffuse information as described by this participant:

> [with] redevelopments and there's a lot of uncertainty. So rather than having that individual thing where people aren't sure about what they are going to do and that impacts on their health, but if they know that other people have got things where they're working well…you can tap into that and that's another good network (PE10)

Existing community networks is a desirable attribute but not a must-have as we found peer educators not connected to established networks also thrived and used the program as a launching pad to build confidence to reconnect with others and develop their network. **Being embedded in social networks can also indicate high knowledge of local community**, meaning intimate knowledge of services and infrastructure which is another important contextual element. Understanding of specific contexts and challenges residents face means people can negotiate and advocate for others better.

The right peers

Peer Recruitment

- Lived experience and shared characteristics (necessary BUT not sufficient).
- Skills and capabilities.

Peer Qualities

- **Buy-in**: alignment with goals of the program i.e. social determinants of health play a role in health, people have agency but also need support in achieving better health, community members can work together to support each other.
- **Positive attitude**: realistic expectations, believing that they can play a role, make a difference
- **Motivation**: community-minded, connection, seeking and working toward better (individual and collective) wellbeing.
- Respected by peers, visible in community, involved **in social networks**, can create trusting relationships.
- **Capacity to participate in training, planning and delivery of programs**: reflexive, can/is open to developing peer skills.

The right program

We identified different building blocks that contributed to emergent impacts at the level of program coordination, training and facilitation.

Trust and rapport

- **Building safe spaces**

In a context of high social vulnerability and marginalisation in the Waterloo community, building safe spaces where people feel comfortable being themselves and sharing was an

important first step for knowledge exchange. Adult education is premised on the idea of people being active participants in exchanging, reflecting and making sense of information together and this requires specific mode of engagement to build trust and rapport (8,30). Otherwise, people can struggle to listen to others with an open mind, and may revert to being defensive because they are used to (and come to expect) being judged and stigmatized (31). In the program the **building of safe spaces was deliberate** and facilitated by skilled staff who had pre-existing connections with the community.

Building safe spaces in the program – how and why it works:

- development of "ground rules" that emphasize respect and confidentiality (document, ground rules)
- modeling and positively reinforcing examples of open communication and active listening (observations Jan-May 2023)
- acting with sensitivity and tact: e.g. separating the person from the issue/behaviour; refraining from unsolicited advice (observation Jun 2023)
- keeping peer educators safe: no one-on-one interaction but a group of educators delivering to a community group (document, program design)

This is an ongoing process that was not linear and took time. It required skilled facilitation and frequent reminders

> workshops were really helpful…. Because then it allowed me to practice. I was in a place where I was safe, and non-judgemental (PE1)

> It's all about bringing out the best in people and I think we've all created a safe environment (PE Reflection session, May 2023)

- **Time and resources: investing in a proactive and sustained approach of engagement**

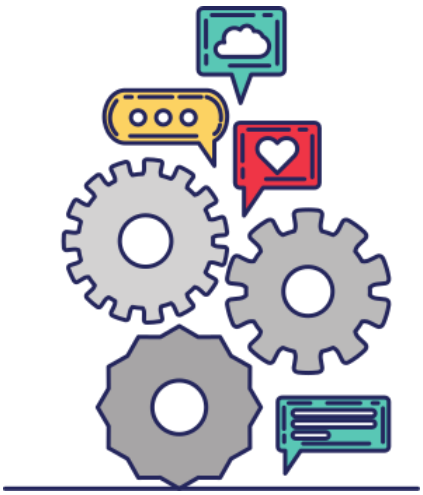
To broker trust and rapport in a context of high social vulnerability and high staff and service turn over, we know that "**sustained, unhurried, and non-judgmental relationships**" are needed (32). We found that this was a key aspect of the mechanism that makes the program successful.

Engagement that is **proactive and unhurried** requires more time and resources in the early stages of the program in particular. For example:

- keeping regular contact with participants using their preferred method of contact, multiple follow ups to facilitate reach (*proactive*)
- meeting at an NGO that people are familiar with and located in the neighbourhood. Health activities are co-organised alongside established, routine community events.

If the program is easy, simple and convenient for people to attend and participate, it is more likely they will be encouraged to keep showing up.

"Rapport and trust take a long time to build"
(service provider 1)



This type of engagement also involves adopting **generous and realistic timeframes (33)**, "not expecting people to be work ready and deliver [workshops]" to community immediately but giving time to build skills, confidence and knowledge base and sense of a collective and collective ownership (correspondence, service provider).

A sustained approach is also crucial. In a context where community challenges are great, where people's capacities and availability fluctuate, and a lot of underlying issues that drive poor health persist and are out of direct control of individuals, **the ongoing and open-ended** approach of the program is important to sustain relationships and maintain trust (32,33).
For example, conversations at the start of the program were broad and not limited to the health services, but exploring the different factors that enable or prevent people to stay healthy including home environment, built environment, social relationships, or stigma (document, training materials).

All the key partners in the program know there is no quick fix to improve health and wellbeing in Waterloo. Therefore**, investing time and resources** in people, with workers *showing up consistently*, and having the **consistency of the regular training and catch ups provides some stability** and is important for trust.

This consistent approach was underscored by both participants and service providers:

> we are local, we never leave. We look after our communities (PE Reflection session May 2023)

> …communities like Redfern and Waterloo, they get a lot of tourists. They get a lot of people that come in and decide they want to help people. And then it's not like always like – they don't always get a "thank you" or whatever, and then they decide they don't want to help people anymore. And the community has seen a lot of those people come through (S5)

Being genuine and transparent in all approaches is key to create and maintain trust.
One staff member summarised this philosophy as "ask people what they need, tell them what you're going to do and then do it" (correspondence, service provider). There are different ways to do this. **Clarifying and re-calibrating expectations** so they match what is possible within the scope of the program is an important part of this process (observation, staff debrief July 2023; S3 interview). **Regular constructive feedback** that provides reassurance, encouragement and means of adjustments also sustained participation and buy in from participants (S3; S5).

Overall, **engagement based on time, trust and rapport** produced outcomes that went beyond our initial assumptions. Group training (stage 1) and workshop delivery (stage 2) not

only provided benefits for social connection. Opportunities for ongoing group discussions in a safe environment produced a **therapeutic effect** in itself (correspondence, service provider; observation, staff debrief Oct 2023). Comments from participants spoke of "relief" gained from open discussions in a safe space:

> when you can talk about it, even though sometimes it might be hard to start with, you do get a sense of, well, that's a relief and you have shared it with other people (PE10)

Doing information differently: centring collaboration and equity

Initial assumptions placed emphasis on information for the purpose of health education, but it was not always clear what was meant by information: what it is; who creates it; and how it is imparted, so we delved deeper into that particular assumption.

- **Adapting to learning needs and preferences**

Information regarding health conditions, referrals, and the characteristics of the services available is important to dispel myths and misunderstandings. Peer educators reported benefiting from this knowledge base especially when **training was adapted to different learning needs and styles and used "creative vehicles"** (correspondence, service provider; document *guideline working with peer educators*). For example, myth busting games that involved moving around the room; scenario-based activities; group work; using a range of teaching aids and material; regular breaks; fun/playful low-pressure exercises. Peer educators applied these same methods when designing community workshops like the mental health trivia night:

> We just had an open mic' …how the peer educators prepared for it, they really incorporated ways that there was so much discussion around the room and that people could share about their lived experience of drug and alcohol use, of using services of mental health (S2)

- **Disrupting power relations: learning collectively through more equitable approaches**

At the same time, information in and of itself is not enough. People need to be able to appraise the information, relate it to their own situations and feel like they can enact it (8). To engage in this process, **active participation and parity** are key ingredients of success that came up over and over in interviews. In the words of interviewees, people could get more "involved" because the process was led by community and not "patronising" (S5), as this peer educator put it:

> It's been a bottom and a community-led thing about what's the most important areas for community and what we really want to get involved in as well. That's the key to why it's so successful. (PE10)

Participants described a **shift in mindset** from traditional roles of health providers as experts and leaders to being **more equal partners**. Comments about "acceptance", "mutual respect" (PE4) humility and a mindset of **reciprocal learning** reflected how power differences were disrupted through the program:

> there's a sense of acceptance, everybody pulling together and supporting everybody. I think that's very important. No one's over anybody (PE Reflection session May 2023)

> that's the thing about peer education, you're all equal and if you want, you can go to the expert, but you don't have to unless there's something you don't know. (PE2)

Another way to describe this shift is the move from a deficit approach to **a strengths-based approach** that was central to how some service providers engaged with the program: "*Working with them, at a level of strength based and understanding some of their lived experience"* (S2).

Recognising and **explicitly valuing the experiential knowledge, skills and capacities** that people bring to health issues was at heart of the program and highly commended by peer educators (PE Reflection session, May 2023) and staff: *"topics draw on the strengths of the peer educators themselves and their different strengths" (correspondence, service provider).*

There is a tension between creating information with someone versus doing information to someone (23,34). We found that learning that centred **equity and collaboration** was more likely to produce quality engagement and outcomes compared to more didactic training workshops:

Peer educator training session

This "**two-way" dynamic** during training sessions is a process of **co-constructing knowledge** (25,33). It opens up a space for **social learning** which encouraged peer educators to ask questions (**dialogue**), learn from others' stories they could relate to (**role modelling**) value their own knowledge and experience (**confidence/self-esteem**) which ultimately promoted **empowerment and action** (PE10).

> We all have input, we all engage… and then if we can pass on the information we've learnt and be a liveable, visible connection, that's where the power is; living, seeing, believing (PE3)

"We could relate [to the information] But what's important is that it shouldn't be all one way. So it should be *two ways*" (peer educator 11)

Sometimes things did not go as planned and ideas did not work out as well as anticipated. Learning, trying and failing together is also part of the two-way dynamic participants talked about as they recognized that **the program created room for trial and error.**

> We are all walking together, making the journey together, making the mistake and getting up together" (PE Reflection session, may 2023)
>
> I can say something and didn't matter if it was right or wrong, I was there to be able to share, and my voice mattered… that helped me (PE1)

The collective, group dynamic is instrumental in the process of learning. This was underestimated in our initial assumptions.

"We had common ground that brought us together…People want to talk and are interested and are supportive in our group of each other. And I think that flows through everyone" (PE3)

> The program gives people means to express themselves and their needs within a social environment that is in the words of participants, safe and "supportive", resulting in feelings of "pride" and "achievement" and you can "lift your head" (PE Reflection Session, May 2023)

Feelings of "pride" and "achievement" were more broadly connected to a **changed perception in social status** because "*there is stigma around people living in housing*", one service provider explained, but the Peer Educator Program showed *"you've got all these people…that are obviously intelligent and resourceful*" (S5). In the words of a peer educator, the program cast a different lens on social housing and residents ("housos")

Peer educators at a community workshop on nutrition

> if you've got experts talking to you, it's like, "Oh, housos don't know anything, we've got to tell you." Whereas, if I'm a houso talking to housos, it's like, "Hey, we're cool, we can do shit." We're real people looking after ourselves, living our lives just like everyone else. And our problems are not really any different to anyone else's. But the stigma's a thing. And the government does it (PE2)

"The bigger thing of having peers deliver information... it's normalising that those issues have occurred ...for the people that are hearing it" (service provider 5)

Open conversations in the group also contribute to **challenging shame and stigma** around particular issues, explaining and demystifying behaviours connected to hoarding and squalor, AOD or mental health for instance. Group training for peer educators therefore contribute to *"break down" and "unlearn stigmas and judgment"* through better understanding of contributing factors and medical conditions (PE1)

Challenging stigma is something that also happened through the peer-to-peer interaction when participants led community workshops:

> to have someone say well I had it and this is how I got through it… they're going to go "oh, she's speaking about it out loud'. And she doesn't seem to be embarrassed so maybe I shouldn't be (PE3)

Peer educators used techniques they learned during training sessions to challenge stigma and promote positive impacts**.** For example:

- using inclusive language**:** substance use rather than addiction, or declutter and spring clean rather than hoarding; depersonalize by talking about the issue rather than the person (observation, Jan-Nov 2023)
- adopting a harm minimization approach and being explicit about it in communicating with residents: e.g.: "*we are not here to fix you but to keep you safe", "not preaching… telling people to quit drinking*" (observation, Jan-Nov 2023)

Challenging shame and stigma takes time and effort and was a continuous ongoing process in the program.

- **Appropriate and acceptable information**

The 'how' is important but the 'what' equally matters. **Not all information is equal**. Information from health services was tailored and refined with peer educators' input through this process of knowledge co-creation. The end result was different from standard, didactic health promotion information and this made a real difference according to the peer educators (PE Validation session, Dec 2023).

The information considered the **whole person**, rather than separate health issues they may face, in the words of one participant: *"the health topics are multifaceted in the peer educator program unlike other programs that may focus on one health topic" (PE Reflection session, May 2023).* For example, in the nutrition workshop, topics included connections to mental health but also the budgeting and cooking constraints that many residents are confronted with (observation, Feb 2023).

Information presented **diverse course of actions** to be **adapted to people's circumstances,** the **needs and priorities** they have identified for themselves, and the stage of change they are at. This recognized that prescriptive approaches and recommendations from health experts tend to be ignored (PE 2).

Instead, peer educators build **on their own personal stories of change, emphasising "*little steps*" and the capacity to appraise information and feeling empowered to make informed decision** (over actually following the exact health advice from doctors, observation Mar 2023; Jun 2023; Nov 2023)

We also found that **information that people could readily use** and apply appeared more impactful. This is evident in survey results post training (see **Error! Reference source not found.** and **Error! Reference source not found.**; topics like population health and health system sessions scored lower). Peer educators also expressed that they wanted **actionable information** like a directory of services and access points (observation, Nov 2022).

Together this contributes to producing community workshops where appropriate and acceptable approaches to tackling difficult health issues are promoted, approaches that centre people and are holistic; no judgement; staged approach to change; and with lived experience stories illustrating how change can happen.

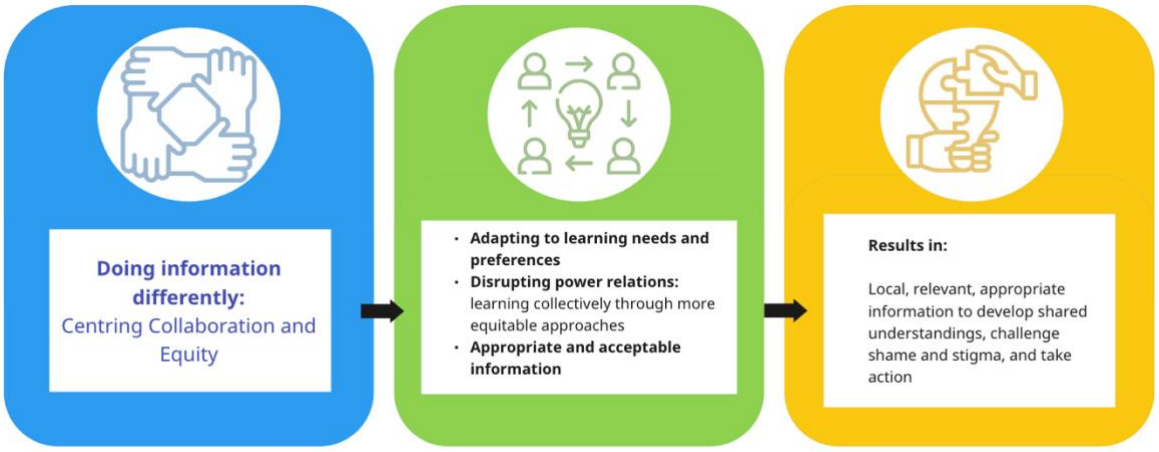


Figure 5 Centring equity and collaboration in training for health promotion

Peer Educator skill building

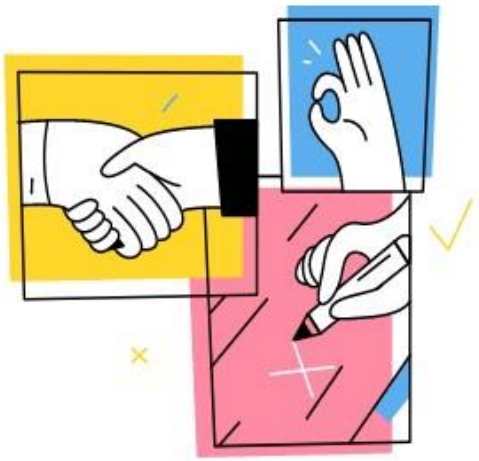
Participants with a foundation of diverse life experiences, knowledge, and capabilities also **need training and upskilling** to become effective peer educators. This is a distinct characteristic of the program – investment in training and relationship building is critical to build a sense of achievement and get outcome, something also highlighted in the literature on peer workers (35).

Peer skills include a range of other specific skills. This includes, understanding of boundaries, appropriate levels of disclosure, sharing information about common ground while seeing and respecting that people in apparently similar circumstances may have different experiences (13). This is not an easy thing – the risk of trauma transfer or "*trauma bouncing around the room*" is real (observation Oct 2022). Sessions that featured members of the peer/lived experience workforce were helpful for peer educators to role model these aspects of the role (observation data 2023).

" If you don't train people properly you won't get a good result" (service provider 3)

Maintaining safety and pitching a response at the appropriate level also takes skill and practice. For example, having empathy and understanding but not at the expense of personal safety: "*you can't be giving them your phone number and your address" (PE2),* it's about finding the *"cut-off point" for "protection*" (PE3). Resourcing peer educators to know how to respond in different situations and scenarios was also important (observation, Feb 2023): "*you've got to be sensitive to those situations [DV, AOD] and find a way to balance that*" (S5).

Program facilitator



In a context where people are often isolated, experience low social status, and can fear negative judgement, supportive relationships are essential to enhance participation, and encourage confidence and motivation to self-manage health.

We found that the **program facilitator,** the manager for Healthy Living Program, was instrumental in creating an environment that was conducive to supportive relationships. Key characteristics are summarised in figure 6.

Figure 6: Program facilitator key characteristics

Encouraging	Flexible but structured	Assertive	Ongoing support
• Not "passive recipients" but people with ideas • People can do things to improve health and wellbeing	• No rigid proforma but scaffold provided • Managing red tape: "he knows the halls and the people that run the halls" (PE3)	• Steering people back on track • Managing disruptive behaviours • Maintaining safety and boundaries	• Affirmational support • Instrumental and logistical support

ENCOURAGING: There is a real risk that community activities can become a "*forum to air complaints*" and reinforce "*hopelessness" (*observation, staff debrief Oct 2022*).* However, the facilitator reinforced the idea that the group **can do** something to improve health and wellbeing of residents: "*most of the time, they're just passive recipients. And in this case [of the peer educator project] they're all active and they have ideas" (S3)*
This prompted a gradual understanding that peer educators and community have agency at their level to effect some changes. Peer educators described the facilitator as *"so friendly, and so supportive and so optimistic" (PE2)*

A FLEXIBLE BUT STRUCTURED APPROACH: There was freedom to run health activities of choice for peer educators. No rigid proforma or reporting was required but the facilitator provided a scaffolded approach with project management and negotiating red tape: *"[the facilitator] knows the halls and the people that run the halls" (PE3).*

ASSERTIVE: Steering people back on track if needed; re-establishing boundaries; managing disruptive behaviours or prejudiced views was equally important during the training phase (observation Jan-Nov 2023).

ONGOING SUPPORT:

- Affirmational support: encourage, acknowledge and value participation every step of the way, no matter how small the contribution.
- Instrumental and logistical support: for instance, payment to cover expenses; giving people a lift; liaising with relevant services and external organisations for workshop delivery, support with problem-framing and problem-solving but ownership resting with peer educations.

Skilled and supportive facilitation contributed to key outcomes like positive group dynamic and a feeling of reduced social isolation. Supportive relationships can also counter a sense of hopelessness and powerlessness that characterise entrenched inequities (32,33) and there was evidence of this in the program (see 5.1. impacts section). The facilitator had capacities that enabled these characteristics including having worked in the community for a significant period, skills and experience in program management, team management, providing group supervision, and counselling. Their role within the organisation being based in the Integration and Partnerships Portfolio also meant they could span multiple clinical streams, in response to what community members request.

The right program

- Program is perceived as **appropriate and acceptable** by community members because engagement is **easy, convenient and sustained**, facilitated by someone known to the community. Proactive and encouraging approach also means more willingness to participate in the program.
- **Reframing information and learning**: shared accounts of the problem, articulating potential strategies and solution, discussion, reflection, engagement, critical thinking and appraising feasibility of change in context.
- **Learning together** also means accepting mistakes and trying again
- Dialogue is needed for **social learning** and rapport but needs careful facilitation: keeping people on track, keeping the environment safe (culturally, individually), and keeping a positive outlook
- Process underlined by **autonomy and control for peer educators** over the training process.
- Peer educators feel they are **valued and given credibility**.
- **Change in social perception** (social status, stigma, shame) feeds into increased confidence, sense of control and efficacy. These are needed for empowerment. Peer educators feel confident they can deliver health promotion activities and a sense of achievement.

The right environment: Organisational and policy factors

Levers of change and mechanisms that enable or constrain outcomes can often work in the background at the level of culture and policy. These building blocks are not always explicit or tangible, so they are easy to overlook but they are a key part of the program's success (this is in line with the literature on embedding change in systems (35–38)).

A supportive environment

Beliefs, values, and priorities that are shared in the organisation impact the implementation of the program through the attitudes and practices of staff involved and the processes they are expected to follow. The program is housed in Priority Populations and Places, which is part of the Integration and Partnerships portfolio of SLHD, and is part of a suite of initiatives focusing on Waterloo and social housing residents. It was recognised that the team's culture and ways of working supported the implementation of the program. Additionally, the co-location of the program and partnering with Counterpoint Community Services to deliver the program contributed to the supportive environment for the program providing shared values, local knowledge and opportunities for collaboration.

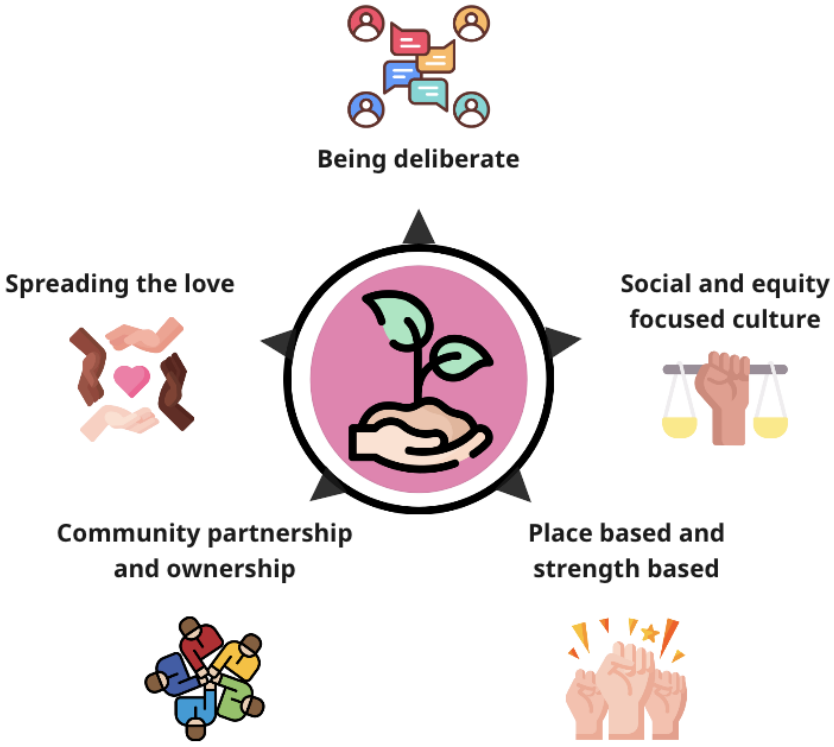


Figure 7: A supportive environment

SOCIAL AND EQUITY FOCUSED CULTURE: The program takes a social determinant of health lens. Understanding that health is a complex thing that is also affected by social and environmental drivers and broader context. This means health professionals acknowledge broader constraints that shape people's health behaviours and aim to support and enable people to look after their health where they are. In practice, this translates as a no wrong door policy when it comes to getting health advice or navigation.

PLACE BASED AND STRENGTH-BASED APPROACH: The model recognises and understands community strengths, needs and challenges in a particular place.

COMMUNITY PARTNERSHIP AND OWNERSHIP: The team believes that best outcomes come from sharing power therefore a higher degree of autonomy and control was given to community. This was a cornerstone of the program design as well. It is a messier process and requires being open to experimentation and trial and error.

"SPREADING THE LOVE":[4] with the understanding that health and social issues and inequalities in Waterloo are entrenched and complex, comes the understanding that many actors are needed to tackle the problem. Good will, sharing ownership and sharing credit with other organisations is part of the culture of the program (see more in "finding fellow travellers" below)

BEING DELIBERATE in sharing this approach with newcomer staff/services was also crucial to maintain the integrity of the culture.

These factors contributed to making the program a collaborative, strength-based, culturally appropriate and community-driven initiative more likely to produce desired outcomes.

- **"Finding fellow travellers"**[5]

Stakeholders repeatedly emphasised the importance of partnering with like-minded people and services from the start, as this was a way of giving **legitimacy and spreading ownership** so that a broad range of people become invested in the success of the program.

What we learned is that people who are *already on board with the culture* (values, beliefs, priorities) are the best partners to begin with – **it is best to go where the culture, energy and enthusiasm already is.** For example, partnership with Counterpoint Community Services was very important in this regard and happened right from the start: they were part of the design of the program and gave in-kind support to make it happen. On the other hand, pursuing connections with parts of the health system or with community services less ready to embrace this way of working proved time-consuming and yielded limited results (observation, staff debrief 2023)

Lesson learnt: partnership with community organisations is key. It is best to go where the culture, energy and enthusiasm already is when looking for fellow travellers.

Bringing other stakeholders around shared values is important also because it enables innovation diffusion via community networks. By this we mean that another reason for broad collaboration is that **it can embed and amplify change within and beyond health system pathways**. For instance, Mission Australia and Oz Harvest became partner organisations to

[4] We borrow this expression from Harris et al'. evaluation of place-based initiatives for physical activity in England (38)
[5] ibid

the program because they share community development goals and promote health and wellbeing through social support, housing (Mission Australia) and affordable food (Oz Harvest).

Navigating power structures and challenges

These values and ways of working are strongly embedded in parts of the SLHD and particularly in the portfolio that house the program. However, this is not consistent across the organisation and some parts of the health system may find it challenging to distribute authority and control to participants, and may not fully recognize the benefits of participating in community development as an integral component of health service provision. Structural, systemic, and organisational level issues can reinforce siloed ways of working. Leading to, siloed and activity-based ways of working enduring. This is a significant obstacle because it means parts of the system may be reluctant to buy-in and support programs. Portfolios like Priority Populations and Places and Integration and Partnerships that sit outside of a single facility or clinical stream are important enablers of activity occurring across multiple areas within the health systems, in response to community needs.

How to navigate obstacles at organisational levels?

We found different ways the program influenced the health system, nudging in various ways and working for better alignment.

- **The role of advocates and intermediaries**
  Staff working closely with peer educators acted as a link between communities and the health system, conveying information across systems, from top to bottom and vice versa. Without this link, things can get lost in translation. This proved essential to bringing other parts of the health system on board with the values and ways of working of the program. Eventually, this also enabled bringing further resources to peer educators.

- **Leadership and senior buy-in**
  The program was endorsed by managers and more senior level executives in the organisation and is also an action item on the Waterloo Human Services Action Plan which has multiagency buy-in at a senior level. This increased the credibility of the work and encouraged participation from other staff members and services. In other words, when leaders are convinced of the value of the work, this shapes policy and practice and resourcing.

- **Being strategic and creating momentum for collaboration**
  Other stakeholders and sectors that contribute to health outcomes like DCJ and LAHC also need to be on board, but they often have other priorities – it is important to lead with what these partners are most interested in and what matters for their reporting and agendas. As the program facilitator explained, they need to see that their agendas can be advanced through the program. Importantly and realistically, this is not always possible. Collaboration can be inhibited when other organisations have other priorities and activities and when these are at odds with what residents want, causing frustration for some peer educators interviewed.

Peer educators won additional funding at the SLHD Pitch

Creating momentum is another way of navigating structures of power and bringing partners to you. Program leaders made sure to use their relationships and communicate widely about the program and the positive stories of change taking place: *"we've done a good job with publicity because lots of health staff know about it in a positive way" (S3)*. This signalled that something different was happening in Waterloo and it was worth joining. By having a program that is clearly labelled as **community-driven,** embedded at Counterpoint Community Services and backed by SLHD funding and leadership – and with an air of success and **enthusiasm**, a **snowballing effect** could take place and more partners joined.

Policy alignment and coherence

- **Policymaking**

  Culture is important for the success of the program, but its **effects are amplified if the overall policymaking approach and strategic direction of the organisation supports the culture** (39). Part of our initial assumption was that supporting policy that is receptive of local knowledge and aims to boost existing capacities in community can contribute to support innovative, community-based approaches to health and wellbeing.

  The SLHD's approach to policy making broadly endorses the value of participation, empowerment and patient-centred care in achieving good health care (10). The culture of the program is not only aligned with this policy direction, it contributes to achieving the SLHD strategic plan goals of "Respectful and purposeful partnerships that support integrated and collaborative care".

  The program **refined what participation and collaboration with communities can look like to achieve best outcomes**. While community participation is important, it needs to be actively supported as people benefit from having access to specialist knowledge from health professionals and from community workers who know how to navigate system hurdles. Collaborative efforts where health system's knowledge, assets and resources are used in conjunction with local knowledge and experience enables positive outcomes.

- **Ensuring policy coherence**
  Collaboration for community development and wellbeing is optimised when other parts of the organisation contribute and work together for a common goal (countering tendency to work in silo). Besides having this shared goal formalised at the policy level, measures to ensure coherence and alignment like departmental strategies and appropriate KPIs helped to create synergies for the program. For example, collaboration with AOD and HARP was facilitated by the fact they all use peer or lived experience workforce and report on their community engagement. Having the program as an action item in the Waterloo Human Services Collaborative Plan means that it is viewed in the context of a broad range of activities happening in Waterloo all aims at improving the situation of Waterloo residents.

- **Training staff**
  A coherent policy approach also translates **at the level of workforce and staff training**. We found that **cultural literacy** on the part of health service providers is uneven and could be enhanced to strengthen the alignment with the program's culture.

  Staff have different capabilities and ways of working. They may not be familiar with a community development approach (value, purpose, facilitation style) and how to incorporate it in how they work with peer educators (35). This was evident in how some training sessions acknowledged and used community norms, values, incorporated social identity and context while others did not (observation, Dec 2022- July 2023). It is easy to revert to biomedical frameworks, information deficit models, and top-down approach.

  This underlines the importance of culturally sensitive and appropriate training for staff delivering the program as well and the resources used in training.

Adequate resourcing and monitoring

- **Adequate and stable funding**
  Enduring and complex health and social challenges require **time and continuity** for outcomes to develop . Staff shared that given time and workload pressures, as well as insufficient staffing and scarce resources, this is often challenging. Programs are operating within a context of limited resources where often only the most urgent needs or acute issues are able to be addressed, and resources for integrated and complex care are limited.

  This program is an innovative pilot that tries to get to the core of complex health and social challenges by empowering people and improving relationships between community and services .

> it doesn't have to get to an emergency department. We can do things that aren't band-aid fixes and we can do things that are more sustainable (S5)

Addressing complex issues and partnering with people means that delivery might take longer to achieve outcomes, and progress at times is slower and not linear. Therefore, funding that allows for adequate time and resources for relationships to develop and for impact/outcome to emerge is important and part of the program's enabler of success.

The health system needs to recognise and value the process, the capacity building and collaboration which requires long term timeframes and ongoing resourcing. We already know that the alternative looks like: short term funding cycles put pressure on staff (risk of turnover), focusing on achieving KPIs that may not align with the program (not true to program value) and do not deliver quality or sustainable outcomes (32).

The impacts of program resourcing also go beyond the direct enablement of the program. The commitment of resources also sends a signal. It shapes organisational stakeholders' expectations and commitments to the program (intangible) and this is important as well. For example, winning funding at the SLHD Pitch competition was a milestone in creating additional momentum and buy-in for the program. We can infer that underinvestment on the other hand can negatively affect staff support to the program.

Lastly resourcing is important here because it is meeting a demand – there is appetite and enthusiasm in the community to do something different and this is an energy that should be harnessed.

- **Quality monitoring and evaluation**
  Evaluation and monitoring metrics that are relevant and suitable to the program are essential to demonstrate success. The fact that this was a small pilot program developed in genuine partnerships with community members, key local NGOs and a group of applied health equity researchers meant that we were able to develop, tailor and adapt the evaluation and monitoring framework.

  A flexible evaluation framework concurrent to implementation is also useful because learnings from emergent outcomes can be used to modify the program. Checks along the way from "critical friends" can be useful to encourage diversity of thought and action, provide challenge and objectivity and check assumptions.

The right environment

- A supportive culture that values equity, people and places.
- Strong and early partnership with community-based organisations.
- Navigating challenges through senior buy-in, link workers and other staff making the link between community and health services.
- Aligning policy making and culture to strengthen incentives for community-based approaches to health and wellbeing.
- Staff trained in cultural literacy and community development approaches.
- Adequate resourcing and monitoring: valuing the process, capacity building and collaboration. Expect (and document) incremental progress, at times slower and not linear.

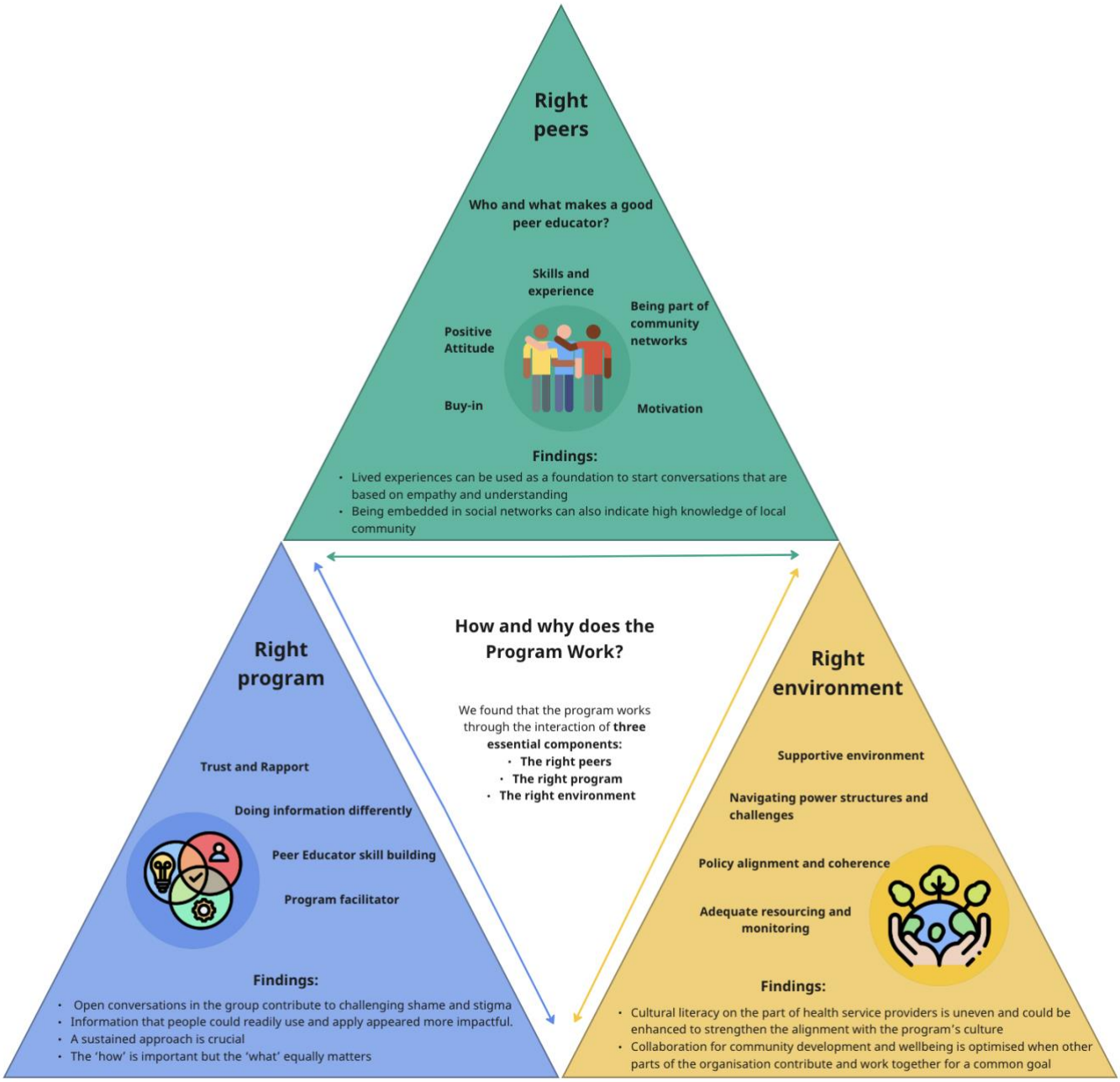


Figure 8 Synthesis of findings. How and why the Waterloo Peer Educator Program works to promote health and address inequities

6 Next steps and recommendations

6.1 Next steps for the program in Waterloo

SUSTAINABILITY The current Waterloo Peer Educator Program has demonstrated a positive impact and participants (including peer educators, community participants, SLHD participants) want to the program to continue and to be involved. Ongoing sustainability could be supported by:

- Building opportunities for the current program to continue using best practice principles identified in the evaluation.
- Co-developing monitoring tools (i.e. program performance metrics, program implementation KPIs) and measures to guide implementation based on evaluation findings.
- Leveraging existing initiatives, resources and capacity: in places and communities where there is already a health presence or outreach, peer educators could become involved and collaborate in existing forums/outreach and become embedded in them. This needs to be done collaboratively with people already involved in local projects.
- Identifying ways of sustainably resourcing the Program so that it can become part of business as usual.
- Future research could include an assessment of costs and benefits of the program for stakeholders including opportunity costs.

TRANSFERABILITY: This is a successful pilot that can be implemented elsewhere in different places (including other health districts, PHNs and NGOs) and different communities. The building blocks and model can be adapted.

- Identify communities within SLHD that would be suitable for scaling out. Consider:
    - Priority areas for SLHD.
    - Existing community demand for this type of empowerment and interest to be more in control.
    - Invest time on the initial phase of identifying stakeholders and partnering with them at the start (spread ownership), community consultation, build strong governance.
    - Spread the love and the experience: possibly use existing cohort of peer educators in training delivered elsewhere and current facilitator to mentor new program facilitators.

7 Implementation guidelines

7.1 Implementation guidelines and lessons learnt

The evaluation identified how community-based peer education can contribute to improved health literacy and navigation as well as better health and wellbeing outcomes for community participants.

We emphasised what was different and significant about the way different people worked together to make this work.

We identified the building blocks or mechanisms (like resources and reasoning) that are activated to bring positive impacts and drive success in Waterloo (see Figure 9). We found that you need the right people, the right partners, and the right environment for the program to achieve its objectives to its fullest.

Not all building blocks are necessarily required or present at all times – they are a collection of attributes that emerge and interact in a place, eventually enabling better health and wellbeing.

There is no cookie-cutter approach to community engagement for health and wellbeing. The program's approach and lessons learned can be used elsewhere but strategies and building blocks will need to be adapted and tailored to the unique situation of a place and particular communities' strengths and needs.

Table 6 below lists factors identified as supporting the implementation of the program - some are framed as lessons learnt (things to strengthen next time).

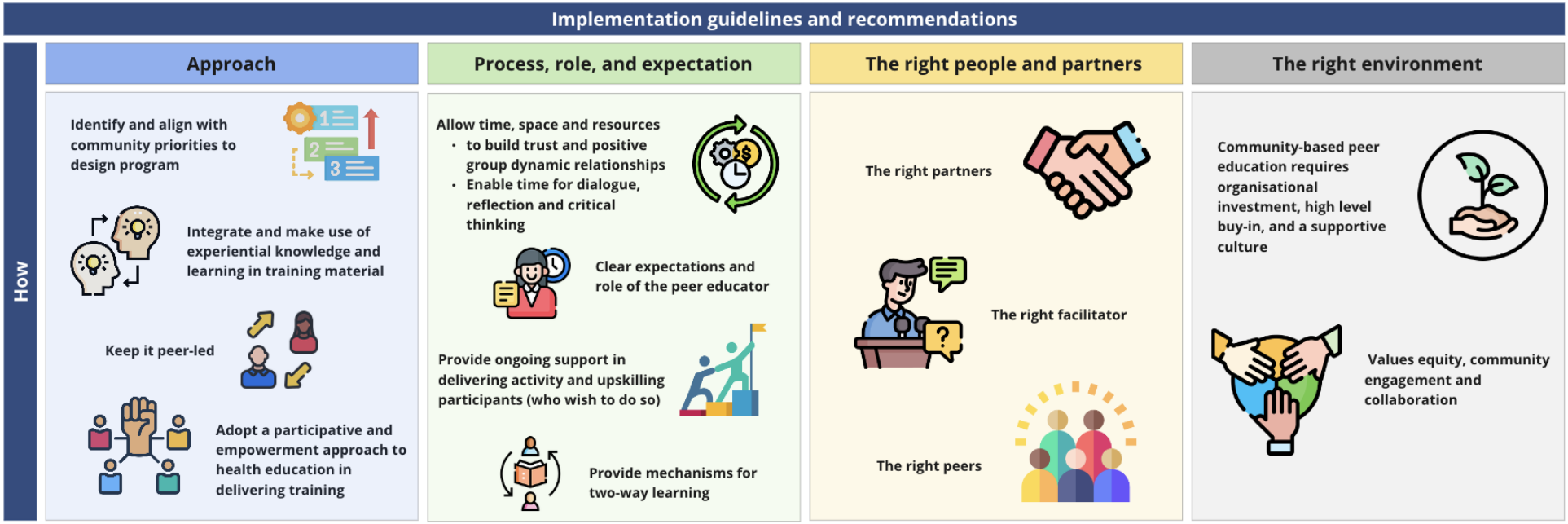


Figure 9 Building blocks for the Peer Educator Program - implementation guidelines and recommendations.

Table 6 Factors supporting implementation

What	How	Example actions	Why
Approach	Identify and align with **community priorities** to design the program	• Implement co-design approach to planning, designing and producing the program[6].	• Program is tailored and appropriate to local context. • Co-design approach builds capacity and skills through process itself. • Enables bi-directional learning.
		Lessons learnt – To strengthen and enhance training content • Cultural awareness - racial and First Nations (early in program). • Greater emphasis on peer skills and more formal training on this aspect of the role • Continue to include topics identified by peer educators. This is a continual iterative process as more topics are raised as the peer educators learn more. (e.g. some peer eds said they wanted more on mental health).	• Address bias/prejudice and create safe space. • Building greater capacity in peer educators and addressing potential risks.
	Integrate and make use of **experiential knowledge and learning** in training material	• Implement co-design approach to planning, designing and producing the program.	

[6] For details of what we mean here, we refer the reader to the ACI guide for building co-design capabilities in planning, designing and producing programs in health contexts (ACI 2019)

What	How	Example actions	Why
	Keep it **peer-led**	• Ensure peer educators have control and autonomy over the activities	• Program needs to remain adaptable, true to community issues and to what participants would like to address in relation to health and other issues. • People with lived experience have lots of ideas and are very savvy.
	Adopt a **participative and empowerment** approach to health education in delivering training	• Implement co-design approach to planning, designing and producing the program. • Pay attention to power and who is included in decision making.	• Strength-based approaches have been shown to be effective in building capacity for health and wellbeing in the long term. This requires a shift of mindset and sharing of power
Process, role, and expectation	Allow **time, space and resources** • to build trust and positive group dynamic relationships • Enable time for dialogue, reflection and critical thinking.	• Provide resourcing and support for peer educators to be able to attend training and deliver activities. • Plan training and activities to allow for time in sessions for reflection and also between activities.	• Reflective learning and critical thinking are skills that require time to develop and practise in a safe environment.
	Clear expectations and role of the peer educator	**Lessons learnt-** • **Clarify what it is not** – e.g. not one-on-one support/ not changing people's lives or saving them; not delivering health services or diagnosing. • **Clarify what it is** – e.g. emphasis on health promotion and taking small steps for change; being explicit about process of change. • **Emphasis on risk management** and keeping peer educators safe e.g. physical and mental health (trauma sharing and disclosure). • **Clarify structure of the program** (number of weeks of training, pay structure).	

What	How	Example actions	Why
	Provide **ongoing support** in delivering activity and upskilling participants (who wish to do so)	Lessons learnt • provide regular debrief and feedback opportunities to the peer eds on how they are performing and what they could do differently; • support peer educators if they identify formal training opportunities they want to pursue; • use current cohort to coach/mentor next cohort.	• Building confidence and skills takes time in a context of high social disadvantage and entrenched inequalities. Learning is a continuous process that is not linear. It needs to be sustained and proactive. • Peer educators are keen to share what they have learned and to spread the model.
	Provide mechanisms for **two-way learning**	• Invest in feedback channels and two-way learning mechanisms (e.g. link workers intermediaries/advocates-type roles).	• Intermediaries and translators between community members and health services are crucial for (1) coordination and facilitation in the program (2) influencing the system and taking insights/learning from peer-led approach back to the system. • To get the full benefit from this type of program, feedback to health system is crucial to optimise service delivery.
The right people and partners	The **right partners**	• Identify key players to partner with to support change at the local level. • Promote partnerships and collaboration with community organisations to embed the program in community, e.g. link with existing services and community activities.	• Areas of focus and actions will often be beyond sole remit of health. • Helps support sustainability of program through having engagement and support from multiple stakeholders.

What	How	Example actions	Why
		• Use local networks and community champions to attract and recruit peer educators	• Supports recruitment of peer educators that have attributes that are likely to support program achieving intended outcomes
	The **right facilitator**	• Ensure that staff leading the program have appropriate facilitation and coordination skills • Beneficial characteristics include: experience with working with community members and health system; encouraging; structured and flexible approach; assertive and pro-active, problem-solving and negotiation skills, knowledge of wider context.	• Collaborative co-design approach requires skilled facilitation to adapt program to context and needs.
	The **right peers**	• Supportive/enabling characteristics include: Lived experience and shared characteristics with target community; motivative and positive attitude; relevant life and work experiences; existing community networks; reflexive and open to learning • Lessons learnt a. Tighten criteria and screening of potential peer educators. b. Aim for diversity of background and lived experience. c. Ensure critical mass of people coming from one place.	

What	How	Example actions	Why
The right environment (see below for more)	Community-based peer education requires **organisational investment, high level buy-in,** and a **supportive culture** aligned with program's values and principles, i.e. **equity, community engagement and collaboration in place.**	• High level buy in and support to access adequate funding and protect the space. • Creating an authorising environment for staff to work across boundaries and a mandate for change, promoting a culture of sensitivity, tact and hope/enthusiasm: change is possible, people have agency. • Modelling this behaviour and mindset and spreading the love, ensuring new team members and peer educators share this approach. Lessons learnt • Review dominant models: promote health promotion and health navigation approaches that go beyond information provision enabling collaboration and positivity.	• Beliefs, values, and priorities impact implementation through the attitudes and practices of staff involved and the processes they are expected to follow. High level buy-in signals the program is worthwhile. • Education as partnership and empowerment rather than didactic approaches relies on collective effort and supportive group dynamics to develop capabilities to take action.

7.2 Creating a supportive environment: Implementing organisational capacity and culture in practice

Our evaluation showed that a supportive environment at the level of policy, culture, resources and buy-in are essential to program success. The link between program and supportive environment is also important for enhancing sustainability. Below is a list of recommendations targeted at the organisational levels with example actions and rationale.

Figure 10 Recommendations -organisational level

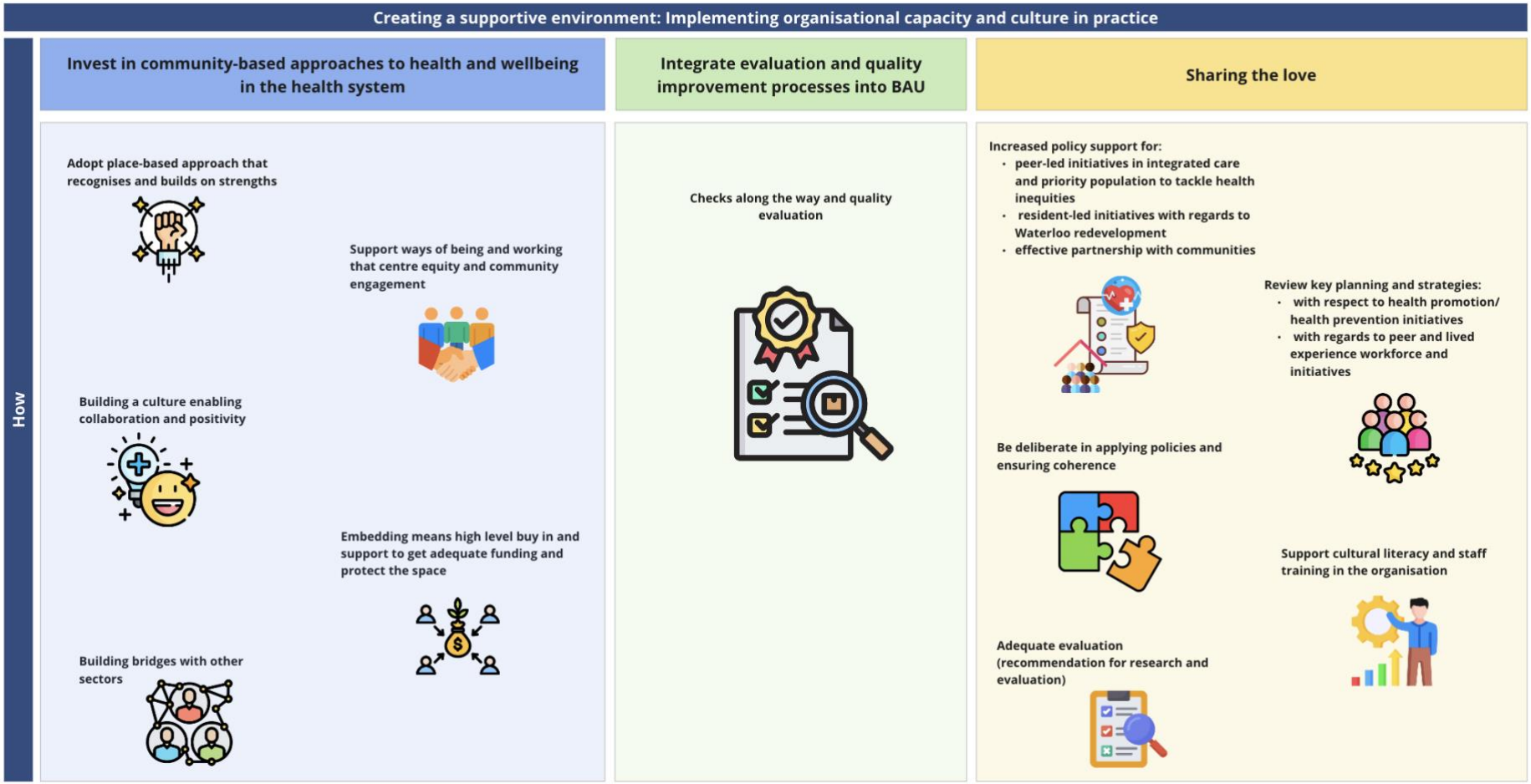


Table 7 Creating a supportive environment

What	How	Example actions	Why
Invest in community-based approaches to health and wellbeing in the health system	Adopt **place-based approach that recognises and builds on strengths**	• Context specific adaptable approach to community engagement for health and wellbeing. • Work with partners that share this vision and way of working.	• Working with the *particular of a place* as well as recognising and building on strengths (pre-existing capabilities and good will) are essential success factors.

	Support ways of being and working that centre **equity and community engagement**	• When developing programs integrate community engagement ways where power and decision-making are shared from the start
		• Program design and setting up the right foundations is important, i.e. Beginnings matter:
		  ○ dialogue between health system and community;
		  ○ collaboration with community service stakeholders;
		  ○ experiential and community knowledge valued (explicit and from the start in ways that inform a joint working approach and program logic)
		• Allow high degree of autonomy and control for community stakeholders
			• Might be messy, sometimes fails but community ownership is crucial to ensuring success.

	Building a **culture enabling collaboration and positivity**	• Shift of mindset: partnering with community members (rather than as experts with worked out solutions).	• Celebrating and building momentum on early success laying the foundation for further collaboration.

What	How	Example actions	Why
		• Genuine transparent collaboration where credit is widely and strategically shared.	• A sense of collective ownership rather than siloed way of working supports sustainability.
	Embedding means **high level buy in** and support to get adequate funding and protect the space	• Engage senior executives to ensure adequate time and resources invested in the program. • Resource and time requirements communicated clearly to program sponsor so that adequate funding is provided.	• Because progress in relation to health and community development is not linear and benefits are generated over longer timelines, there can be a mismatch with the timelines and expectations of other parts of the health system which are much shorter term. • Even when results are not immediately apparent, it is important to protect that space and keep going.

	Building bridges with other sectors	• Identify actions that;
		  ○ the health system can act on directly
		  ○ that require collaboration with other stakeholders and sectors.
		• Continue to work with and advocate for local service providers (e.g. DCJ and LAHC) to respond to concerns raised by residents that affect health and wellbeing (e.g. open the community rooms so residents can meet; participate in concierge training program).
			• Health is determined many factors outside the direct control of the health system and also the individuals affected.

What	How	Example actions	Why
Integrate evaluation and quality improvement processes into BAU	Checks along the way and **quality evaluation**	Lessons learnt • Finding ways to demonstrate early impact and progress is important to build momentum / and to also deliver to other stakeholder's timelines which might be shorter than the program's longer-term impacts. For instance, through qualitative stories of change and impact or evidence of active engagement in health. • Capture impact/outcome of peer-led activities on communities more systematically to add to the evidence base for the program. ○ implement soft evaluation approach to collect data when peer educators are delivering education (e.g. 3 simple questions and pre/post survey) • Program continuously refined with everyone involved in reflecting on how/why it should work (not just the researchers) • Taking the lessons from the Peer Educator Program and spreading the practice	Demonstrating early impact is important as well as utilising approaches that explain how change occurs, in what way, for whom, enabling learning and improvement of the program. Continue to accumulate evidence to validate the model and embed the model as a core part of how the organisation does outreach /health promotion, keeping in mind that even when the link to health services is not completely apparent, part of the reasoning is to build capacity, empower individuals and groups, and strengthen community.

What	How	Example actions	Why
Sharing the love	○ **Increased policy support for peer-led initiatives** in integrated care and priority population to tackle health inequities.	• Protect current program and expand it. (E.g. commit qualified staff and adequate funding (2 years min) to pilot program in other communities, namely Riverwood, Glebe)	
	○ Support **key planning and policy** with regards to **peer and lived experience** workforce and initiatives.	This means for example: • Continue to develop adequate training to develop capabilities and skills of peer roles (sameness/similarities is not enough). • Capture and value peers input and insights to influence system change.	Peer-led and lived experience interventions are implemented using best practice principles and evidence. Establishing models/mechanisms to influence and re-align services with what peers are hearing (i.e. ways to identify, value and act on quality insights and advice from peers).
	○ Support **key planning and strategies** with respect to **health promotion/ health prevention initiatives.**	• Include insights from capabilities approach and adult education principles. • Ensure that information is acceptable and appropriate (tailored, adapted to context and cultural literacy, i.e. best if includes experiential knowledge).	Solely focusing on Didactic approaches are not effective (i.e. the problem is not just information deficit) particularly with disadvantaged populations.
	○ **Increased policy support for resident-led initiatives** with regards to Waterloo redevelopment	• Provide support/ evidence/expertise residents need to support their actions (e.g. documentation of the outcomes of the first Waterloo HIA to be shared, further support the community led HIA). • Advocate for better housing and human/community services provision.	Interviews and observation in the program reveal that redevelopment is continuing to cause uncertainty and distress. It's important to provide support when community members express what issues they face and *what they would like to do about* it (this is what is meant by joint working – not leaving residents to work it all out).

What	How	Example actions	Why
			Interviews revealed that individual and community health and wellbeing is also shaped by quality housing; the community service provision; availability of community assets within the built environment etc.
	○ Increased **policy support** for effective **partnership with communities** .	• Policy needs to be supported by local coordination (in a collaborative style) i.e. paid staff, specialised knowledge base/evidence (staff who are skilled and trained), • Ongoing support (i.e. stable funding that matches longer timelines of community-based work) as key strategies	Effective joint working through convergence of communities' and health system's resources needs to be embedded within the broader health service system and culture at the policymaking level.
	○ Be deliberate in applying policies and **ensuring coherence**	• Policy coherence needs to be deliberate, and filter down beyond higher level of policymaking/SLHD wide values and principles (e.g. what we mean by, for example, strength based approaches is ..) • Identify mechanisms that spread ownership of the program and keep people accountable to the commitments they make , aligning budgets with these commitments and reporting on	People do not go out of their way to do something different if there is not a stronger incentive to do it besides high level value or shared vision. Need strong measures of alignment and accountability. Reward people for doing the more complex, longer term, collaborative work.
	○ Support **cultural literacy** and staff training in the organisation	• Upskilling, training and supervision/mentoring for staff is important to challenge traditional, more individual, biomedical, deficit-based approaches so staff can become more skilled in establishing and sustaining equity-focused action.	Needs to adapt approach to people and places – not all staff are skilled at this. Crucial at the implementation level to enable participants to understand health information better and use it to take action.
		• Evaluation frameworks, metrics and indicators help to track progress,	Community-led initiatives require longer timespans, in contrast to shorter term

What	How	Example actions	Why
	○ **Adequate evaluation** (recommendation for research and evaluation)	demonstrate outcomes and learn. They need to be *adapted, relevant, flexible* (i.e. can be adjusted) and *feasible to achieve* (i.e. not unrealistic expectations for the timeline and nature of the program) e.g. Metrics that are relevant and suitable instead of standardised outcome; provide enough time to do the evaluation • In the evaluation, document and value intermediate outcomes and processes ("initial engagement, relationship building, creating of trusting environment") not just individual behaviour changes and health outcomes[7]	clinical effects that health systems are used to, so need to have realistic expectations.

[7] See Harris et al.

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9 Supplementary Materials

9.1 Appendix 1: initial program theories

Using published literature, and in consultation with the implementation team, we developed and refined hypotheses that explain how and why the program is meant to work (mechanisms). Here is a summary of our initial program theories (IPT)

Initial program theories	Context/Hypothesis
IPT1. Education to improve health literacy through tailored message and trusted connections with community	*If* peer educators share *similar characteristics* as the target population and have *experiential knowledge*, they can *act as trusted intermediaries* between health services (HS) and residents, delivering health messages to community participants and increasing health literacy. Better health information and understanding – including understanding of health services and pathways – is expected to contribute to improved health and wellbeing and therefore reducing inequities. *We assumed* that peer educators based in the community are more likely to be trusted by other community members and can *deliver more targeted, appropriate and acceptable messages* about health and services available, with the support of HS stakeholders. As members of the community with lived experience, they can help to *demystify and de-stigmatise certain conditions or behaviours.* Developing interactive and critical literacy can support a reduction of health inequities in the Waterloo estate by supporting people in taking action for their health and wellbeing.
IPT 2. Reducing social isolation and building supportive networks to promote better health literacy and outcomes, and reduce health inequities	*Context:* People in social housing who are socially isolated because of their age, ability, health issues, sexuality, language barriers, or other factors can face difficulties in managing the demands of everyday life. Increased cost of living pressures and curtailed opportunities for social interaction and community activities/services in the wake of the pandemic have compounded economic and social difficulties for many. Social isolation can deter people from seeking the help they may need , meaning it has negative implications for health-seeking and health-directed behaviour. It can also make appraising and acting on health information more challenging when there is no relay to do this collectively.

	If the program provides opportunities for *building relationships* between social housing residents through structured training workshops (stage 1) and events with the larger community (stage 2), *involving sharing stories, tips and meaningful information*, it can contribute to reducing social isolation and exclusion, build or expand social/support networks, with positive consequences for health literacy and health outcomes.
IPT 3. Empowering residents to self-manage their health and highlight gaps	*If* the program maintains *community ownership* (i.e. control and autonomy) over needs prioritised and course of action; and *recognises and values peer educators' knowledge and skills*, participants will be able to use resources from the health system to improve their understanding and confidence and be more in control of their health. Over time and as a group, they may feel more empowered in advocating for change. The connection with influencing service practice and highlighting gaps was identified but not fully fleshed out in developing this IPT.

9.2 Appendix 2 – Program Logic

Problem/ Need	Inputs	Activities	Outputs	Data source	Impacts/Outcomes	
					Intermediate impact (0-18 months)	**Medium term (18-36 months)**
-Health inequalities experienced by Waterloo residents -Concerns by Waterloo residents about gaps in health care and problems with access to health services - Concerns by residents about	- Program coordinator - Community commitment - Training resources and commitment from SLHD services - subject matter experts	- Recruit, train and maintain engagement of core membership of peer educators - Identify issue, health risks or concerns raised by the community - Connect and liaise with relevant SLHD services to develop and deliver content on the issue - Peer educators are involved in refining content and identifying the most appropriate mode of delivery (co-design, deliberative learning principles). Educators	**Stage 1**- peer educators recruited from diverse backgrounds that also reflect priority target groups (EN) -participation of peer educators in training meetings and project updates (EN) - Training seeks and uses knowledge from different parts of SLHD and new learnings in health and broader sector (AL)	-Position description; # of peer educators recruited; demographic profile of peer educators - description of peer educator core training # of training sessions # of peer educators attending each session and overall - **evidence of peer consultation in documentation of program development and issues identified**. Data source: regular meetings held, meeting minutes, Working Group meeting notes and reflection on planning and decision-making, Working Group includes peers and community members - **evidence of program collaborating with other SLHD services**. Data source: semi-structured interviews with staff and other stakeholders; feedback	-Increased capacity and knowledge: peer educators acquire skill set to become effective facilitators, information gatherers and educators -Peer educators have increased awareness of their own health and wellbeing and increased health literacy. - Increased peer and community awareness and knowledge on	-Improved health outcomes among Waterloo residents across priority issues identified -community members participate in decision making about local healthcare strategy and improvement -Key SLHD services acknowledge and incorporate community needs into service planning and delivery - Improved reach and delivery of more

Problem/ Need	Inputs	Activities	Outputs		Impacts/Outcomes	
			Data source		Intermediate impact (0-18 months)	Medium term (18-36 months)
antisocial behaviour and mental health management - Residents want targeted relevant information on health and wellbeing (health literacy and health promotion) - Residents want to be more in control of their health	- Sponsorship from SLHD services and executive - Collaboration with other community organisations - Resources (venue for engaging with peer	are equipped with relevant training and information. - Connect with and maintain communication/relationship with SLHD services and other relevant agencies - Promote and conduct health education workshops (and/or other intervention identified by peer educators as relevant) - Collect peer insights and other emerging trends, gaps and issues to be relayed back to SLHD.	- Peer Educators' adaptation to the training sessions (AD) (EN) **Stage 2**- #health issues selected by peer educators # meetings and training sessions to co-create content on health issue with relevant service (AL) #peer educators attending these sessions for each topic **Step 3**-delivering health education # workshops conducted # participants and	from stakeholders; meeting minutes - **promotion of peer educator program to services suggesting trust and quality of the program** across the organisation. Indicators could include: # referrals to peer educator workshop # requests for advice and information from other services working with Waterloo residents. Data source: semi-structured interviews with staff; feedback from services; working group meeting minutes -**evidence of co-design of content**. Source: project and service documentation; semi-structured interviews with staff and peer educators -**peer educators hear a range of priorities and concerns from residents** in their workshops. Residents find **workshops are relevant and increase their confidence, understanding** of health issues and capacity to	specific issues of concern leading to change in health seeking and health-related behaviours - Increased self-efficacy/ confidence and sense of agency for peer and community participants (will potentially lead to increased health self-management and improved health outcomes in the long term) -Increased opportunity for community connectedness and social participation	relevant and appropriate services -Improved communications between SLHD, NGOs and other agencies -SLHD services are consumer driven and identify innovative ways to deliver care

Problem/ Need	Inputs	Activities	Outputs		Impacts/Outcomes	
			Data source		Intermediate impact (0-18 months)	Medium term (18-36 months)
and develop capacity to help each other (agency, empowerment)	educators) -Budget (reimbursement for peer educators, catering)	-Services adapt and respond to peer insights and community concerns	demographics for each session Peer educators and community report high levels of satisfaction with peer-to-peer interaction and with workshops (workshop peer skill and engagement quality indicators) (EN) (IN) **Step 4 –** closing the loop Peer insights are collated and shared with services (AD) Peer insights contribute to refining health promotion/literacy programs	access health services and/or advocate for themselves -peer educators and resident experience **increased social engagement and participation** Data source: Interview with peer educators; Peer reflection tool (to be completed post education session) Other survey or tool for community feedback(to be collected by implementation team) **Closing the loop**- evidence peer insights is incorporated in activity planning, filtered up to senior staff Data source: inclusion of updates on clinical council reports, Healthy Strong Communities committee meeting, Waterloo Human Services Action Plan Progress Reports and meeting updates.	-peer network promotes changed perception of social status (what it means to be a social housing resident), and health issues. This has the potential to reduce stigma in the long term -Increased understanding and knowledge of social and environmental factors that affect health in Waterloo, individually and collectively -improved relationships with health services and partner	

Problem/ Need	Inputs	Activities	Outputs	Impacts/Outcomes	
			Data source	Intermediate impact (0-18 months)	Medium term (18-36 months)
			and service delivery (IN)	organisations – stronger engagement as an impact in itself (and potentially leading to better health navigation) -Responsiveness and adaptation within SLHD: peer insights influence understanding of service issues and community strengths & needs (regarding health promotion and other topics)	

Key

EN = engagement/ AD= adaptation / AL= Alignment /IN = influence (W3 Framework, Latrobe University research group)

What works why framework (W3 framework)

1) Engagement with community: peer response interacts, participates and learns from community

2) Alignment: how the peer response collaborates with broader health sector, policy and services, and uses peer insights/skills to strengthen links with community

3) Adaptation: how the peer response learns and adapts to changing environment

4) Influence : how peer response affects its community AND the health sector

9.3 Appendix 3 – Characteristics of participants

Characteristics of peer educators interviewed

Code	Age and gender	Length of residency in social housing	Ethnicity
PE1	45 M	>2.5 years lives alone	South East Asian Australian
PE2	61 F	>30 years Lives alone	White Australian
PE3	63 F	>30 years Lives alone	White Australian
PE4	69 F	>8 years Lives alone	White European Australian
PE5	84 F	>40 years Lives alone	White European Australian
PE6	80 M	>6 years Lives alone	White Australian
PE7	63 M	>3years Lives alone	South East Asian Australian
PE8	67 F	Does not currently live in social housing	First Nation Australian
PE9	70 M	>20 years Lives alone Exited the program	White Australian
PE10	57 M	>5years Lives alone	White Australian
PE11	30 M	Does not currently live in social housing Exited the program Interviewed online	South Asian
PE12	60-70 F	Not recorded	East Asian Australian
PE13	45 F	>3years Lives alone	First Nation Australian
PE14	60-70 F	Not recorded	White Australian

Characteristics of stakeholders interviewed

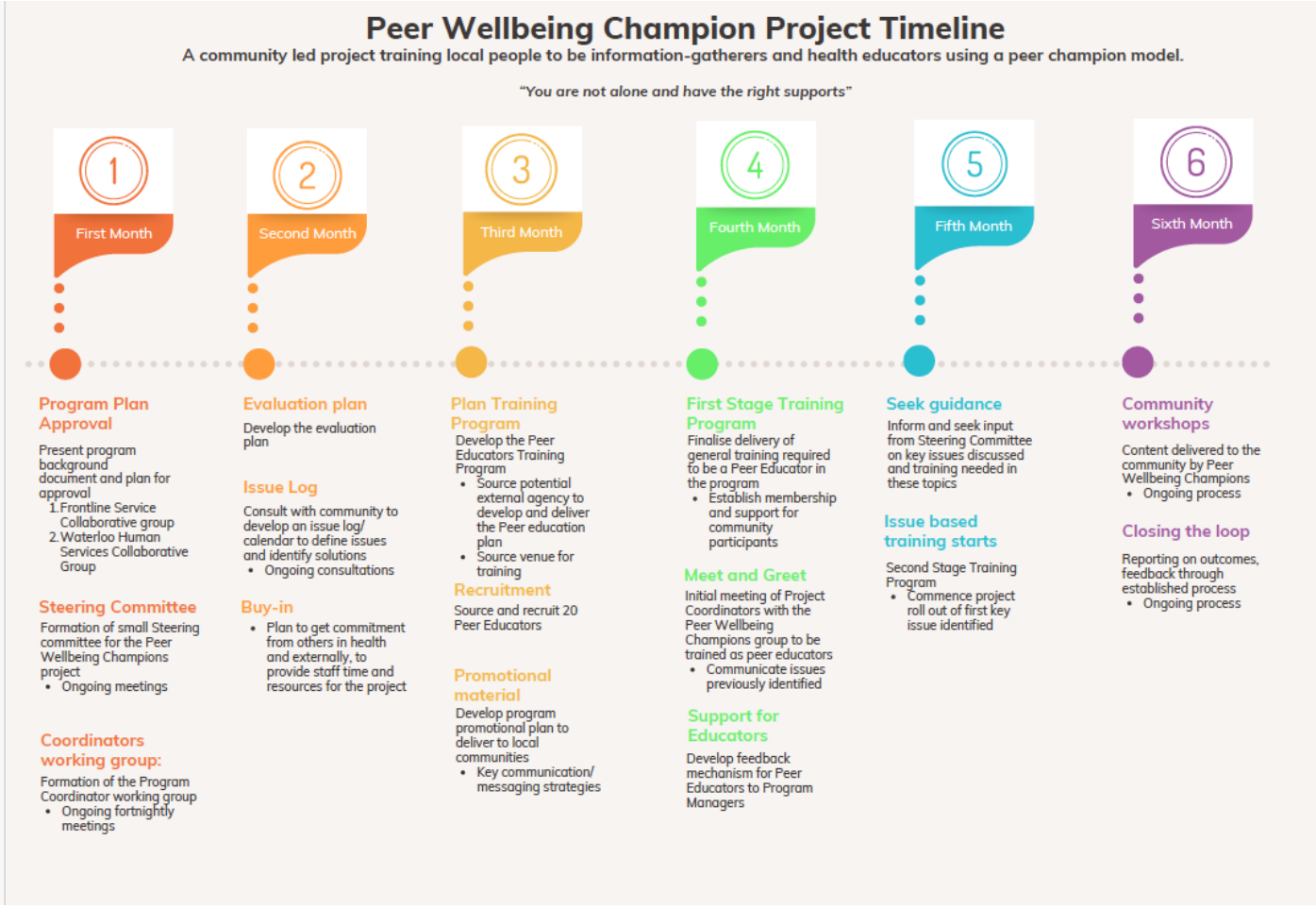
Code	Age and Gender	Organisation and time in role
S1	40-50 M	Health services >10years

S2	30-40 M	Community services > 4years
S3	50-60 M	Health services >5years
S4	40-50 F	Community services
S5	30-40 F	Health services >4years

9.4 Appendix 4 – Peer Wellbeing Educators Project Plan

<table>
<tr><td>Project Name</td><td colspan="3">Peer Wellbeing Educators in Waterloo</td></tr>
<tr><td>Project Sponsor</td><td>Lou-Anne Blunden, Executive Director Clinical Services Integration and Population Health, SLHD</td><td>Project Lead</td><td>Shane Brown, Manager Healthy Living Program, SLHD</td></tr>
<tr><td>Partner Agencies</td><td>• Department of Communities and Justice
• Counterpoint Community Services
• The Settlement
• Central and Eastern Sydney PHN
• City of Sydney
•</td><td>Sydney Local Health District services</td><td>• Integration and Partnerships
• Health Equity Research and Development Unit
• Oral Health Services
• Drug Health Services
• Mental Health
• Community Health
• Population Health</td></tr>
<tr><td>Background</td><td colspan="3">Residents residing in social housing in Waterloo have expressed an interest in finding out more about health and wellbeing, and ways to share what they have learned with other community members.</td></tr>
<tr><td>Project Vision</td><td colspan="3">A community-led project training local people to be information gatherers and health educators, using a peer education model.</td></tr>
<tr><td>Context</td><td colspan="3">This project contributes to various plans and initiatives:
- Waterloo Human Services Collaborative Group Action Plan:
Item 2.3: Investigate the implementation of the Peer Wellbeing Champions project
- SLHD Waterloo Healthy Living Program Evaluation recommendations, particularly:
1. Extending the health navigation work of the Waterloo Healthy Living Link Worker
2. Concentrating the work on significant issues faced by the community
3. Involving the community in the program of work
- SLHD Integration and Partnerships – Place-Based Portfolio
- SLHD CE Priorities
20. Vulnerable Communities
- SLHD Consumer and Community Participation Framework
- SLHD Equity Framework</td></tr>
<tr><td>Project Objectives</td><td colspan="3">• Improve knowledge about health and wellbeing
• Empower residents with information to manage their own health and wellbeing
• Reduce social isolation and build supportive networks
• Expand and illuminate pathways to health services
• Highlight and respond to gaps in service provision</td></tr>
<tr><td rowspan="2">Scope statements</td><td colspan="3">In scope:
• Identify health and wellbeing topics with community members
• Train identified peer educators in how to deliver health and wellbeing messaging
• Develop training packages for 6 to 10 topics
• Co-deliver training with the peer educators, to groups of community members
• Measure the impact, experience and outcomes of participation in the project for: residents, peer educators and providers</td></tr>
<tr><td colspan="3">Out of scope:
• Providing individualised referrals and support for health and wellbeing issues
• Providing education about non-health issues which align with other agencies (e.g. housing)
• Managing conflict between community members</td></tr>
<tr><td>Key Deliverables</td><td colspan="3">▪ A core training package for identified and new peer champions
▪ Training modules for 6 to 10 health and wellbeing topics
▪ A 2022 schedule of health and wellbeing sessions for the community
▪ An evaluation plan
▪ Regular reporting on progress to Waterloo Human Services Group
▪ An evaluation report, discussing feasibility of rollout in other areas of SLHD</td></tr>
<tr><td>Key Resources</td><td colspan="3">▪ Project Lead – Manager Healthy Living Program
▪ Project Working Group – comprised of key staff from SLHD, partner agencies and at least two community members
▪ Peer Educator Group
▪ Budget for allowance for food and travel for peer champions, administered by a NGO partner
▪ Site and/or online platform to deliver core and module training with Peer Educators
▪ Site to deliver community wellbeing sessions</td></tr>
</table>

	Activity:	Date:
Key Milestones	Finalise project plan	March 2022
	Seek endorsement from SLHD CE (via brief) to commence project	March 2022
	Present project to Waterloo Frontline Services Working Group	March 2022
	Send letter to Counterpoint requesting they host the project, and seek an invoice from Counterpoint	March 2022
	Invite suggested members to Project Working Group	March 2022
	Hold first Project Working Group meeting and finalise TORs	April 2022
	Develop core training package	May 2022
	Finalise community information session schedule for 2022	April 2022
	Book in and deliver core training session and training on first module	June 2022
	Finalise first three training modules	July 2022
	Commence delivery of community information sessions	July 2022
	Apply for Pitch Funding	Dec 2022



9.5 Appendix 5 - Peer Education activities delivered to community

Information provided by SLHD Healthy Living Program (updated March 2024)

Activity	Location	Date	Attendees	Outcomes	Partners
AOD Presentation	WWSAG Panel discussion with personal stories and information about addiction, stages of change etc	March 2023	65 Mostly social housing residents	Referrals to counselling services. Interest in becoming peer educators. Referrals to psychology services. Referral to family support service	City Of Sydney Community Services staff. Existing community forum Drug Health Redfern Drug Health Mission Australia
Mental health and wellbeing Quiz evening	Common ground 20 question quiz about mental health and prizes Food and drinks	24 March 2023	55	Opportunity for residents to socialise. Talk about serious mental health issues in a safe environment. Three referrals to Mental health services.	Mission Australia SHLD Mental health SHLD Homelessness service
Diabetes workshop	Northcott Community Centre Presentation/Quiz and discussion and lunch	30th March 2023	65	65 people. We had to turn people away. Lots of interest in how to manage diabetes. Requests for more healthy eating workshops. Three ref to Diabetes Aust	Diabetes Australia DCJ staff Northcott
AOD Quiz night workshop	Redlink Aboriginal resident focussed workshop /Quiz with prizes	June 2023	18 Aboriginal residents	One Resident requested support to attend detox and completed rehab	Redlink staff HHAN social worker Drug Health social worker

Open Art, social connection through creativity	Factory community centre, Waterloo	17 August (6 sessions) 21 September 2023	6 workshops x10 people	Resident who had no contact with others regularly attended and were encouraged to attend other activities, in so reducing social isolation	Counterpoint Community Services
Healthy eating lunch and BBQ	Cope Street social housing block Presentation from peers and lunch in the backyard	7th June 2023	25	Social housing residents in three blocks got together for the first time. Lots of socialising new friendships made.	Counterpoint community services
Naloxone	Various including Redfern NSP BBQ Redlink BBQ Staff and resident education @ Haymarket Foundation AOD nurse led clinic @ Common Ground	13 August and at 4 other dates	Six peers were trained to administer Noloxone/ Nyxoid by SLHD Harm minimisation service Interacted with >100 people	Improved awareness of overdose and how to deal with it. Naloxine given to 12 people	Drug Health
Declutter workshop	Waterloo Neighbourhood centre	19th October 29th February	70 people plus weekly Skips sessions	Improved access to hoarding and squalor treatment programs. Lots of interest. A particularly sensitive issue brough out into the open in a gentle way.	Social worker integrated community care SLHD Catholic Care Fire Brigade Specialist Waterloo housing office

Concierge Project	Waterloo housing	November-Dec Work in progess	Not actioned as yet staff and managers 3	Improved referrals to support services Improved knowledge of support system particularly local services.	LAHC Counterpoint Housing
APEC Conference	Workshop, Conference participants	15 November	30 people plus online	Participants interested in model. Canberra Health wants to investigate model.	Peer Educators presented Shane Brown Esther Alloun
Planned					
Diabetes and Health Bingo Provide Bingo questions with some messages about staying well and how to get information and support	Waterloo neighbourhood centre	February 2024			

Sydney Local Health District Peer Educator Program: Waterloo Pilot Program Evaluation Report

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NSW GOVERNMENT Sydney Local Health District

UNSW SYDNEY