


# Participatory approaches to delivering clinical sexually transmitted infections services: a narrative review

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## ABSTRACT

Although sexual health programming and clinical sexually transmitted infections (STIs) services have traditionally been developed through ‘top-down’ approaches, there is emerging evidence that participatory approaches benefit the development and implementation of such services. Although other studies have already highlighted the benefits of participation in research and implementation of clinical STIs services delivery, this narrative review focuses on how community participation in clinical STIs services delivery has been operationalised and on the various aspects of clinical STIs services delivery in which participatory processes have been implemented. A PubMed search was conducted in January 2022 using the search terms that reflected the topic of participatory processes in clinical STIs services delivery to identify relevant papers. Only peer-reviewed papers published in English were reviewed, and no timeframe was selected. After reviewing existing studies, we identified how community participation has been incorporated across stages of clinical STIs service delivery, including planning, developing, delivering, evaluating, and scaling up, as well as gaps and challenges faced in implementing such approaches. This review highlighted how a wide range of participatory processes characterised by varying depths of participation have been used in the above processes. Challenges such as funding, socio-cultural barriers, technical barriers and the digital divide, issues of quality assurance, and standardising the measurement of participation remain, which may impede the uptake of participatory processes in clinical STIs services.

**Keywords:** co-creation, community engagement, community health, community interventions, community participation, health services, methodological issues, patients’ views.

## Introduction

Sexual health programming and clinical sexually transmitted infections (STIs) services have traditionally been developed through ‘top-down’ approaches, or approaches where decisions are made only by the highest levels of governance or authority, with minimal participation from communities. The World Health Organization describes participation as ‘population involvement in decisions that affect their health’,<sup>1</sup> which includes defining the problem, implementing programs, organising research, and providing advice.<sup>1</sup> We define communities in this context as individuals or groups of individuals whom STIs may impact.

Community participation is often used interchangeably or synonymously with other terms that denote community participation or engagement in research or clinical services, such as ‘co-creation’, ‘community engagement’, ‘public and patient involvement’ and many others.<sup>2–4</sup> We recognise that these terms have been defined and conceptualised differently by scholars in the respective fields, and that the uncritical use of such terminology may lead to further issues in defining and conceptualising communities’ participation. Therefore, this paper defines ‘community participation’ as a broad term that denotes the range of participation that communities may contribute to clinical STI services (e.g. including co-creating services and varying depths of community engagement).

Past studies have shown that incorporating participatory elements spearheaded by communities and key populations affected by STIs (e.g. gay, bisexual and other men who have sex with men [MSM], and sex workers) are more effective in addressing barriers such as stigma and promoting clinical STIs services uptake.<sup>5–8</sup> These are especially important given challenges such as mistrust in medical institutions or research that may lead to poor implementation or uptake of such clinical STIs services, especially among communities disproportionately impacted by STIs.<sup>9–11</sup> Poor participation in clinical STIs services development has also led to the failure of efforts, such as early tenofovir trials for HIV pre-exposure prophylaxis among key populations such as MSM and sex workers.<sup>12</sup>

As structures for community participation are increasingly used or mandated in research and in the development of clinical STIs services,<sup>13,14</sup> it is now not just a matter of whether participation takes place or not, but rather, the depth of participation. Scholars have attempted to measure the depth of participation in several ways. For example, the United States National Institutes of Health highlights how the depth of community participation can be characterised by levels of community involvement, impact, trust and communication flow. These span across five levels: outreach (least engaged), consult, involve, collaborate, and shared leadership (most engaged).<sup>4</sup> Others like Fung have also characterised participation through its intensity, inclusivity and influence, whereas Arnstein has described it as a ‘ladder’ of citizen participation.<sup>15,16</sup> Studies that report on the effectiveness of participatory elements by communities in clinical STIs services delivery have shown that such services have typically been premised on deep collaboration and shared leadership between researchers, service providers, and community groups.<sup>6</sup>

Research has shown that deeper participation by communities in developing and implementing clinical STIs services has benefits. For example, crowdsourcing activities such as open calls, which typically involve a group of diverse individuals contributing to solving a health problem and then sharing identified solutions with key stakeholders, and designathons that typically involve an open call for submissions, which lead up to intensive activities that bring people together via online platforms to complete a specific task within several days.<sup>17</sup> Evidence has shown that these allow communities to iteratively refine clinical STIs services delivery and have enhanced diversity among participants compared to traditional community advisory boards,<sup>18</sup> and create more effective solutions than expert, ‘top-down’ approaches.<sup>17,19</sup> Various community-led clinical STIs services delivery have been proven to be superior in reaching communities affected by STIs, and who may face barriers to accessing such services in traditional facility-based STIs services run by healthcare professionals.<sup>20,21</sup> Apart from the benefits of participation in developing and implementing clinical STIs services and increasing the uptake of such

services, it is an ethical imperative that communities be involved in the development of such services, given that members of the public pay for research through taxes, participate in trials, and advocate for policy changes.<sup>22</sup>

It is now timely to discuss the use of participatory processes in clinical STIs services delivery in the 2020s and beyond for several reasons. First, the coronavirus disease 2019 (COVID-19) pandemic has widened the gap in the uptake of such services around the world,<sup>23</sup> and driven deeper inequities among communities and key populations affected by STIs,<sup>24</sup> and this has led to a shift in the organisation and distribution of STIs risks in various settings.<sup>25,26</sup> Second, many barriers to addressing the spread of, and negative impact of STIs remain today,<sup>27</sup> whereas criminalisation of and stigma towards key populations affected by HIV and other STIs threaten progress towards addressing such issues.<sup>28</sup> These dynamics warrant a deepening of effective, participatory processes that will hasten efforts to address inequities that communities and key populations face in the uptake of STIs services as a result of the COVID-19 pandemic.

Therefore, this narrative review sought to explore how community participation in clinical STIs services delivery has been operationalised in the various aspects of clinical STIs services delivery. The findings of this narrative review will allow service providers and policymakers to understand better the breadth of how community participation can take place in varying stages of clinical STIs service delivery, as well as provide researchers with new ideas and directions for future research into the use of participatory approaches to delivering such services.

## Methods

We adopted a narrative review to identify and summarise how participatory approaches have been utilised in clinical STIs services delivery. A narrative review in this area would help provide a general appraisal of studies with keen highlights of the current knowledge gaps and rationales for future research.<sup>29</sup> We took guidance from Ferrari on the steps to conduct this narrative review.<sup>29</sup> To identify relevant papers, a search of PubMed was conducted in January 2022 using the following search terms: (people-cent\* OR community advisory board\* OR codesign\* OR co-creat\* OR participatory OR crowdsourc\* OR community-engage\* OR public engagement OR patient engagement OR PPI OR patient and public involvement OR public involvement OR patient involvement [tiab]) AND (sexually transmitted\* OR STI\* OR STD\*) AND clinic\*. Only peer-reviewed papers published in English were reviewed, and no timeframe was selected. PubMed was selected given its relevance to papers describing and discussing the range of clinical STIs services.

We then sought to appraise the available studies retrieved from our search critically. The appraisal included evaluating

the key results of each article, methodological rigour of these findings, interpretation of the results, as well as the contribution of these findings to the range of participatory approaches to clinical STIs services delivery. These were done by the two co-first authors (RKJT and GM) who met up to discuss these issues. During these discussions, the co-first authors found that varying studies focused on different aspects of clinical STIs services delivery that spanned across a continuum of service delivery stages. Following this, we then categorised our findings into themes that represented these stages of clinical STIs service delivery (i.e. planning, development, delivering, evaluating, and scaling up), and how participatory approaches have been incorporated or utilised across them. We then consolidated and reported on gaps and challenges faced in implementing such approaches. Given the lack of a systematic approach in a narrative review, we opted to reflect the breadth of topics and issues covered, rather than assess the extent of evidence in the papers reviewed.

## Results

Past research has described the use of participatory processes across many stages of clinical STIs service delivery (as summarised in [Table 1](#)), and the challenges to implementing participatory processes. In this section, we first discuss how participatory approaches have contributed to these stages of clinical STIs service delivery, provide a brief overview of the methods of participation, and finally the potential barriers to implementing participatory processes.

### Planning clinical STIs services delivery

Although traditional STIs surveillance mechanisms allow us to evaluate and further investigate issues around the

increasing incidence of STIs in the community, they do not provide a complete picture of the issues faced by the community in the context of STIs. These may include syndemics of sexual violence, mental health comorbidities, poverty, poor health service access, and related structural or policy barriers.<sup>30–33</sup> Participatory methods have been shown to effectively elucidate key issues around STIs that are pertinent to communities related to the planning of clinical STIs services delivery.<sup>17,35,36</sup>

For example, a study in the United States adopted a series of participatory ideation workshops with youth and other key stakeholders in STIs services.<sup>35</sup> The researchers found that such an approach led to identifying themes beyond general barriers and motivators to STIs testing and included relevant solutions as well. The same team also adopted creative visual mapping approaches to better understand the youth's experiences in clinical STIs services uptake, which helped to identify issues and solutions informed by their lived experiences of utilising such clinical STIs services.<sup>34</sup> Crowdsourcing open calls have also shown to successfully generate a wide variety of high-quality ideas,<sup>17</sup> but also broaden and diversify input from marginalised community segments within community advisory board processes.<sup>18</sup>

### Developing clinical STIs services

Once key issues are identified, communities can also participate in developing the interventions and services themselves. Co-creation is a bidirectional, iterative process between researchers and communities.<sup>37</sup> Beyond simply identifying issues or suggestions around solutions to address STIs in the community, participatory processes can enable community members to be directly engaged in co-creating clinical STIs services delivery strategies. This presupposes a deeper level of engagement, and have included participatory approaches

**Table 1.** Thematic areas of clinical STIs services developed through participatory processes.

Stages of clinical STIs services	Examples of clinical STIs services
Planning	<ul style="list-style-type: none"> <li>• Participatory workshops and creative visual mapping exercises among communities, stakeholders, and clinical services providers for ideation and solutions<sup>34</sup></li> <li>• Crowdsourcing open calls at a national level to solicit a wide range of high-quality ideas and solutions<sup>17</sup></li> <li>• Crowdsourcing perspectives to enhance community advisory board contributions in clinical STI research and services<sup>18</sup></li> </ul>
Development	<ul style="list-style-type: none"> <li>• Participatory approaches where communities are either consulted or lead the development of intervention material or processes<sup>88</sup></li> <li>• Communities participate in shaping clinical service processes or digital health interfaces that aim to address STIs<sup>42,89</sup></li> <li>• Communities are engaged to co-create or co-design research study protocols and workflows in the context of clinical STIs services<sup>38</sup></li> </ul>
Delivery	<ul style="list-style-type: none"> <li>• Approaches that co-opt members of the community in the delivery of health services through their networks<sup>43–45,90,91</sup></li> </ul>
Evaluation	<ul style="list-style-type: none"> <li>• Community scorecards and quality improvement processes that are led by communities<sup>46,47</sup></li> </ul>
Scale-up	<ul style="list-style-type: none"> <li>• Approaches that involve training and certification of community members, and allow for shared leadership with community members in the delivery of comprehensive clinical STIs services<sup>48–54</sup></li> </ul>

where communities are either consulted or lead the development of intervention material or processes, shape clinical service processes or digital health interfaces for STIs, and design research study protocols and workflows.<sup>38</sup>

For example, clinical guidelines for STIs services delivery, such as treatment and prevention, have been developed alongside and in consultation with key populations, including MSM and sex workers, in many settings.<sup>39,40</sup> Researchers have also worked collaboratively with communities, such as young Indigenous Australians, to develop and implement research protocols that prioritise ethical and social considerations that were important to communities.<sup>41</sup> Regarding co-creating digital health interfaces, one example saw STIs practitioners seeking to create a gay-friendly health services platform in collaboration with a gay dating app in China that allowed MSM to crowdsource, find and access gay-friendly healthcare services.<sup>42</sup> This app was developed through a crowdsourcing open call and focus group discussions that solicited community input to identify potential improvements and implement creative solutions.

### Delivering clinical STIs services

Once key issues are identified and the design and workflows of services are developed, communities can also effectively participate in delivering clinical STIs services. This article will distinguish between the co-opting of communities in the delivery of services (e.g. peer-driven services) by non-community entities versus community-led initiatives. The former is not necessarily community- or peer-led and therefore does not imply deep participation by community members and peers themselves. Some approaches to the co-opting and collaborating with communities have included peer secondary distribution of clinical STIs services such as self-testing kits for HIV and other STIs, or the training or assisting of individuals who have tested positive for STIs to notify their sexual partners to test and get linked to care.<sup>43,44</sup> These have allowed for clinical STIs services to be decentralised or extended in terms of their reach.

For example, a study in China on the secondary distribution of HIV/syphilis self-test kits among MSM utilised social media ads as a means of primary self-test kit distribution, but were instructed to pass such kits to their peers or sexual partners as well.<sup>45</sup> Partner notification strategies for STIs come in several forms; first, enhanced patient referral services where patients receive training to pass on information, testing kits, and even counselling to their sexual partners; second, expedited partner therapy, where index partners receive and deliver medication or therapy to their partners; third, provider referral where third parties are brought in to contact or notify partners; and lastly, contract referral, which is a hybrid form where an agreement or contract is made between the patient and the clinic on the date by which patient-led referrals would be made, otherwise the clinic or a third party may intervene.<sup>43</sup>

### Evaluating clinical STIs services delivery

Communities have also participated in the evaluation of clinical STIs services delivery in several settings. These processes typically involve communities working to develop scorecards of the quality of clinical services and their experiences at the clinic, which are in turn used by community members in evaluating clinical STIs services.<sup>46,47</sup> These studies have shown that such approaches have been effective in raising community members' self-efficacy and confidence, develop relationships of mutual trust and respect, and have led to improvements in the quality of services over time.<sup>46,47</sup>

For example, a study in Vietnam saw community representatives develop community scorecard indicators with inputs from health staff at the HIV healthcare facility. Researchers found that undertaking quarterly ratings led to substantial improvement in services delivery; including added access to free HIV prevention commodities and information material, greater privacy and comfort, as reported by clients, and friendlier services.<sup>46</sup> Another study in Malawi engaged both healthcare workers and women living with HIV through a community scorecard approach to identify service quality and uptake issues and implement actions for improvement. Although this study did not find any significant improvements in client retention, researchers found that relationships between clients and healthcare workers were strengthened, and the collective efficacy of clients to create positive change improved because of this participatory process.

### Scaling up clinical STIs services delivery

Community- or key population-led services presuppose a high level of participation across all aspects of clinical STIs service implementation. In some instances, community members have also been recruited as 'peer educators' where such individuals conduct regular outreach to key populations and other individuals who may be affected by STIs.<sup>48,49</sup> Adopting peer educator programs has been vital in reaching members of key populations affected by STIs (such as youths, members of a geographically demarcated communities, and gender minorities) with essential STIs services, especially in resource-limited settings.<sup>48,50-54</sup>

A meeting of community experts in 2019 convened by the The Joint United Nations Programme on HIV and AIDS (UNAIDS) secretariat focused on the need to define 'community-led' services, following a survey of 475 respondents in 97 countries around definitions of community-led and key population-led responses.<sup>6</sup> In a scoping review of community-led responses to HIV,<sup>6</sup> the authors found that such responses ranged from peer-led education or prevention interventions, to community-led testing, care, and treatment, and developing human rights programs, community support groups, adherence programs and

drop-in centres. The review found strong evidence that such community-led approaches effectively improved clinical STIs services delivery, were associated with cost savings, and showed promise for expanding clinical STIs services coverage in the future.<sup>6,55</sup>

Apart from community-led services, scaling up of clinical STI services also means ensuring that patients and the public have meaningful frameworks of participation. To this end, standards have been developed on how patient and public involvement in research and clinical services have been developed, alongside efforts to audit the level of patient and public involvement in the delivery of clinical STIs services.<sup>56-59</sup> A series of audits on patient and public involvement plans in the United Kingdom had demonstrated how understandings of patient and public involvement varied across units, lacked goals, and were limited in their depth of soliciting participation.<sup>60</sup>

**What participatory processes have been used in delivering clinical STIs services?**

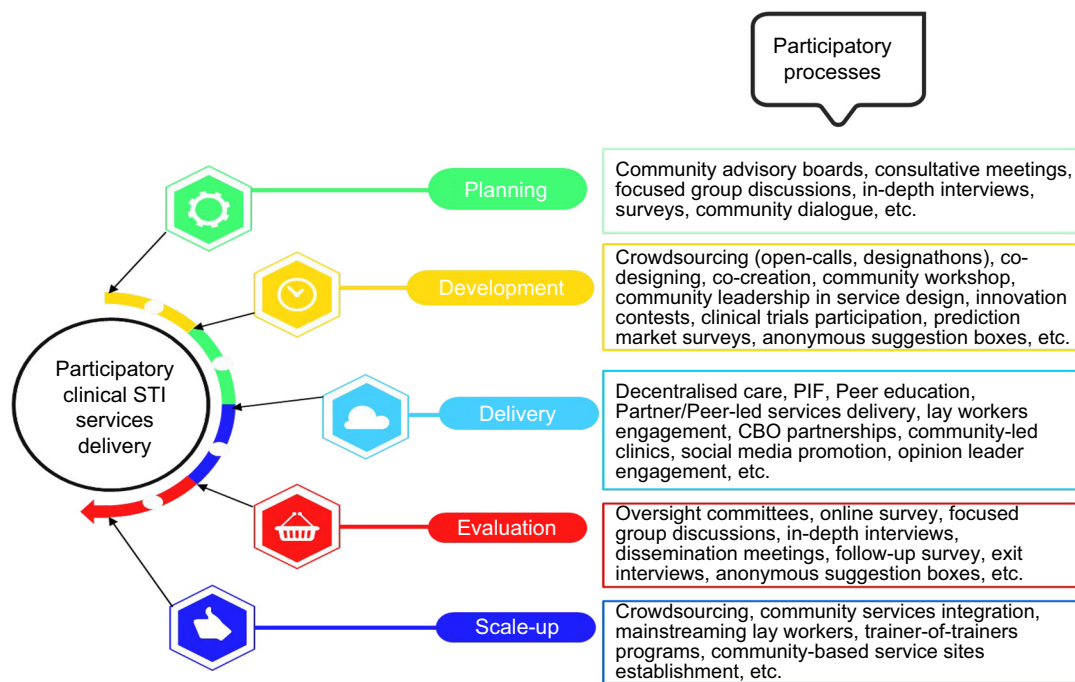
Participatory processes, as highlighted above, were diverse and presupposed varying levels of engagement. Different approaches were also selected based on various factors, including resource availability in the study setting and the phase of service delivery to which participatory processes could contribute to. For example, some studies have opted for crowdsourcing open call approaches, which have significant cost savings and allow for diverse participants to be engaged in participatory processes.<sup>17</sup> In contrast,

others have opted for smaller groups of community representatives who are tasked with leadership roles or intense co-creation and co-development processes through hackathons or co-creation groups.<sup>61,62</sup> Traditional methods such as online surveys and qualitative research methods may also be utilised, though these may only marginally allow for communities to participate and can be combined with other approaches. We thematically recategorised the areas of clinical STIs services delivery above and highlighted the participatory processes that have been used in these various stages; namely planning, development, delivery, evaluation and scale-up. Fig. 1 summarises these processes.

We note in this review that participatory processes are not a ‘one-size-fits-all’ concept, and the variety of approaches highlighted here can be adapted accordingly to varying contexts. Participatory processes are also not mutually exclusive, given that several projects have used multiple approaches to ensuring that communities participate in different aspects of developing and implementing clinical STIs services.<sup>62,63</sup> Nevertheless, the underlying principles of participatory processes remain regardless of approach; these include ensuring inclusive, intensive, and influential communities that embody shared leadership in the implementation of clinical STIs services.

**Challenges to participatory processes in clinical STIs services delivery**

Although community participation in health care has evolved to include more active engagement in program



**Fig. 1.** Participatory processes by stage of clinical STI delivery. CBO, community-based organisation; PIF, pay-it-forward services.

designing and implementation,<sup>25</sup> the degree of community participation in clinical STIs services delivery is determined by varied factors including resource availability and socio-cultural structures. Thus, scaling up participatory community processes is not without challenges and participatory processes are not without disadvantages.

### Challenges in the funding of clinical STIs services

From 14.7% of total global health aid funds in 2016 to 12.5% in 2017, donor funding for non-HIV STI control programs has declined for the past two decades, with >70% of donor funds still allocated to HIV programming.<sup>64,65</sup> Many donor-dependent low- and middle-income countries (LMICs) lack the financial resources to implement participatory STIs services delivery activities and struggle to bridge the gaps in STIs control caused by the diminishing international funding.<sup>66,67</sup> In essence, financial resources to facilitate participatory activities and incentivise community participation in STIs services delivery are non-existent in these resource-limited settings. Additionally, participatory research as an emerging field is not valued much in many LMICs because governments are not keen on funding decentralised projects due to path dependency and limited evidence. Thus, lack of funding poses a fundamental challenge to the sustainability of progress made in participatory processes.<sup>64</sup>

### Socio-cultural barriers to participation

The level and intensity of involvement in participatory clinical STIs services delivery and their efficacy is influenced by socio-cultural factors and subject to local-context paradigm shifts.<sup>68</sup> For example, women are less likely to participate in research and secondary health services delivery in settings where gender inequality persists and women have no voice in decision-making.<sup>69</sup> Also, members of key populations are less likely to actively partake in participatory processes in settings with criminalisation of gender non-conformity and sex work, stigmatisation and discrimination, and societal intolerances.<sup>70,71</sup> Furthermore, a decline in the use of traditional social spaces (such as pubs and clubs) and the widespread use of online spaces for anonymity among key populations presents some challenges for existing traditional engagement methods such as community open forums.<sup>35</sup>

### Technical barriers and the digital divide

Aside from external factors, technical hiccups from unsuitable methods for community engagement or poor implementation of selected strategies could impede community involvement in participatory processes.<sup>4</sup> At the onset of interventions, inadequate orientation on intervention goals could create misconceptions among community members and low publicity may undermine the importance of their involvement.

In crowdsourcing for example, using solitary methods (such as only one official website) to promote open call contests limits public reach, and inadequate information on call adverts reduces motivation to participate.<sup>72,73</sup> Both of these technical hiccups translates to less community engagement and fewer submissions.<sup>73</sup>

Similarly, low engagement can occur in the use of qualitative approaches like focus group discussion when systems are not in place to prevent hierarchical valuation of participant submissions. Further, overlooking the promotion of STIs services uptake using social media for community-based testing events may cause low turn-outs and leave the service needs of hidden high-risk key populations (such as closeted MSM) unmet.<sup>74</sup> Thus, proper planning of community engagement with adequate risk assessment and mitigation profiles before implementation are equally essential to alleviating the barriers to community participation in clinical STIs services delivery. Finally, there may be issues of privacy that arise when adopting digital approaches to participation, and scholars have previously articulated several ways of mitigating such risks in certain participatory processes.<sup>75</sup>

### Quality assurance in participatory processes

Establishing and maintaining a continuum of community engagement throughout participatory processes is essential to safeguarding the integrity of participatory processes.<sup>76</sup> However, true community engagement can sometimes be derailed by low levels of engagement, or tokenism, due to solitary engagement of researchers rather than public audiences, and the use of engagement strategies untailored to meet local contexts.<sup>77</sup> Additionally, the actions and inactions of community members for personal benefits (such as incentives), altruism or sheer want of inclusivity further compromises the quality of participatory processes and outcomes.<sup>76,78</sup> For example, findings from a community-based HIV prevention trial in South Africa was significantly biased by the manipulation of the eligibility criteria by some participants to enable their enrolment. Others even attempted to co-enrol in multiple trial sites to gain more financial reimbursements.<sup>79</sup>

Successful implementation of community-developed solutions to expand STIs services delivery and coverage is the notable end-goal of all participatory processes. However, overlooking or manipulating essential quality control measures to foster higher community participation compromises the overall quality of services delivered through the process. Unfortunately, many communities ignore the need to substantially revise these solutions to upscale quality in services provision due to the 'Ikea effect'. The 'Ikea effect' is the phenomenon where people who build/setup items themselves are less likely to see its flaws as easily as onlookers.<sup>80</sup> To that end, rigorous monitoring

and evaluation processes and standardised approaches would still be required, even in contexts with deep participation by communities.<sup>81</sup>

## Measuring participation

With the growing popularity and global advocacy for adopting participatory community processes as part of public health interventions, it is imperative to standardise and assess the depth of community participation in processes. Some studies have argued that current impact assessments are unstandardised in their application, and lack reliability and ways to improve the accuracy of their generated outcomes.<sup>82</sup> However, guidelines and tools to measure the depth of community participation are still emerging for some methods (such as crowdsourcing and co-creation) and remain unclear for others (such as open forums and suggestion boxes).<sup>83</sup> Even where such standards and assessment tools exist (for example, in advisory groups and focus group discussions), their actual accurate use is limited, especially in LMICs, where experts to guide their proper application in participatory processes may be lacking. Also, in many cases, the use of participatory methods is guided by the executor or the designer of the research mechanism and this begs the question, who should be the evaluator? Nonetheless, a recent study has suggested the adopted use of a sequential impact matrix that considers the decision-makers' preferences before the participatory mechanism to see the extent of citizen ideas that align or diverge from their own agenda.<sup>82</sup> This recommendation and similar ones from a recent study should be considered and further investigated to inform standardisation of participatory processes and the development of depth assessment tools.

## Discussion

This narrative review sought to identify strategies for incorporating participatory processes into clinical STIs services delivery and summarised the areas where such services have been impacted and the methods through which communities have participated and been engaged. We described how participatory processes have been used in the planning, development, delivery, evaluation, and scaling up of clinical STIs services, and have clear benefits for articulating issues that impact communities, reaching underserved populations, improving quality of clinical STIs services, and empowering communities. In spite of these advancements, several focus areas remain in the implementation of participatory processes in clinical STIs services.

First, our review highlighted how deep engagement processes characterised by shared leadership, such as those involving community or key population-led services, the use of co-creation processes, or community scorecards,

were still not widespread practices and were limited to certain populations and settings. Greater efforts would be needed to train STIs clinicians, policymakers, and researchers on frameworks for deepening participation by communities in clinical STIs services,<sup>4,15</sup> as well as provide guidance on how participatory approaches can be implemented through practical guides.<sup>37,84</sup>

Second, our review also highlighted several barriers to implementing participatory processes for clinical STIs services. These have to be addressed through policy, institutional, and organisational efforts to ensure appropriate funding for both clinical STIs services and participatory mechanisms, and solutions to address technical and digital inequities. Researchers can also ensure that beyond guides to implementing participatory processes, these should be accompanied by robust monitoring and evaluation frameworks suitable for participatory approaches.

Third, there has also been a shift toward digitising clinical STIs services delivery and research, especially because of the COVID-19 pandemic. Although some participatory processes in this review have adopted digital approaches to participation,<sup>42,62,85</sup> most studies involved in-person processes or did not specify how participation had been structured through digital approaches. Greater effort is needed to consider how online participatory approaches can practically be implemented to deepen community participation in digital clinical STIs services.

Finally, most participatory processes have also largely focused on key populations impacted by STIs. Although this is justified due to the disproportionate barriers to care and stigma that such key populations face, less focus has been given to how participatory processes can positively affect the general population. Further research on participatory processes is warranted, especially in primary care settings and general STIs services.

One weakness of this paper is that narrative reviews do not typically include a pre-defined selection or inclusion strategy,<sup>29</sup> which may have biased our results. In contrast, more systematic approaches such as scoping or systematic reviews have standardised guidelines on selecting studies and mapping themes.<sup>86,87</sup> To mitigate such bias, we have attempted to situate this review as more exploratory than explanatory. We recommend using this review as a guide for further debate and research into the area of community participation in clinical STIs services delivery.

This narrative review also provides researchers with ideas and references to guide the piloting of participatory processes in various clinical STIs service provision areas. These approaches may be considered by researchers and clinicians who have not previously considered participatory processes in their respective clinical settings. Those currently implementing participatory approaches in clinical STIs services could also consider how participation can be deepened in their respective projects and settings.

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**Data availability.** The data supporting this study's findings are available on request from the corresponding author, RKJT.

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