Types, Costs, Benefits and Resourcing of Community-led and Other Responses for Sexual and Reproductive Health and Rights: A Scoping Review

REPORT FOR THE LOVE ALLIANCE

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Love Alliance
Together for health and human rights

HIV Policy Lab

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ABSTRACT

Introduction:
This scoping review's overarching objective is to promote investment in and reliance on community-led responses for the sexual and reproductive health rights of HIV's key and vulnerable populations. It does this by mapping evidence on the financial resource requirements and benefits of these responses as well as the costs of inaction on the law and policy determinants of sexual and reproductive health and rights. While there are previous and forthcoming evidence syntheses on community responses and the law and policy determinants, there are no studies that seek to bring these siloed bodies of evidence into dialogue with one another and, thereby, interrogate the interdependency of community empowerment and legal environments for enabling sexual and reproductive health.

Methods and analysis:
The scoping review was conducted in accordance with *JBI Manual for Evidence Synthesis* methodology and has been registered with the Open Science Framework. MEDLINE, Embase, Web of Science, Sociology Abstracts, and Google Scholar were searched. All sources were screened for relevance, assessed for inclusion and subjected to data extraction by two independent researchers with a third research intervening in case of disagreement.

Sources concerned with HIV and the responses' of key and vulnerable populations were eligible for inclusion when they explored community-led responses for sexual and reproductive health rights or the law and policy determinants of sexual and reproductive health. These sources also explore the costs, benefits or financial resource requirement of these interventions.

Ethics and dissemination:
Following further consultation with key population-led organisations on the first two drafts, a series of policy briefs and research proposals will be produced for use in guiding responses for sexual and reproductive health rights and a research agenda centred on community-led research. The report may also be published in a peer-reviewed journal to contribute to the literature.

Results:
A large proportion of sources on community-leadership touch on its potential for improving legal determinants. The sources also show how the legal environment can be both a barrier to and enabler of community leadership. Taken together these sources coded with cross-cutting observations indicate a literature that explores, albeit infrequently overtly, the mutuality of community leadership and legal determinants.

The types of community-led responses described in the literature vary significantly in terms of the community ownership over these responses and the degree of community ownership appears to affect the priorities and aims of these responses. As community ownership increases, the types of community-led responses seen become more diverse and less narrowly focused on service delivery. The included sources substantiate the already well evidenced benefits of community-led responses but also show that few sources are describing these benefits in terms of cost-effectiveness.

There are few studies providing precise measures of the financial resource requirements. There is often a reliance on underpaid or unpaid labour from volunteers within the community. A large number of the sources describe resource requirements in terms of the challenges of unreliable, insufficient or overly prescriptive funding.

The sources more commonly feature laws, policies and practices that negatively impact sexual and reproductive health and rights. The most common pathway for negative impact is discrimination and criminalisation and the most common pathway for positive impact is anti-discrimination and decriminalisation. Negative laws, policies and practices are characterised in the literature as undermining access, availability and quality of health services and also undermine health promoting behaviours with various direct harms to health consequent to this. Positive laws, policies and practices vary but highlight in particular the limitations of isolated reforms and the need for concerted approaches of mutually supportive legal reforms as well as broader societal interventions.

Conclusions:
This review demonstrates how fundamental attention to the legal determinants is for realising the full potential of community-led responses and ensuring progress on ending HIV and preventing deaths from AIDS. It also confirms the interrelationship between investment in community leadership and realisation of progress on the societal enablers. The included sources also show that community-led responses are of significance in improving the legal determinants and such improvements are a common aim and outcome of community-led responses.

This review supports investment in and advocacy for community-led responses to HIV and related sexual and reproductive health challenges. All sources cite benefits to health and they are shown to have impact in delivering health services, ensuring prevention and moving the needle on critical legal determinants and related societal enablers. At the same time, funding challenges make delivering the services or programming needed challenging, difficult or impossible. More subtly, they can also warp the character of the community-led response by requiring communities to fit the prescriptions and reporting requirements of funders rather than the needs and processes preferred and most suited to the communities themselves. High-quality and high-ownership community-led responses require capacitation and organisational development over the long-term which makes sustained and predictable funding essential.

The literature is disproportionately focused on limited, time-bound and low community ownership responses that do not and cannot capture the benefits and value of community leadership. There is insufficient research on the financial and other resource requirements of community-led responses as well as the overall share and character of community-led responses within the HIV response. There is also a need for further research on how positive legal determinants enable and strengthen community-led responses and how negative legal determinants undermine and frustrate community-led responses.

Strengths of this study:
- The breadth of the study's eligibility criteria helped ensure that many relevant documents that speak to the review's objectives were included.
- The search strategy was carefully trialled and designed to be as comprehensive as possible within a manageable degree of precision.
- This research agenda has been set by a consortium of community-led organisations and meaningful consultation with these partners has,

within the limits of practicability, been relied on in determining that the search is complete as well as in framing and presenting its results.
- The complementary reliance on extensive consultation with subject matter experts has helped ensure much of the relevant grey literature is captured.

Weaknesses of this study:

- Only English language documents were considered eligible for inclusion but if time and resources permit extension to French, Arabic and Portuguese may occur later.
- The focus on key populations and vulnerable populations as defined with UNAIDS material means that other populations have been deemphasised in the search and data extraction process. This may skew the results and, in particular, has resulted in insufficient coverage of sources focused on people who use drugs.
- The scoping review is limited by the state of the extant literature which is characterised by inadequate representation of publications by key population-led and community-led organisations.
- Not all relevant grey literature will have been captured and further efforts to investigate and assess this literature will only be carried out if time permits.
- The outcome-oriented focus of our review questions meant that studies and other sources covering process and interim outcomes were often excluded which lessens its breadth and ability to speak to certain other important questions.
- As a scoping review, this reports maps and identifies available literature without seeking to critically appraise included sources or produce conclusive synthesised answers or definitive results in response to its foundational questions.

SCOPING REVIEW PURPOSES

Introduction

Sexual and reproductive health services and rights are systematically denied communities and people on the basis of their actual or perceived health status, sexual orientation, gender identity, sex characteristics and behaviours.[1] Those belonging to one or more of these vulnerable and marginalised communities are less likely to enjoy sexual and reproductive health and more likely to suffer from reduced access to high quality sexual and reproductive health services.[2,3] This is a function of negative legal determinants of health including actively discriminatory and criminalising laws, policies and practices as well as the absence of laws and policies for protecting and fulfilling sexual and reproductive rights by eliminating discrimination and providing for substantive equality in health services.[4,5,6,7,8] Responses led by affected communities are effective at ensuring access to quality health services and improvements in the legal determinants but are underfunded, underutilised and often stunted by inhospitable or even punitive legal environments that deny them their rights and ability to organise.[9,10,11]

With or without official recognition, communities have often led their own responses to counter neglect, discrimination and criminalisation with mutual aid strategies of community prevention, treatment and care in substitution for denied or inadequate health sector provided services as well as through advocacy and organised resistance against the laws, policies and practices which abridge their sexual and reproductive rights.[12,13,14,15] Their responses are, in fact, most necessary in the presence of legally endorsed, permitted or tolerated hostility.[16] Community-led organisations will, however, better improve health outcomes and the legal environment when sustainably financed, integrated as a complement to the health sector, accorded legal recognition, protected from discrimination, and able to cooperate with public actors responsible for key upstream determinants of health.[17, 18,19,20]

Communities ensure their own sexual and reproductive health and rights by, inter alia, advocating for, delivering, designing and monitoring health services, designing, implementing and participating in research, and monitoring and advocating for human rights accountability as well as reforms to laws, policies and practices. For community responses to be effective, the communities themselves must be empowered and financed to lead at a governance level in the determination of priorities, resourcing and the design of interventions as well as at an operational level through their own actual delivery and implementation of services and other programmes.[21,22,23,24]

In response to the immense success and proven potential of community-led responses, the Love Alliance commissioned this review. The Alliance is a consortium of community-led organisations operating across Burkina Faso, Burundi, Egypt, Kenya Morocco, Mozambique, Nigeria, South Africa, Uganda, and Zimbabwe as well as in partnership with Aidsfonds and the Global Network of People Living the HIV (GNP+).

This review adopted the definition of community-led responses arrived at in a June 2019 consultation convened by UNAIDS.[25] Importantly, community-led responses comprise a diverse set of interventions carried out at varying scales and levels but are all informed, implemented and determined by communities for their own members.[26] Not all responses involving community members or community-led organisations are, themselves, community-led, even if described as such, but, equally, a response may still be community-led even when not termed as such with, for example, certain interventions and programmes described as “peer-led” or “community-based” still characterised by a sufficient element of community leadership and ownership. These programmes not only go beyond tokenism but are also distinct from co-creation that, even if meaningful, is limited to determining methods and means rather than priorities and goals or otherwise occurs within the bounds of strict externally prescribed criteria.[27,28,29,30]

A model for progress exists in the Global AIDS Strategy 2021-2026 which links the 30-80-60 targets on the need for community-led responses with the 10-10-10 targets for improvements in the societal enablers of the HIV response which, in turn, need to underpinned by action on the legal determinants of sexual and reproductive health—see appendix 5.2 for the text of these two sets of targets.[31] The Strategy’s model contains the potential for catalysing progress on sexual and reproductive health challenges. Firstly, through its prioritisation of community-led delivery of health services and programmes supportive of the legal and social determinants of sexual and reproductive health.[32] Secondly, creating space for genuinely community-led delivery and responses is, itself, reliant on realising improvements in the laws, policies and practices that drive progress on the societal enabler targets.[33]

Implementation of these twin sets of targets in the HIV response and their transference to other areas of sexual and reproductive health is, however, preconditioned on intergovernmental actors, national governments and other funders addressing their deficit of political will and closing financing gaps.[34] This review intends to narrow the gap between aspiration and achievements with its comprehensive scoping of the evidence available and absent on the resources needed for change as well as the benefits of action and the costs of inaction. It also lays the foundation for specific policy recommendations and a proposed agenda of further research.

The first aim of this review was to determine the types, financial requirements, and benefits of community-led responses for providing sexual and reproductive health services and how they can improve the legal determinants of sexual and reproductive health rights. The second aim was to contextualise the benefits of rights-affirming responses by mapping evidence on the benefits of laws, policies and practices that affirm sexual and reproductive rights as well as the costs of laws, policies and practices that fail to protect, provide or fulfil sexual and reproductive rights. For both aims, the review focuses on the HIV response and related sexual and reproductive health challenges experienced by the pandemic's key and vulnerable populations. Together these aims serve an overarching objective of promoting investment into and reliance on community-led responses by mapping evidence on the financial resource requirements and benefits of scaled-up community-led responses for sexual and reproductive health services and rights. This review provides an evidentiary basis for specific policy recommendations and has also delimited gaps in the literature around which we are constructing a research agenda.

Prior to commencing this review, the scoping review by Ayala and colleagues was identified as highly relevant to aim one and the systematic review protocol by Hempel and colleagues was identified as highly relevant to aim two.[35] While we have built on previous and forthcoming evidence syntheses on community responses and the law and policy determinants, our research amounts to more than sum of either review's parts. It brings these siloed bodies of evidence into dialogue with another and, thereby, interrogates the interdependency of community empowerment and legal environments for enabling sexual and reproductive health.

A search for further evidence syntheses was conducted in February 2022 to comprehensively assess the originality of the proposed topic. The search included the following databases: *JBI Database of Systematic Reviews and Implementation Reports*, *Cochrane Library* and *MEDLINE via Ovid*. The search did not reveal any additional systematic or scoping reviews on this review's topic but did find various systematic and scoping reviews on subsidiary and related topics. Of these, the relevant concerned capacity building among key populations to increase demand for access to health and rights and a review of human rights and HIV-related outcomes. [36,37] There were other partially related reviews on community-led responses for malaria control,[38] key population health system engagement,[39,40,41] sexual health,[42,43,44] and drug harm reduction.[45,46] For legal determinants there were reviews found that were related but distinct due to their narrower focus on one or two key and vulnerable population groups, a small subset among the forms of discrimination or criminalisation, or the effectiveness of particular interventions rather than broader outcomes, costs or benefits.[47,48,49,50,51,52,53,54,55,56,57,58]

Review Questions

1. With a focus on HIV and related health challenges experienced by key and vulnerable populations, what are the types, costs, benefits and financial resource needs for community-led delivery of sexual and reproductive health services and responses to stigma, discrimination, criminalisation and gender inequality?
2. With a focus on HIV and related sexual and reproductive challenges, what are the costs of implementing discriminatory and criminalizing laws, policies and practices targeting marginalized communities and key populations and, conversely, what are the benefits of implementing non-discriminatory and rights-affirming law and policies?

Scoping Review Search Strategy and Methods

Methods and Analysis

We developed and are following a participatory research strategy based on guidance from Fran Baum and collaborators in their *Participatory Action Research Glossary* and Laurel Sprague and collaborators in *Participatory Praxis as an Imperative for Health-Related Stigma Research*.[59,60] In line with integrated knowledge translation approaches, our research agenda originated with and centres the research and advocacy priorities of our partner thought-leaders from key population communities and networks.

The scoping review was conducted in accordance with *JBI Manual for Evidence Synthesis* methodology for scoping reviews.[61] This review was registered with the Open Science Framework.[62] An *a priori* protocol was developed and is available upon request. Our search strategy was informed by the *PRESS Peer Review Guideline Statement* and methods for de-duplication recommended by Wichor Bramer and collaborators.[63,64] The review's eligibility criteria were structured according to the *JBI Manual's* participant, concept, and context framework. The review is being reported in line with the *JBI Manual*, the *Preferred Reporting Items for Systematic Reviews and Meta-analyses extension for scoping review (PRISMA-ScR)* checklist and explanatory paper as well as the *JBI Manual* and the guidance by Micah Peters and collaborators.[65,66]

Participatory Action Research and Expert Consultations

In line with our commitment to participatory action research, meaningful consultation with our partners has occurred through two sets of meetings focused first on the broader research and advocacy aims of the review and second on some of the specific findings. Our review and this report have drawn on their subject matter expertise and lived experience. For example, in response to feedback and comments received in our first consultation on preliminary results with our partner organisations we introduced a variable grading Aim 1 sources by their degree of community ownership. These and following consultations guided the development of this report and also

guided the development of subsidiary products for disseminating and extending the review's findings through a policy brief and research proposal.

We have contacted experts at international organisations and research institutes involved with sexual and reproductive health rights, the societal enablers of the HIV response and community-led responses to HIV and other sexual and reproductive health issues. Those contacted had affiliations including UNAIDS, UNDP, the Global Fund, the Gates Foundation, the World Bank, WHO, the Johns Hopkins Bloomberg School of Public Health, the Geneva Graduate Institute, the Drexel Dornsife School of Public Health, and the USC Institute on Inequalities in Global Health.

Search Strategy

We have located both published and unpublished primary studies, government reports, research reports, theses and dissertations using a search strategy that encompasses both of the review's aims. First, to identify search terms, an initial limited search of MEDLINE, Embase and Google Scholar was undertaken along with extensive consultations with subject matter experts at international organisations and research institutes. Second, the text words contained in the titles and abstracts of relevant articles, and the index terms for the articles were used to develop a separate search strategy for each aim of the review with adaptations as needed for each database and other source searched—see appendices 1.1 and 1.2 for a record of the search strategies used for each database.

The databases searched include MEDLINE and Embase via Ovid, Web of Science via Clarivate, and Sociology Abstracts via ProQuest, and EconLit via EBSCO. Following the guidance of Bramer and colleagues, Google Scholar was searched twice with terms based around each aim with the first 200 most relevant results returned selected for eligibility criteria screening.[23] Further grey literature was also searched for using ProQuest Dissertations and Theses. We trialled searching HeinOnline and other legal databases with search terms related to aim two but did not have success in developing a sufficiently precise search string for this database.

Specific journals were searched for additional documents including AIDS Patient Care and STDs, Journal of the International AIDS Society, The Lancet HIV, AIDS Journal, African Journal of AIDS Research, AIDS and Behavior, Current Opinion in HIV and AIDS, BMJ Sexual & Reproductive Health, Sexual and Reproductive Health Matters, International Perspectives on Sexual and Reproductive Health, International Journal of STD & AIDS, Sexual Health, and Health and Human Rights.

Eligibility Criteria

Participants

The review targets the HIV responses' of key and vulnerable populations. This review adopted the evidence-based and epidemiologically grounded definition of key populations used by UNAIDS that presumptively centres people living with HIV, men who have sex with men, transgender people, people who inject drugs, sex workers and their clients.[67] Vulnerable populations and marginalized people include, at minimum, women and girls, in particular adolescent girls and young women, as well as incarcerated people and others living in closed settings.[68] Documents focusing on other populations were usually excluded unless the epidemiological context of the particular country or countries in question determined otherwise—for example, indigenous peoples, migrants and other LGBQTIA+ communities may be vulnerable populations in certain settings.[69] Publications that include key populations and vulnerable populations alongside others were excluded unless it was possible to separate evaluations and estimates by subgroup.

Concept

Publications were included when they concerned community-responses for guaranteeing sexual and reproductive health services and rights related to preventing, managing and treating HIV or improving the societal enablers of HIV response (aim one). Related services were adapted from those set out in relation to community responses in the Global AIDS Strategy 2021-2026 and those identified essential by the *Guttmacher– Lancet* commission on sexual and reproductive health rights 2018.[70,71] Related responses for the societal enablers include the factors identified in Global Fund's framework from the Breaking Down Barriers Initiative.[72]

Sources were also included if they concerned the legal determinants of the HIV response (aim two). These legal determinants comprise laws, policies and practices that promote, fail to support, or undermine the societal enablers of the HIV response and related sexual and reproductive health rights with a focus on rights-affirming and non-discriminatory measures as well as measures that are criminalising, discriminatory or stigmatising. The non-exclusive list of focus determinants was developed using the indicators of the HIV Policy Lab (HIVPL), our pre-scoping contextual research and feedback from consultations—see the HIVPL indicators.[73]

This review included sources with outcomes that describe, evaluate or estimate the types, financial resource requirements and benefits of community-led responses for sexual and reproductive health services or promoting rights-affirming responses (aim one). To be community-led, the responses had to fit within the definition set out in appendix 2.1 and needed to centre community leadership in a way that goes beyond tokenism, mere engagement or circumscribed co-creation.[74,75] Sources exploring community responses that did not meet this standard were

excluded. Documents not focused on community responses were, however, included when they evaluated or estimated the benefits of adopting and implementing laws, policies and practices that respect, protect and provide for the right to health and freedom from discrimination and stigma for focus populations as well as the costs of failing to make these reforms (aim two).

We prioritised studies and analyses that evaluated or estimate costs and benefits in terms of measurable gains in health (e.g. QALYs, DALYs, HALYs), fiscal returns on investment (including costs-averted), and broader economic effects—including fiscal and economic returns—of community-led and other responses to HIV/AIDS and related sexual and reproductive health challenges. At the same time, we also included documents featuring substantive evaluations or analyses of other forms of benefits and costs that are not easily quantifiable or readily reducible to accurate cost-benefit figures. As such, this review adheres to the inalienability of human rights and its eligibility criteria were designed and have been applied to reject any implication that such rights are to be respected only to the extent that doing so is economical.

Context

All documents and studies have been included regardless of the contexts or settings focused on. Global comparisons were considered relevant where cross-national data and analysis described important aspects of our focus topics in the review that could not be explained otherwise.

Types of sources

We did not consider evidence-syntheses that did not contain original research or meta-analysis. This review otherwise included all peer-reviewed and grey literature, regardless of study design. Only documents with full-text available in English were included.

Source of evidence selection

All identified citations were collated and uploaded into EndNote 20 (Clarivate) and duplicates removed.[76] The titles and abstracts were then uploaded into the web-based systematic review software *Rayyan* and, after piloting among the reviewers, screened for relevance by two independent reviewers for assessment against the eligibility criteria for the review.[77] The full text of selected citations was then uploaded into *Covidence* and assessed for inclusion in detail against the eligibility criteria by two independent reviewers—for the eligibility criteria tool, see appendix 2.2.[78] The reasons for all eligibility decisions during the full-text review were recorded and are reported in full in appendix 2.3. A third reviewer resolved disagreements between the two reviewers at each stage of the selection process. The search, screening and selection process are presented in a *PRISMA-ScR* flow diagram, below.[79]

Data extraction

Data was extracted by two reviewers working independently using a modified version of the *Covidence* data extraction tool. A third reviewer resolved disagreements into a consensus extraction as needed and in discussion with the other two reviewers where necessary. Data extracted includes details of the populations, concepts, contexts and findings with disaggregation by aim where this is illuminating. This tool was piloted and revised during the process of data extraction with the draft version set out in appendix 3.1 alongside an explanation for key extraction criteria in appendix 3.2. The complete extractions from and the original full text files for all included studies may be found at this link. A reference list of included studies may be found in appendix 4.1.

Data analysis and presentation

Results are presented graphically and with tables accompanied by a narrative summary to describe how the results relate to each of the review's aims and its overall objective.

SCOPING REVIEW RESULTS

Our search strategy identified 6,093 sources of which 3,291 were unique and 2,802 duplicates. The titles and abstract of the unique sources were screened for relevance with 2,072 deemed irrelevant and a further 270 removed due the lack of available English language full-text records. To the remaining 958 sources we added a further handpicked 194 from our pre-scoping searches, consultations with experts, and scrutiny of the bibliographies of key sources, including existing evidence syntheses. Of the 1,143 sources subsequently subject to full-text eligibility assessment, 356 were included and 787 were excluded. During data extraction, 86 were coded as relevant to aim one, 253 as relevant to aim two, and 16 as relevant to both aims. The below *PRISMA-ScR* flow diagram sets out this process graphically.

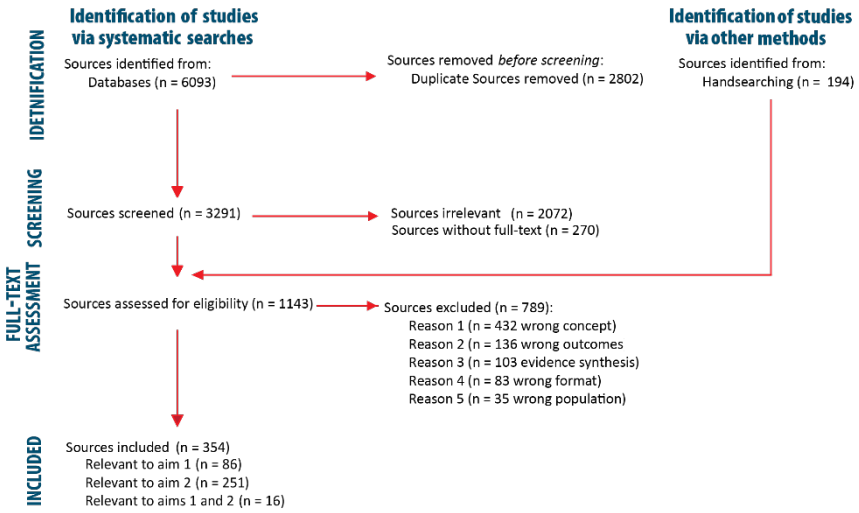

Figure 1: PRISMA-ScR Flowchart

Results for Aim One

Overview of results

Of the sources included, the majority were published within the last four years with a steady trend toward more relevant sources being produced—see figure 2, below. This reflects a shift in the types of community responses being actioned, funded and documented. Indeed, this can be traced to the introduction of the Community Systems Strengthening Framework by the Global Fund in 2010.[80] The framework relies on community-led structures as one of its core components. Later, the 2016 Political Declaration on HIV and AIDS included the commitment of "expanding community led service delivery to cover at least 30 per cent of all service delivery by 2030."[81] The increasing frequency of relevant sources will reflect the shifts in the types of responses funded and researched as a result of the institutional changes these documents produced and were produced by. The trend likely also reflects a shift in the terms and language caused being used to describe community-led responses within published literature. This review's search terms and eligibility criteria are likely weighted toward modes of describing and conceptualising community responses and leadership more common in recent sources despite efforts to balance against this.

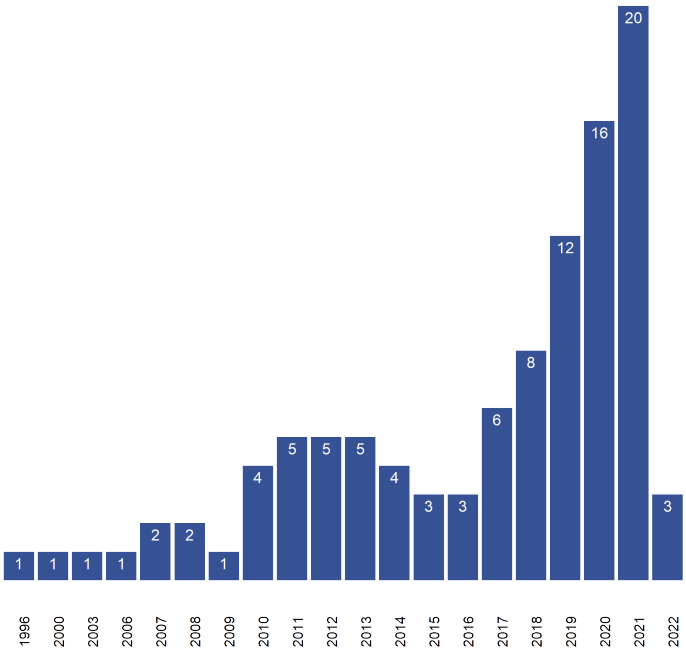

Figure 2: Year of source publication under Aim 1

The sources included under this aim are largely comparable to the settings and circumstances of the Love Alliance countries. Of the 103 sources coded as informative of this review's first aim, 21 explore a Love Alliance partnership country setting with certain sources exploring more than one. Morocco and Egypt are, however, not among these and this may be a result of our search being limited to English language results. See figure 3 below for the relative frequency included sources explore the ten focus countries. A further 56 sources explore at least one country setting deemed similar to those of the Love Alliance countries. In the case of 10 sources this is because they feature countries in the same or neighbouring regions to the Love Alliance countries. A further 46 were coded as similar because they feature low- and middle-income countries. A final 26 studies focus on high-income settings and were coded as dissimilar.

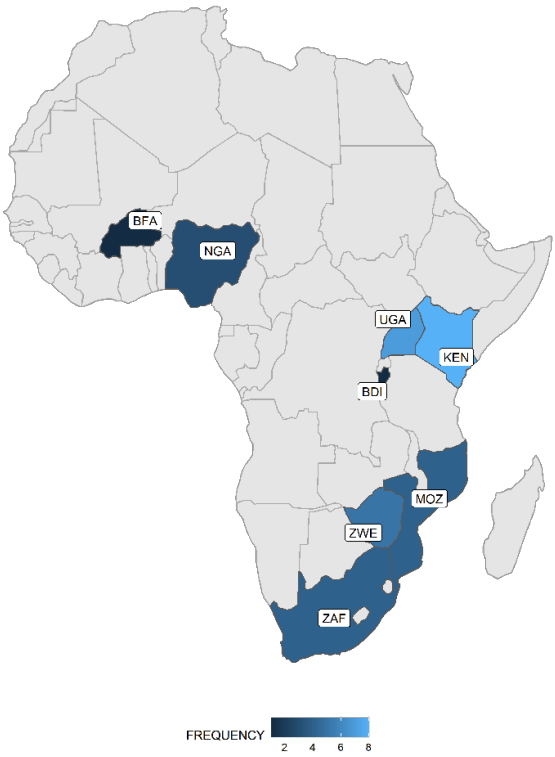

Figure 3: Love Alliance countries under Aim 1

Within the sources included under aim one, the population most featured is sex workers followed by men who have sex men, people living with HIV, transgender people and then people who inject and use drugs. Many of these sources concerned more than one of these populations and people among them with intersecting identities. This is reflected in the large number of sources that have been coded with “other” observations which often encompassed intersecting identities as well as additional priority groups. See figure 4, below.

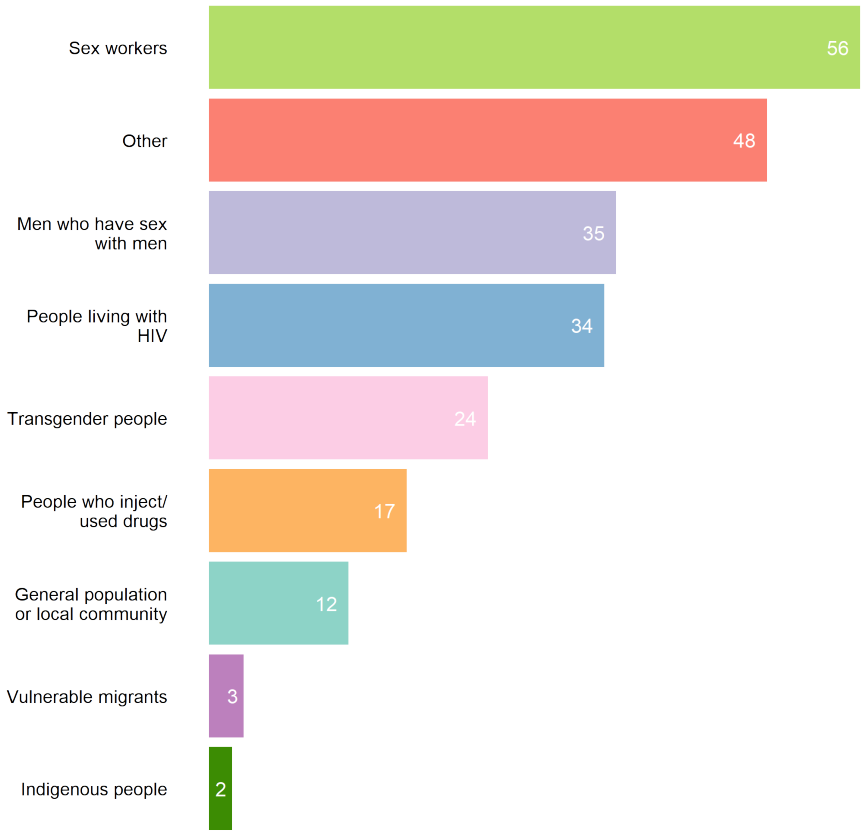

Figure 4: Focus populations under Aim 1

Of the sources, 14% used qualitative and quantitative methods, 39% used qualitative research methods, 58% used quantitative research methods. Among these, the most common study type was observational followed by descriptive and experimental (see figures 5 and 6, below).

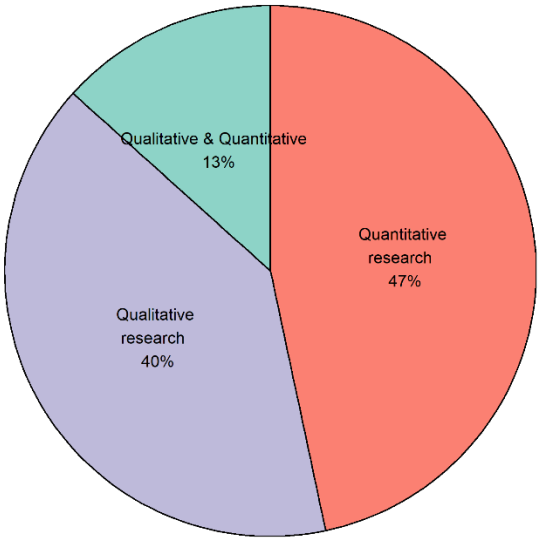

Figure 5: Aim 1 sources study method

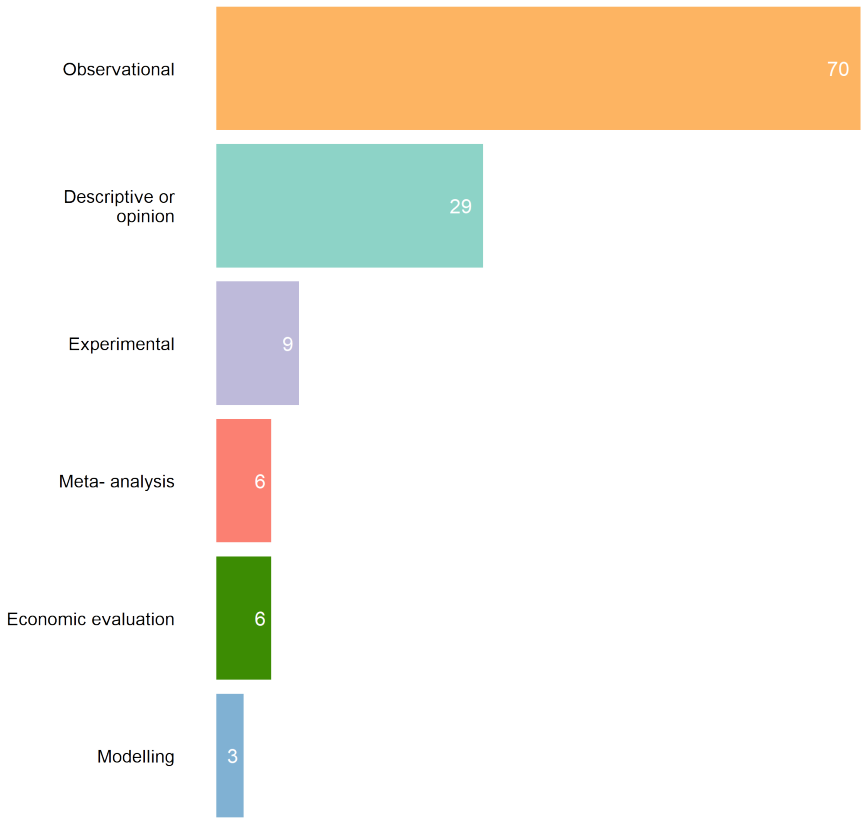

Figure 6: Aim 1 sources study type

Community-led responses and organisations

Of the 104 sources under aim one, we have two constellations of organisations and responses that are featured more than once: those associated with the Avahan Initiative and those associated with the Durbar Mahila Samanwaya Committee (DMSC).

Close to quarter of the sources, 22, describe responses initiated, funded and often implemented as part of the Gates Foundation funded Avahan India AIDS Initiative. This encompasses Project Parivartan and Project Pragati as well as work completed by implementing organisations Swasti and Care-Saksham. Numerous, often unnamed, community-led organisations and subgroups are established as part of and involved in leading, to a lesser or greater extent, these organisations. Particular mention is made of Swathi Mahila Sangha, Nari-Saksham and, most notably, the Ashodaya Samithi collective. The Ashodaya Samathi collective, including its subgroups Adarsha and Ashraya, are the focus of nine different sources.

Four sources described responses, including the Sonagachi Project, led by DMSC and its associated sex worker-led organisation Sampada Grameen Mahila Parishad (SANGRAM) and the Veshya AIDS Muqabla Parishads (VAMPs) collectives (#445, #3251, #874, #177). Although the model used to establish Ashodaya was based on the DMSC (#86), the DMSC evolved organically out of a peer-led community intervention.

Other organisations featured as the focus in more than one source include Queensland Positive People (n = 3) and the International Treatment Prepardness Coalition (ITPC) (n = 2) (#234, #367, #149, #108, #459). Two responses featured in more than source include Princess PrEP (n = 2) and Project Shikamana (n = 2) (#399, #774, #155, #1811).

The frequent reappearance among our included sources of responses connected with the Avahan Initiative reflect the extensive research conducted alongside these interventions due to its scale and collection of data that could substantiate this research.

Tensions in rating community-ownership

Our method for rating community ownership during data extraction is set out in appendix 3.2 and based on our discussions with the Love Alliance partners as well as the definitions of community-led responses and organisations set out in appendix 2.1. As noted already, in each of our two partner consultations there were tensions regarding the definition of

community-led responses which, after the first, caused us to introduce this variable grading responses by their "community ownership". Many of these ratings were adjusted after our second consultation which included feedback and discussion on our overall approach to making the ratings and the specific ratings we arrived at for various responses.

As issue which was subject to further discussion at a third meeting with interested Love Alliance partners was whether we need to further adjust our ratings to remove responses led by organisations that were established and designed by external initiators from the "high" category into the "medium" category. This point of feedback applied, in particular, to responses from organisations established and funded under the Avahan-India AIDS initiative, including those led by the Ashodaya Samithi collective.

The review team's initial stance was that a community-led organisation established by an external initiator and funder could, eventually, graduate into independence and from there lead community responses with a "high" degree of community ownership. There was, however, much to be said in favour of the contrary position. In response to feedback we have applied a stricter criterion on this point.

Community-ownership of included community-led responses

Of our 103 aim one sources, four were modelling or prospective studies that could not be rated, eight could not be rated because they described various community-led responses of differing qualities, and the remaining 90 were rated for community ownership. Of these 28 were rated "high", 38 were rated "medium", and 22 were rated "low" for community ownership (see figure 7, below).

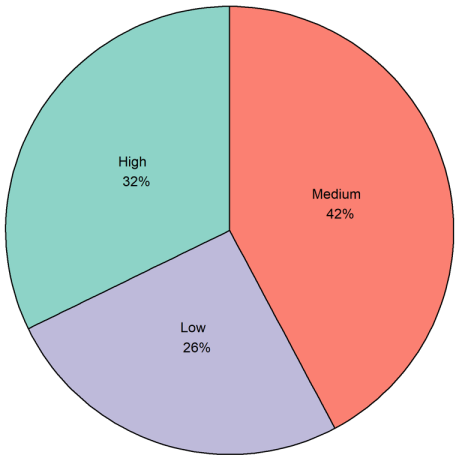

Figure 7: Aim 1 community ownership ratings

In general, responses rated as "high" when principally initiated and implemented by one or more community-led organisation. Difficult case

concerned organisations that, although community-led, were not endogenous community projects but, rather, part of exogenous donor, government or non-governmental initiatives. In these cases, responses often rated as “medium” instead of “high”.

In line with this, apart from responses led by the Ashodaya Samithi collective, all responses associated with the Avahan Initiative were rated either “medium” or “low” for community ownership. For example, Swasti, an NGO, and Swathi Mahila Sangha, a sex worker collective, together implemented the Pragati programme which included provided sexual health services as well as responses targeted toward key determinants of health such as financial wellbeing, addiction and violence.[i] Despite involving a community-led organisation and regular consultation with the broader community, it was rated “medium” due to insufficient evidence showing that Swathi Mahila Sangha had ownership of the design of the response and the structures of its governance. It, instead, appeared that Swathi merely received a model from Swasti and the Avahan Initiative that they were only empowered to implement.

By contrast, the Ashodaya Samathi collective’s responses were in four cases rated “medium” and in five rated “high” for community ownership. These differences in ratings for the same organisation’s responses and the ratings given other Avahan Initiative associated responses turned on the particular descriptions of specific responses provided in the sources. The judgement of our review team was that Ashodaya Samathi had, as an organisation, sufficient independence from its originators as demonstrated by its over sixteen years of operation, fourteen years with independent democratic governance procedures, and its independent establishment of subsidiary initiatives based on community needs. This did not, however, mean that all of its responses were characterised by “high” community ownership. For example, a number of sources describe response being led by the collective that was, nonetheless, clearly externally driven: The PrEP Demonstration Project (#345, #306, #66). In these cases, Ashodaya was only rated as having “medium” ownership for merely implementing a demonstration of community-led provision of PrEP under tightly circumscribed criteria necessary for the production of evidence.

Unlike the Ashodaya Samathi collective and other organisations associated with the Avahan Initiative, Sonagachi Project was not a response based on a prefabricated externally initiated model. Partly due to this difference, all the responses under DSMC and related organisations were rated “high” for community ownership. Responses predominately initiated and owned by

[i] #2734

what appeared, based on the sources, to be similarly organic community-led organisations were also rated as high. Similar examples also rated "high" include responses led by the sex worker-led Scarlet Alliance in Australia, the Kenyan Grassroot Organization Operating Together in Sisterhood (GROOTS), the New Zealand Prostitutes Collective, CHAI (the Uganda Community-led HIV/AIDS Initiative) and organically formed community savings groups among female sex workers in Tanzania.[ii]

In other cases, responses were rated as "medium" or "low when the source in question did not provide enough detail to establish a "high" or "medium" level of community ownership. For example, Consumidores Associados Sobrevivem Organizados (CASO), an association of people who use drugs, was involved with an intervention to provide mobile drug consumption rooms but the source was unclear on whether their involvement went beyond providing recommendations and data collection (#289). Because we could not determine whether CASO implemented the response and how much weight their recommendations were accorded in the planning process, the response was rated "medium" rather than "high".

In general, responses were rated as "low" when there was a significant community-led element within a nonetheless predominately externally framed and driven programme. Usually this element was one of service delivery with control over the response extending only to shaping and improvising form at the point of implementation. For example, the *Sisters with a Voice* programme in Zimbabwe is a top-down government programme with services delivered by sex workers using their networks of community mobilisation and leadership at the point of implementation (#437). Despite elements of community leadership, the response is couched in an overall agenda and plan set by public actors, based out of clinical settings, and supervised by non-sex worker outreach workers.

That less than a third of the community-led responses are rated as having "high" community ownership reflects, in part, the general landscape of funded and researched interventions. It is, however, also a product of our inclusion criteria which narrow the literature down to sources that explore community-led responses with specific outcomes for health and the determinants of health. As is noted next, the types of responses with observable outcomes of this nature are more likely to be focused on services and, because of this, will be more entwined with health system actors and funders which have traditionally prioritised these interventions.

[ii] #3035, #148, #3264, #217, #439

Types of community-led responses

As set out in 30-80-60 targets for community leadership, we have committed to ensuring a broad range of community-led responses including delivery of testing and treatment, programmes for the societal enablers, and prevention programmes. In particular, 60% of all programmes for the achievement of societal enablers are to be delivered by community-led organisations. Despite this, the literature on community-led responses eligible for inclusion in this review is heavily focused on responses for and concerning services.

Three of the five most common observations extracted from our sources on the focuses of described community-led responses are delivery (n = 82), monitoring (n = 44) and advocacy (n = 38) for health services for 164 service related 164 observations out of a total 374 observations for the variable or 44%. Responses also commonly focused on the community's own capacity (n = 60; 16%) and other determinants of health, e.g. financial wellbeing and housing (n = 44; 11%). By contrast, community-led responses related to legal and other structural determinants of health make up only 27% of the total and are among the least common observations with educating to change practices (n = 34), law and policy reform advocacy (n = 36), human rights, law and policy monitoring (n = 17) and legal support within community (n = 14) trailing behind responses aimed at services, community capacity and social determinants (see figure 8 below).

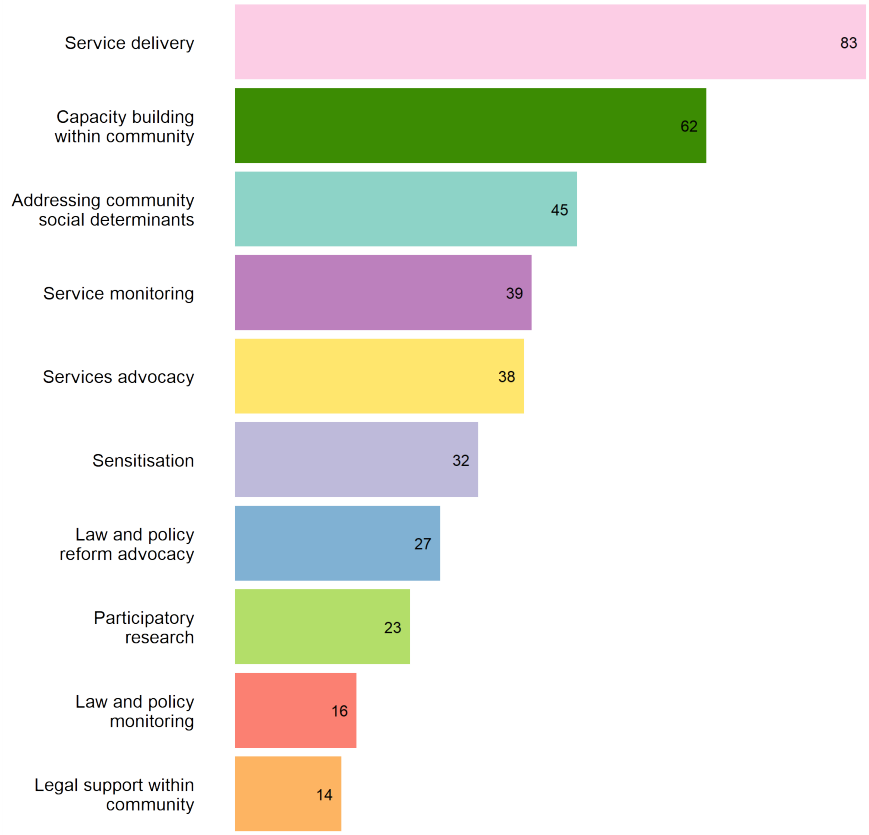

Figure 8: Types of Aim 1 responses

There are interesting differences when we split results for the same variable by level of community ownership (see figure 9, below). For responses with “high” community ownership 34% % (n = 40) of observations relate to services, 30% (n = 39) relate to improving legal determinants, 17% (n = 21) relate to community capacity building, and 14% (n = 17) relate to improving other social determinants. Compare this to responses with “medium” community ownership (118 observations) for which 45% (n = 54) relate to services, 19% (n =22) relate to community capacity building, 11% (n = 13) relate to improving social determinants and only 17% (n = 21) relate to responses for improved legal determinants. Finally, for responses with “low” community ownership 55% (n = 39) relate to services, 17% (n = 12) relate to community capacity, 10% (n = 6) relate to improving social determinants and only 14% (n = 9) relate to responses for improving legal determinants.

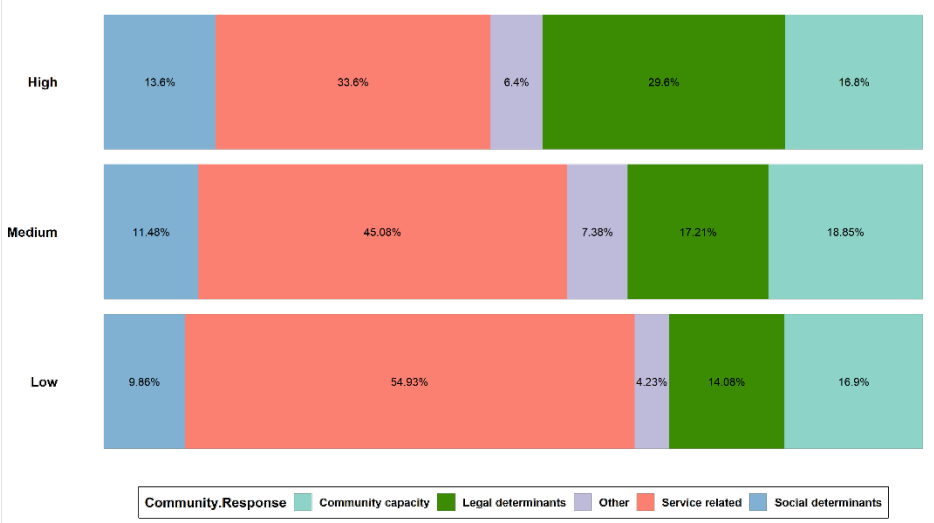

Figure 9: Types of Aim 1 responses split by community ownership

While a similar proportion of responses were targeted toward community capacity (17%, 19%, 17%) and the social determinants (14%, 11%, 10%); across all three levels of community ownership, there are significant difference when we compare the proportion of those aimed at legal determinants (30%, 17%, 14%) against those aimed at services (34%, 44%, 54%). The clear conclusion is that community ownership affects the target of community-led responses and, compared with external actors, communities consider legal and other structural determinants a higher priority and services a lower priority. This is also important because the literature's focus on responses with less community ownership and the differences in the focuses of responses based on ownership means the included sources only provide a partial evaluation of community leadership's potential.

This difference in priorities is also important because it indicates us enhancing community ownership is one mechanism for ensuring on-the-ground programmes are in line with our global commitments. More specifically, achieving the 30-60-80 targets requires accelerating implementation of the relatively under-implemented commitment that 60% of programmes for advancing societal enablers be delivered by community-led organisations.

Benefits of community-led responses

Unsurprisingly given the eligibility criteria, all sources cited benefits to health that were either direct, indirect or mediated through improvements to the social determinants of health. In none of sources included under aim one was there a health benefit set out in terms of health adjusted life years (HALYs), quality adjusted life years (QALYs) or disability adjusted life years (DALYs). Benefits for HIV and related sexual and reproductive health challenges from the community-led responses described in our sources are rela-

tively evenly observed for prevention (n = 77), service access (n = 67), service quality (n = 67), and service demand, retention and utilisation (n = 63). Specific benefits in the form of reduced HIV incidence are only recorded in 15 sources.

Generally, health benefits are described in terms of clinical or epidemiological indicators. These are commonly preventive outcomes such as number diagnosed or the number initiating PreP.[iii] Fewer sources explore the phase after diagnosis to describe benefits in terms of access to treatment as well as access and adherence to ARTs.[iv] Among the most frequently cited benefits in the sources is an increase in condom use, which is often directly associated with a decrease in sexual transmitted infection prevalence or incidence.[v]

The sources also describe benefits using qualitative indicators to represent individual circumstantial and behavioural changes that enhance a person's willingness or ability to access health services.[vi] These includes health literacy skills such as an increased ability to understand HIV risk status and interpret test results, and better negotiation skills for safer sex practices.

Various sources analyse the intersection of HIV and other health services. For example, there are studies exploring mental health related outcomes, including psychological distress and referral to psychological services.[vii] Other interventions look at the impact of community-led services on harm reduction services, such as syringe exchange programs or the prevalence of oral drug use.[viii] Similarly, studies explore the intersection of HIV and broader sexual and reproductive health services, including one focusing on maternal health and another on family planning among female sex workers.[ix]

Nearly half of the sources (n = 51) cited increased community capacity, as many (n = 51) cited structural impacts, such as equity, as a benefit (n = 51)

[iii] #2734, #297, #226, #552, #149, See #543, #533, #388, #142, #104, #102, #86, #362, #160, #116, #55, #774, #437, #399, #165, #66

[iv] #886, #2963, #860, #17, #392, #785

[v] #3251, #2786, #2921, #442, #149, #117#227, #453, #2933

[vi] #1811, #151, #309, #115, #138, #197, #3251, #431

[vii] #892, #251

[viii] #395

[ix] #459, #155, #267, #785

and, of these 31 sources cited both increased community and structural impacts as benefits. In only four of the sources included were fiscal benefits such as costs averted or return on investment cited.

Structural impacts included the acquisition of new skills within the community, especially ones relevant for policy reform or the monitoring of laws, policies and practices.[x] Most sources highlighted the long-term benefits of community-leadership for the effective development and timely implementation of relevant and efficient programs. Among the sources citing community capacity, one commonly described benefit was community empowerment through a better definition of community identity and its effectiveness to enable structural changes.[xi] Financial and housing security were cited as a benefit of community-led responses within four sources that explored economic empowerment and social determinants.[xii]

A significant number of sources explore the benefits of community-led responses aimed toward reforming or sensitising external actors such as the police.[xiii] These efforts involved community-led groups, most often sex worker-led organisations, targeting law enforcement officials and their discriminatory treatment of HIV focus populations to lessen violence and increase physical security.

The pathways for realising these benefits include the securing of rights (see figure 10, below) and the provision of services (see figure 11, below). As is to be expected given the emphasis on service related goals within our includes sources, the sexual and reproductive health rights most frequently observed are related to services. This is likely also a function of our health outcome-oriented inclusion criteria and the types of conclusive benefits

[x] See #543, #533, #388, #142, #104, #102, #86, #362, #160, #116, #55
[xi] See #2921, #2786, #863, #227, #106, #266
[xii] #142, #114, #2734, #887
[xiii] #3251, #197, #55, #277, #226, #53

that can most easily be observed within the timeframe of standard research.

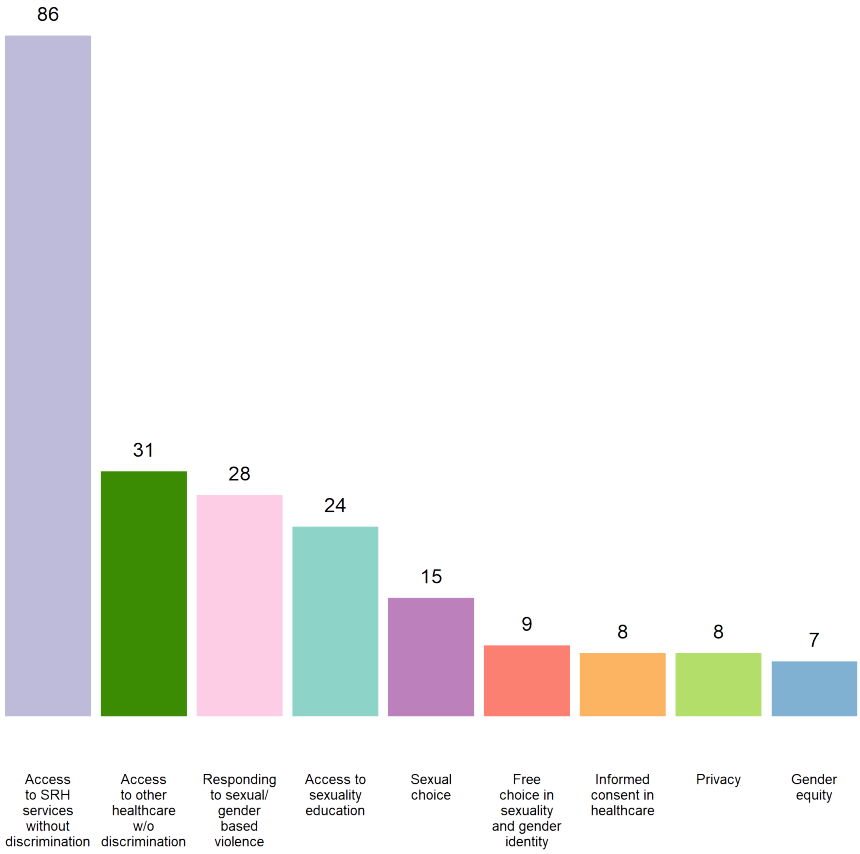

Figure 10: Sexual and reproductive health rights in Aim 1 sources

In total, the included sources cite 458 benefits associated with community-led responses ranging across all areas of the 30-80-60 targets including testing and treatment, prevention, and programmes for the societal enablers. The value of community-led responses is, accordingly, clear to the extent that they have been found repeatedly to be of benefit in responding to all the pressing issues they are called to address in our global commitments.

Despite these diverse findings associating the responses with various benefits, there is an absence in the included literature on the current share of services and programmes delivered as part of community-led responses both globally and in individual countries. This is a glaring issue given that the quantitative targets in Global AIDS Strategy specifically require that, by 2025, 30% of testing and treatment, 80% of prevention and 60% of societal

enabler programming are to be delivered by communities globally and within countries.

A systemic issue is that studies, implementers, and funders do not accurately distinguish or commonly disaggregate in publicly available information between community-based interventions and community-led interventions. This partly because, although there is a well-accepted definition of community-led responses that originates with communities, its application can be challenging. This can be seen within this study in the differences in the community ownership of relevant interventions and the fact that even certain interventions labelled as "community-led" were excluded from this study for not meeting the standard of what we classify as low community ownership. A result is this glaring research gap which leaves us in the dark as to how well the global commitments on the 30-80-60 targets are being met.

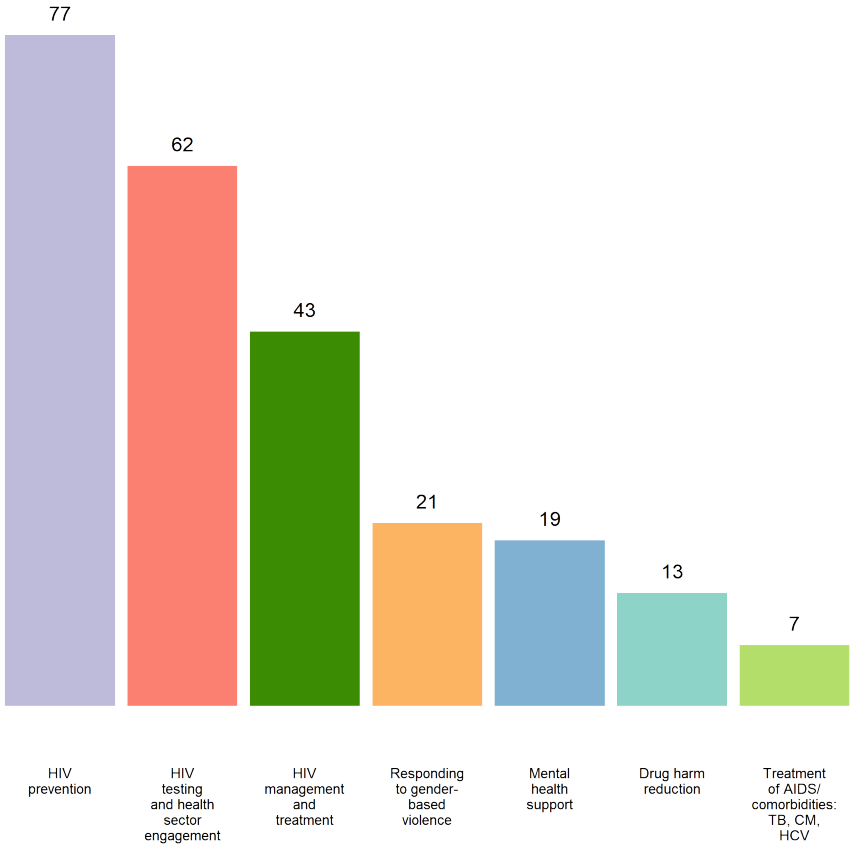

Figure 11: Sexual and reproductive health services in Aim 1 sources

Funding, financial and other resource requirements

Of our sources included under aim one, 31 of these did not contain extractable information on financial and other resource requirements of

community-led responses. Of the remaining 75, 34 sources look at both financial and other resource requirements, 29 covered only financial resource requirements, and 11 sources only at other resource requirements (see figure 12, below).

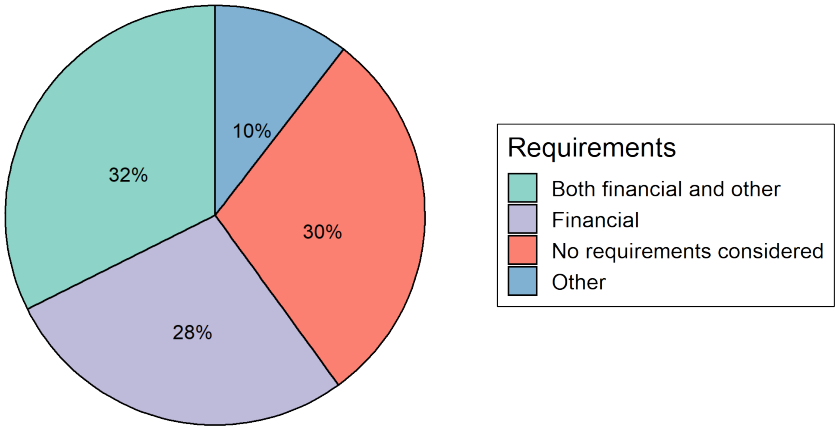

Figure 12: Financial and other resource requirements in Aim 1 sources

Of the sources that investigated financial resource requirements, seven also assess cost-effectiveness and two identified relative cost savings. Four of these found the responses they explored to be cost-effective[xiv] while two had mixed findings[xv] and one found the response in question to be cost-ineffective.[xvi] The four studies finding cost-effectiveness encompassed a digital community-led prevention and legal rights education response (rated with high community ownership) and three responses focused on the community-led distribution of HIV self-testing kits—one through peer networks of men who have sex with men (medium community ownership) and two within local village groups (both low community ownership). One of the two sources with mixed findings was a meta-analysis of various interventions and the other concerned self-testing (low community ownership) The one finding of cost-ineffectiveness turned on the particular design of a self-testing intervention in an area with low prevalence of undiagnosed HIV (high community ownership). The two studies that identified cost-savings were both assessments of responses carried out as part of the Avahan initiative and compared the community-led responses with government-run targeted interventions in India.[xvii]

[xiv] #246, #305, #333, #686
[xv] #55, #167
[xvi] #548
[xvii] #142, #2734

The predominance of studies focused on assessing particular self-testing campaigns in discrete areas and over specific periods of time shows a limitation of and gap in the literature. That is to say, the cost-effectiveness of community-led responses implemented to scale and over a prolonged period of time is not generally being assessed. The particular need for scale and long-term investment is acute in the case of community-led responses that often will require capacity building to realise the advantages of co-creation and scale to maximise cost-effectiveness—for one of the Avahan interventions increasing scale is recorded as reducing relative costs.[xviii] Further, we also see that a number of these responses were not characterised by a high degree of community ownership and were, instead, externally initiated interventions.

In many cases, the types of information on resource requirements was not in depth and only briefly alluded to resource needs or funding sources. In certain cases, however, specific resource requirement figures were provided.[xix] Those specific figures, evaluations and estimates that are found in the sources vary substantially as is to be expected given the wide variances in types of response and settings under consideration. For example, one assessment of a targeted HIV prevention programme for sex workers found a cost of US$1.5 per person helped per year which was cheaper than comparable programmes without a community-leadership component.[xx] Another similar study found a cost of US$38 per sex worker per year as part of an intervention which was equivalent to the cost of comparable national programmes but with a greater range of services delivered. In another intervention, the total financial resource requirement is cited as being $285,065 with 46% of this being human resources, 23% for HIV self-testing kits and 8% for vehicles.[xxi]

Sources of funding identified varied with the main categories being government, donors, user fees and voluntary contributions from community members and implementers. The reliance of many community-led responses on the time, money and other resources of volunteers is characterised in our sources as both a strength and weakness. In many cases, community volunteers remaining unpaid or underpaid and, in many cases, providing financial support to the response is left unquestioned and, thereby, naturalised.[xxii] In other sources, reliance on unpaid or underpaid volunteers is identified as a cost-saving advantage of community-led

[xviii] #2734
[xix] #142, #431, #2734
[xx] #142
[xxi] #333
[xxii] #126, #167, #193, #305, #494, #548, #686, #863

response.[xxiii] For example, one study notes how 'Unpaid volunteers alone add an estimated 56 percent, on average, to CBO [community based organisation] budgets in Kenya, Nigeria, and Zimbabwe'.[xxiv] In a few sources, the sustainability and limitations of leaving volunteers unpaid, underpaid and under-resourced are questioned.[xxv] We see in many cases workers being paid wages and volunteers being paid small fees or inducements—although even in these cases it is unclear whether the level of remuneration is appropriate or sufficient.[xxvi] For example, in one study we see a $40 fee paid to trainees for attending different types of sessions as part of a sex worker-led response.[xxvii]

Numerous sources raise resource requirements and funding as problems and challenges for community-led responses. We see community-led organisations shuttering or reducing programmes due to an insufficient and uncertain funding.[xxviii] In particular, where funding is limited to narrow vertical interventions via social contracting reimbursements from government or as part of donor driven priorities, we see community priorities underfunded and overall community capacity building under-resourced.[xxix] Funding interruptions and shift in governance arrangements are also identified as causes for community ownership over responses either failing to eventuate or degrading.[xxx] Conversely, we see in one case funding for specific targeted interventions being leverage to rejuvenate and build capacity for broader community-led responses.[xxxi] Specific consequences of challenges related to underfunding and lack of other resourcing are left unexplored in certain sources.[xxxii]

Underpinning the 30-80-60 targets on community leadership in the HIV response was the commitment to ensure the sustainable financing of community-led organisations and networks. The source included within this review indicate that this commitment serves to address a pressing concern that is broadly reflected in the literature. Ensuring adherence to it, will, accordingly, be crucial for achieving the targets as a whole.

Results for Aim Two

[xxiii] #55, #277, #333
[xxiv] #55
[xxv] #106, #148, #354, #2925
[xxvi] #289, #431
[xxvii] #431
[xxviii] #354, #442, #785
[xxix] #227, #345, #354, #442, #494, #785
[xxx] #229, #345
[xxxi] #306
[xxxii] #224, #305, #533

Overview of results

Of the sources included, there is a more even distribution of sources across the last 15 years than is seen for aim one. The trend toward more frequent eligible publications since the early 2000s likely reflects the increasing emphasis on stigma, the structural determinants and the societal enablers of the HIV response as well as the limitations of the language in our search terms and the collections of the databases we accessed (see figure 13, below). To some extent, the long-standing and steadily accumulating evidence on this point may also reflect both the urgency raised by the significant harms criminalisation causes and prevailing inaction despite this evidence.

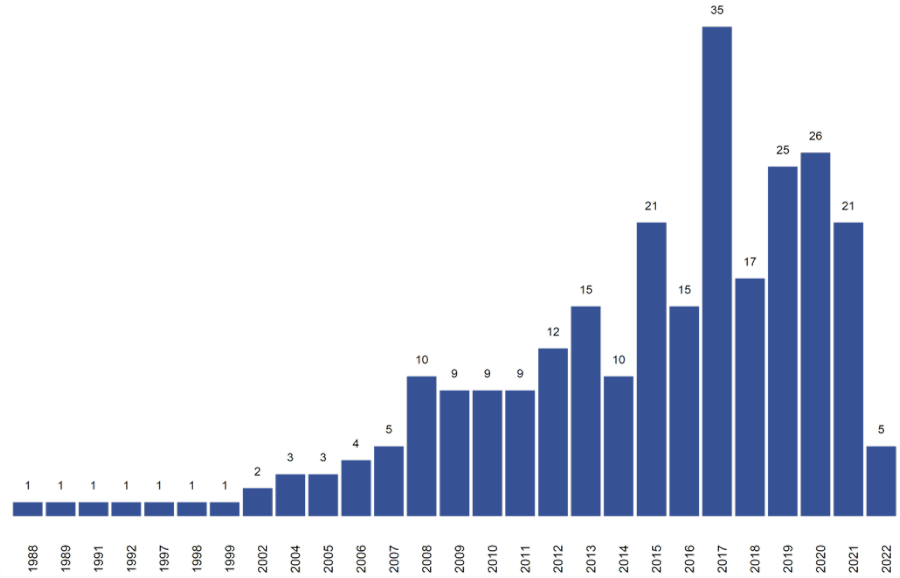

Figure 13: Aim 2 sources by year of publication

Of the 267 sources coded as informative of this review's second aim, 59 explore a Love Alliance partnership country setting with certain sources exploring more than one. Burundi is not, however, not among these. See figure 14 below for the relative frequency our sources explored these ten focus countries. A further 88 explore country settings deemed similar to those of the Love Alliance countries. In the case of 13 sources this is because they feature at least one country in the regions and neighbour regions of the Love Alliance countries. The remaining 75 sources are similar because they explore low- and middle-income countries. A further 91 studies focus on high-income settings and were coded as dissimilar. A final 23 sources do not contain all the countries they explored in their full-text.

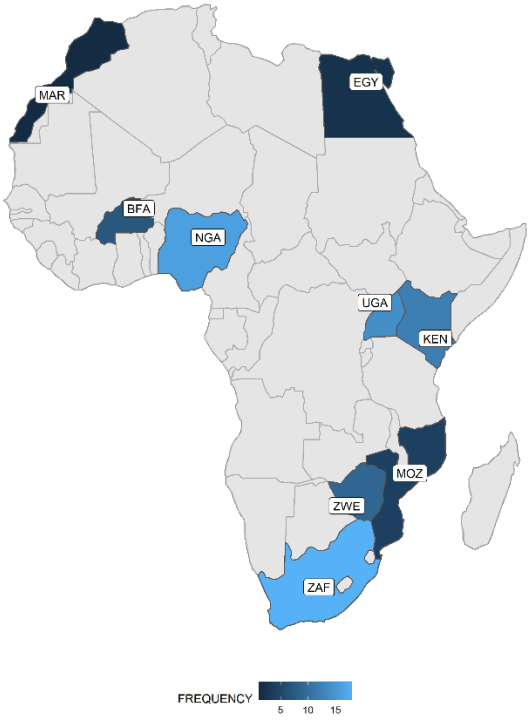

Figure 14: Love Alliance countries under Aim 2

Within the sources included under aim two, the population most featured is people living with HIV (n = 119), followed by sex workers (n = 115), men who have sex men (n = 81), people who inject and use drugs (n = 49) and transgender people (n = 45). As with aim one, many of these sources concerned more than one of these populations and people among them with intersecting identities. See figure 15, below.

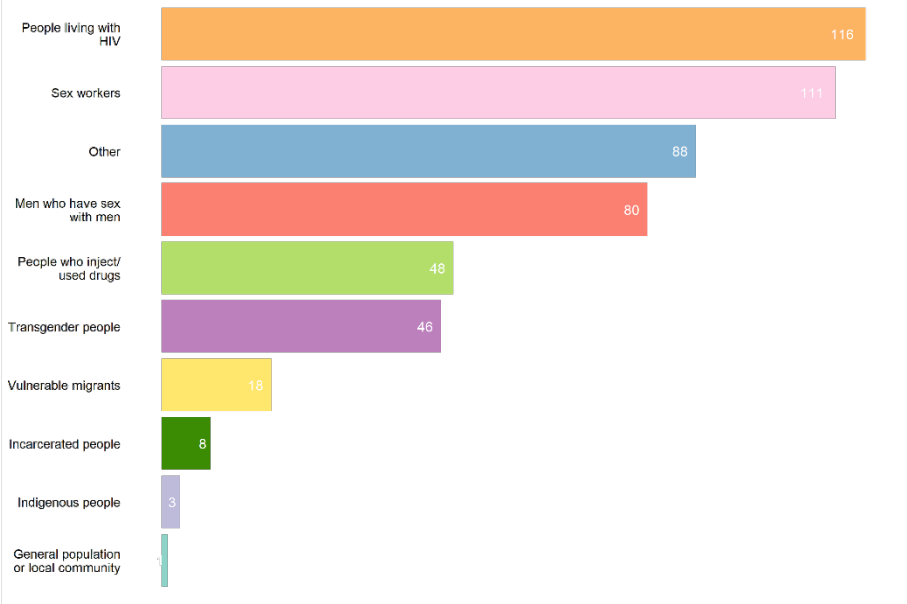

Figure 15: Aim 2 focus populations

Of the sources, 65% used qualitative research methods and 35% used quantitative research methods (see figure 16, below). Among these, the most common study type was observational followed by descriptive and then modelling (see figure 17, below).

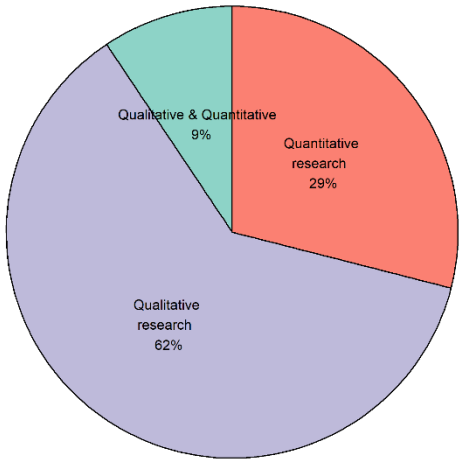

Figure 16: Aim 2 sources study methods

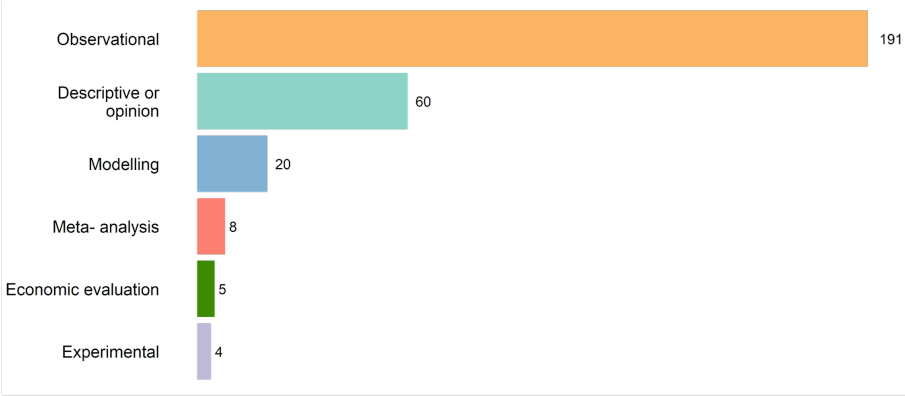

Figure 17: Aim 2 sources study type

Laws, policies and practices addressed

Among the aim two sources, the legal pathways to relevant outcomes are more often negative legal determinants than they are positive. In merely 19 sources are there only positive legal determinants observed whereas there are 186 sources in which only negative legal determinants are observed. There are a further 63 sources in which both negative and positive legal determinants are observed. This is despite having a search strategy and inclusion criteria that was equally open to both negative and positive laws, policies and practices. This shows that relevant the literature focuses more on the cost of negative legal determinants than benefits of positive legal determinants.

For both the positive and negative legal determinants observed, we see discrimination, criminalisation and access to health services predominating across the sources (see figure 18 and figure 19, below).

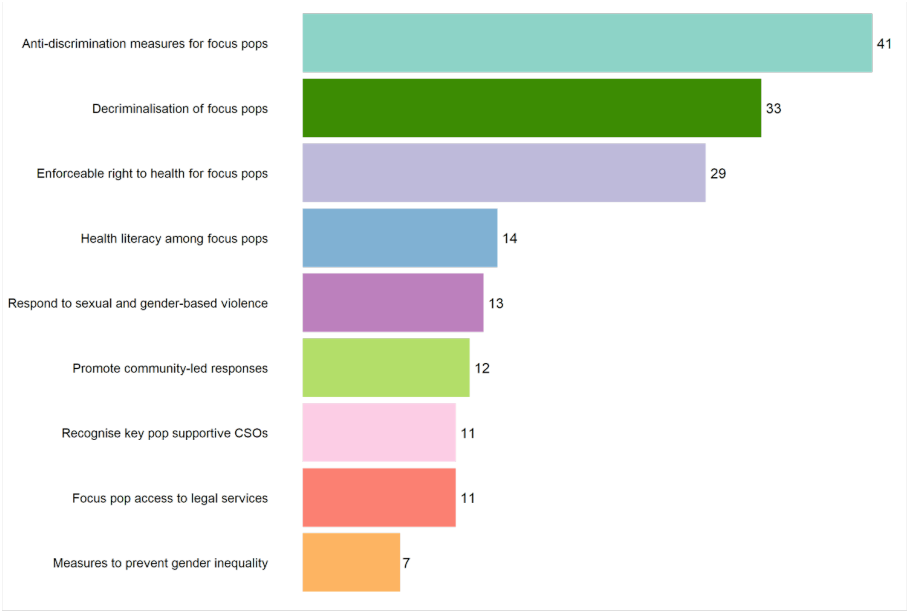

Figure 18: Positive legal determinants in Aim 2 sources

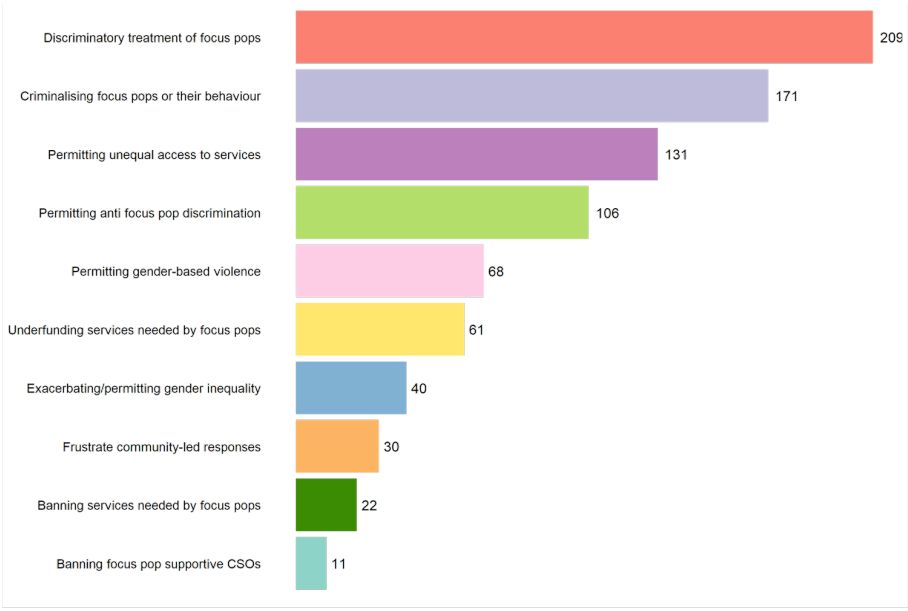

Figure 19: Negative legal determinants in Aim 2 sources

Costs addressed

All but one of the included sources described costs or benefits of legal determinants in terms of impacts on health whether direct, indirect or mediated through the social determinants. This one source focused on the structural impact of laws, policies and practices aimed at reducing the ability of civil society to organise in favour of sexual and reproductive health

rights.[xxxiii] In none are relevant costs described in terms of HALYs, QALYs, or DALYs.

Among the most commonly described costs of negative laws, policies and practices described in the sources is the effect that criminalisation and discrimination have on utilisation of and access to health services, including preventive and harm reduction services.[xxxiv] Often observed in the same sources are the harms from criminalisation and discrimination affecting the quality and acceptability of health services.[xxxv] Certain sources interrogate the legal soundness and reasonableness of criminalising HIV transmission by pointing to issues of consent, burden of proof, disclosure and prosecutorial discretion.[xxxvi] Various negative laws, policies and practices, including most prominently criminalisation, are also more directly associated in the sources with reduced availability, accessibility and adoption of harm reduction services and practices.[xxxvii] The types of harm reduction referenced include sex work harm reduction, practices for harm reduction among those who use drugs, and services to reduce harms for those who use drugs.[xxxviii]

The sources also associate various negative legal determinants with direct harms to health including greater risk of HIV, reduced status awareness and

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[xxxiii] #3249

[xxxiv] See #3078, #2978, #2741, #3125, #3055, #2876, #3008, #2995, #2770, #2803, #2897, #3170, #2845, #2825, #55, #2698, #85, #2726, #2832, #2812, #3062, #2911, #3097, #406, #3126, #2705, #3129, #2874, #3073, #2902, #2979, #2712, #176, #2932, #454, #2887, #2887, #2838, #2951, #3150, #3250, #2696, #2798, #2747, #64, #2843, #2850, #2896, #3252, #2867, #2813, #3112, #559, #511, #3036, #2757, #2943, #3114, #3017, #25, #429, #323, #510, #2814, #3127, #357, #3248, #3146, #2898, #197, #3014, #3121, #2965, #571, #161, #3261, #3080, #3216, #126, #2998.

[xxxv] See #3078, #2946, #3020, #3055, #2995, #2770, #2803, #2771, #2897, #3222, #3005, #3041, #2825, #589, #2673, #2765, #2726, #3062, #3097, #406, #3073, #2902, #2979, #2712, #2785, #3150, #2798, #2732, #2843, #2850, #2896, #2931, #3252, #2813, #511, #3036, #3019, #3102, #3114, #3017, #429, #2811, #3127, #357, #126.

[xxxvi] #2805, #2709

[xxxvii] See #7, #161, #184, #323, #571, #559, #2750, #2766, #2773, #2795, #2802, #2852, #2874, #2887, #2898, #2928, #3005, #3026, #3045, #3062, #3014, #3080, #3097, #3106, #3126, #3140, #3146, #3130, #3155, #3181, #3193, #3247, #3202, #3230, #3226, #3773,

[xxxviii] See #2928, #3005, #3062, #3097, #3126, #2874, #184, #2887, #3193, #3026, #3140, #323, #3247, #3773, #3146, #2898, #3014, #3130, #571, #161, #3230, #3202, #3080, #3226, #7, #2852. #2750, #3045, #2795, #2802

lover viral suppression.[xxxix] The sources frequently observe gender-based and other interpersonal violence as a product of negative laws, policies and practices as well as an important social determinant of health.[xl] Negative laws, policies and practices are also connected with other key determinants of health such as access to and enjoyment of housing, schooling and social services.[xli] Related harms include those caused by private actor discrimination in the form of blackmail or reduced access to insurance.[xlii]

Specific pathways and types of harm to health are frequently identified in legal and extra-legal violence, harassment and extortion by police officers and other public officials.[xliii] Related to this are sources that observe the inaccessibility of justice, legal services and complaint mechanisms.[xliv] A similar pathway is seen in sources that describe the failure to implement or enforce otherwise beneficial and rights-protective laws and policies.[xlv]

There are certain sources that focus more on showing how coercive laws purportedly aimed at improving health not only contradict rights but also either subvert or fail to achieve the sought health objective.[xlvi] For example, a Candia laws criminalising HIV non-disclosure that, although, intended for prevention, in fact, instead exacerbated transmission rates while also disproportionately affecting already marginalised people and women.[xlvii]

[xxxix] See (#2936, #2928, #3296, #3884, #85, #63, #2874, #2712, #3056, #327, #61, #2838, #561, #3074, #356, #3130, #3166, #3244, #571, #2821, #2940, #2820, #3034, #2750, #2998

[xl] See #3201, #3195, #3076, #378, #2936, #2706, #2796, #2751, #2766, #2803, #2825, #2698, #2911, #2822, #3097, #3129, #3186, #3112, #2757, #3026, #3181, #3247, #561, #197, #2947, #3014, #3130, #3166, #571, #161, #3080, #3044, #2852, #3045, #126, #2802

[xli] See #3078, #2946, #2936, #2995, #2803, #328, #2825, #2673, #2698, #2812, #3240, #2798, #3064, #3186, #2943, #3176, #2965, #3088, #3075, #3110

[xlii] See #2981, #2978, #2936, #2876, #2698

[xliii] See #3195, #3201, #2978, #2779, #378, #2936, #2741, #2751, #3125, #2766, #2803, #328, #2765, #2698, #2911, #3097, #3126, #2705, #3129, #2979, #176, #2887, #3064, #2976, #511, #3181, #323, #3247, #3773, #3146, #197, #2947, #3014, #3130, #3244, #571, #161, #2870, #3080, #2720, #3226, #3226, #2852, #3034, #2750, #3045, #126, #2802

[xliv] See #3246, #3055, #2673, #2822, #3097, #2880, #3240, #3056, #3119, #2843, #2931, #3112, #3001, #3026, #3140, #3176, #3127, #3035, #3146, #2909. #2947, #3130, #3121, #3230, #3261, #2720, #3044, #2852

[xlv] #2850, #3252, #3773, #3202, #7

[xlvi] #2861, #3187, #3048, #2696, #3035, #3199, #3131, #3116, #3074, #3179, #3216, #2709, #2670, #3325, #2795, # 2706

[xlvii] #2861

A handful of sources, mostly focused on the situation in British Columbia, analyse how decriminalisation or non-criminalisation of sex work alone is not sufficient when the broader legal environment remains hostile to the labour rights and business practices of sex workers.[xlviii]

Benefits addressed

The benefits of positive legal determinants are described in terms of QALYs and DALYs in three of aim two's sources. The first estimates the QALYs that could be averted through sex work decriminalisation in three cities.[xlix] The second estimates the benefits of extending health insurance coverage transgender care in terms of the QALYs averted through a reduced burden of HIV, depression, suicidal tendencies and harmful drug use.[l] The third evaluates the DALYs saved per HIV infection averted across various structural interventions aimed at priority populations.[li]

Benefits of sex work decriminalisation identified in the sources include measurable increases in safe sex practices, declines in gender-based violence, and reductions in the incidence of HIV and sexually transmitted infection.[lii] In particular, decriminalisation is identified with better control over work, access to social services and protection against exploitation, harassment and violence.[liii] Conclusions on the benefits of decriminalisation are often couched in analyses of connections between vulnerability, criminalisation of sex work, its detrimental impacts socio-economic status and health outcomes.[liv] One study quantifies the economic benefits of decriminalisation in terms of income generated for the sex workers per year and in terms of savings for the criminal justice system and the health system.[lv] Another study draws a link between decriminalisation and marginalisation with child apprehensions and how such populations are treated by the child protection services.[lvi]

Other benefits of better laws, policies and practices identified in the sources range from reduced discrimination and privacy breaches and better insurance coverage in institutional settings with resulting benefits such as

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[xlviii] #2706, #2779, #589, #3181, #3230, #3080
[xlix] #461
[l] #2875
[li] #2716
[lii] #3123, #58, #46
[liii] #2982, #226, #28, #3264
[liv] #2706, #3097,#3076, #3150, #2982
[lv] #561
[lvi] #2729

increased health service engagement.[lvii] The sources identify laws and policies that expand access to harm reduction for people who use drugs, such as the availability and accessibility needle exchanges.[lviii] For example, one study outlines harm reduction within closed settings by showing preventive value for incarcerated people.[lix] In another source, the effect of a law prohibiting police interference with drug harm reduction services is explored.[lx]

Integration of peer and community-based action in HIV programmes is identified as a positive legal determinant and key to uphold rights-based ethos in such interventions.[lxi] This is supported by three other studies, the first of which shows that integration has helped prioritisation of resources for instance by shifting the testing centres from primary healthcare centres to community-based organisations.[lxii] The second showcases that though criminalisation has impacts on access to health care and health outcomes but access to peer-advocacy at testing sites, a common entry point for sex workers, has positive impacts on access and adherence.[lxiii] The third traces the impact alteration in funding policies can have on the availability to community-based services that promote HIV prevention with funding shifts in favour of a punitive approach towards sex workers undermining and, eventually, ending these services.[lxiv]

Certain sources characterise legislative reform as not always itself enough and as needing to be accompanied by other supportive policies and practices to ensure its intended effect. Studies on this point note that legal reforms can be meaningful only with access to adequate and simplified legal information and strong redressal mechanisms,[lxv] including those for ensuring the health, safety and economic security for key populations, such as sex workers.[lxvi] Two studies explore how laws legalising drug harm reduction were, although beneficial, insufficient by themselves when set against police discretion, stigma and competing laws criminalising drug use.[lxvii]

Another series of studies explore how discriminatory practices and stigma institutionalised through criminalisation, will not dissolve merely as a result

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[lvii] See, for example, #3157, #3192
[lviii] #2932, #3085
[lix] #3054
[lx] #3089
[lxi] #2928, 2696
[lxii] #455
[lxiii] #3097
[lxiv] #2705
[lxv] #3119, #2978
[lxvi] #561
[lxvii] #2773, #3089

of partial or full decriminalisation. Various studies indicated the need for reforms that promote destigmatisation, privacy and confidentiality especially from the law enforcement agencies and with healthcare providers.[lxviii] An example includes New Zealand which followed decriminalisation with *occupational safety and health guidelines* drafted for and in consultation with sex workers to share best practices and HIV-related information.[lxix]

Cross-Cutting Results for Aim 1 and 2

Overview of cross-cutting sources and results

In mapping the evidence base related to each aim an overarching objective was to delimit shared territory and points of access between them. In so doing, the review also bring the 10-10-10 and 30-80-60 targets into dialogue with one another. This was facilitated by including certain cross-cutting variables in our data extraction for each aim that speak to the underlying concepts and commitments of the other aim.

Our results indicate a reasonable degree of correspondence and mutuality between the two sets of evidence mapped pursuant to each aim (see figure 20): 13% of aim two's sources (n = 39) and 43% of aim one's sources (n = 51) include at least one cross-cutting variable. There are, thus, 90 sources that speak to both aims and provide the basis for a synthesis of their results.

[lxviii] #3119, #3052, #2935, #2822, #2697, #2902, #2669, #2771, #3202, #3129, #2802
[lxix] #3264

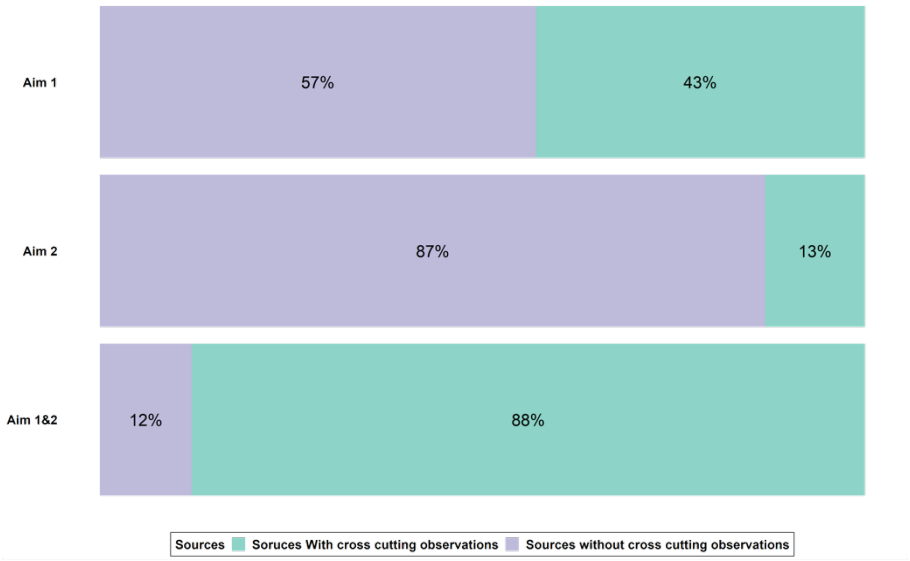

Figure 20: Sources with cross-cutting variables according to Aim

There are five sources that feature community-led response for, in part, promoting improvements in the legal determinants that also explore law, policies and practices for promoting community-led responses.[lxx] Of these, two are particularly interesting because they explore the close interrelationship of two community-led responses and legal environments.

The first features a law that both recognised community-led organisations and removed a barrier to community-led responses can be seen in the initiative for New Zealand's national needle exchange programme.[lxxi] The initiative to recognise the harm reduction service came in response to activism and existing practices in the grey zone of the law. The legislation itself legalised and funded the provision of needles and syringes via local organisations led by people who inject drugs that could apply for recognition. One of these organisations, the Dunedin Intravenous Organisation (DIVO), not only provided the service it was contracted for by the government but also went beyond it to conduct and participate in research, form cross organisation ties, present at conferences, publish community literature, and build up community capacity. Additionally, it also sought to reform institutional and law enforcement practices within prisons and the police squad by educating and lobbying on the importance of harm reduction. In this way, the source presents a positive feedback loop of community-led response leading to law reform that, in turn, promoted yet

[lxx] #118, #55, #3264, #305, #58
[lxxi] #118

more community-led responses including those aimed at improving the legal determinants of health.

The second, a source covering same setting, describes a sex worker-led response in favour of harm reduction and law reform advanced by the New Zealand Prostitutes Collective (NZPC) that resulted in the country's decriminalisation of sex work.[lxxii] From its founding, the NZPC was caught between a police force that was seeking to enforce criminalising laws and a Ministry of Health that funded the organisation to provide certain health promoting and harm reduction services. NZPC's responses to improve the health of its community were frustrated by police action. Eventually, following agitation by NZPC, the broader community and other allies, legislation decriminalising ex work was passed. This law removed an obstacle to NZPC's responses for community health, enabled sex worker collectivisation and promoted further community involvement in shaping policy on health.

Aim 1 sources exploring community-led responses for improving the legal determinants of sexual and reproductive health

Under the third branch of the 30-80-60 targets, the world committed to ensure community-led delivery of programming for the societal enablers which encompasses responses for the 10-10-10 targets and better legal determinants. Within this review, 51 sources included under Aim 1 are coded with cross-cutting observations as community-led responses for improving the legal determinants. Of these, 31 sources include discussion of community-led sensitisation of police, healthcare providers and others as a way of shifting practices, 28 show community-led advocacy for law and policy reforms, 16 explore efforts at law and policy monitoring, and 14 feature the provision of legal support within the community. See figure 21, below, for a breakdown among these four categories as a percentage of the cross-cutting observations made under aim one.

[lxxii] #3264

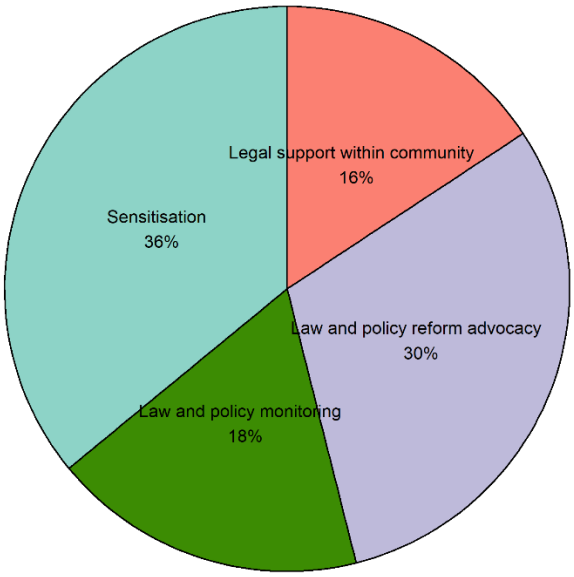

Figure 21: Community-led responses for better laws, policies and practices

Sensitisation activities are the most commonly pursued community-led response for shifting the legal determinants of the HIV response and related sexual and reproductive health challenges. Sensitisation includes both formal training of individual police officers, healthcare providers and other public officials as well as the creation of institutional relationships.[lxxiii] Positive benefits include reductions in police violence and, resultingly, safer sex practices and better access services.[lxxiv] Intermediate benefits such as easier reporting of incidents and better relationships with police are also cited.[lxxv] Engagement with healthcare providers and other power holders, such as government officials and financial institutions, are also described.[lxxvi] Benefits cited include easier access to services and overall empowerment.[lxxvii]

Another means of shifting practices and implementation described in the sources are community-led monitoring, observation and other forms of accountability focused on the gap between the experience of community members and the commitments in law, policy and human rights. The accountability mechanisms noted in the sources range from formal community-led monitoring mechanisms, a crisis response system for

[lxxiii] #53, #86, #151, #155, #177, #226, #229, #266, #197, #362, #431, #2786
[lxxiv] #53, #86, #197, #226, #266
[lxxv] #177, #229, #362
[lxxvi] #177, #197, #431, #2786
[lxxvii] #177, #266, #431

reporting on and responding to violence and discrimination, informal institutional arrangements with official actors, and organisations around specific injustices by the police.[lxxviii] In certain cases, specific shifts in practices and implementation are noted such as ceased overcharging of patients and improved access to services.[lxxix] Paired with this are community-led efforts to provide legal support within the community to those facing injustices or needing access to legal recognition.[lxxx]

As noted, many of the sources described community-led responses for reforming law and policy. These include publication of advocacy tools, direct lobbying with policymakers and officials, protests and advocacy to counter government-led messaging.[lxxxi] Benefits include new policies that lessened police violence, new funding for priority health services and resolutions to interruptions of their own funding.[lxxxii] Other times intermediate outcomes such as shifting the agenda and reframing the issues are discussed.[lxxxiii] We also see the sources describing community-led accountability mechanisms as a means of reframing political issues or triggering specific reforms such as new and revised policies on service delivery and mandatory sensitisation training.[lxxxiv]

Aim 2 sources exploring laws, policies and practices frustrating or promoting community-led responses

There are 39 sources that discuss how law, policies and practices frustrate or promote community-led responses and ally civil society organisations (CSOs). Accordingly, they are relatively few with related observations occurring in only 23% of the aim two sources. Of the total, 27 are focused on negative determinants, 10 are focused on positive legal determinants, and three sources explore both. When considered as a proportion of all sources exploring positive and negative legal determinants, those related to community leadership and civil society disproportionate among the positive determinant sources (40%) when compared with the negative determinant sources (13%).

For positive determinants, recognition of CSO co-occurs with promotion of community-led responses in 12 of the sources while promotion of community-led responses is the sole observation in 16 and CSO promotion in law and policy is observed by itself only four times. For negative

[lxxviii] #191, #459, #785, #3251
[lxxix] #459, #759
[lxxx] #251, #494, #3251
[lxxxi] #102, #151, #205, #442 #874 #886, #3251
[lxxxii] #102, #442, #886
[lxxxiii] #151, #205
[lxxxiv] #108, #459, #498, #534

determinants, frustration of CSOs and community-led responses co-occurs in 12 of the sources, frustration of community-led responses occurs alone in 20 sources, and laws and policies negatively impacting CSOs is not observed by itself.

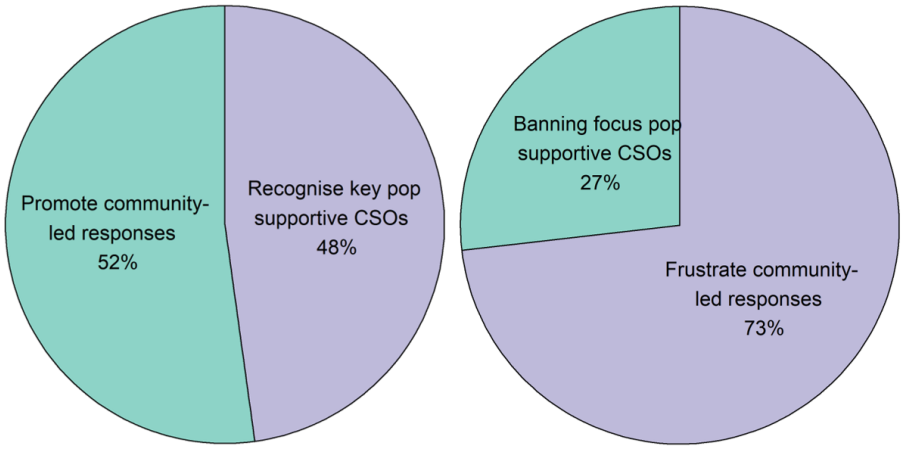

Figure 22: Laws and policies promoting or frustrating community-led responses

Positive laws, policies and practices described in the sources promote community-led responses and ally civil society organisations by directly recognising them and by lifting direct and indirect barriers to their operations.

Legal recognition broadly encompasses activities by policymakers and officials that positively benefit community-led and civil society organisation. One form of recognition seen in the sources is the according legal status to activities, such as harm reduction or testing services, undertaken within community-led responses.[lxxxv] Recognition can also take the form of providing certain forms of legal personality to community-led organisations or government's creation of partnerships with communities of key and vulnerable populations.[lxxxvi] Another is providing dedicated funding for needed services, such as harm reduction, and capacity building among community-led and community-based organisations.[lxxxvii]

The sources describe how community-led responses and the work of ally civil society organisations can be enabled by anti-discrimination measures as well as decriminalisation and legalisation of, respectively, sex work and drug harm reduction services. For example, one source describes how provisions against discrimination toward people living with HIV prepared

[lxxxv] #116, #118
[lxxxvi] #224, #318, #3157, #3287
[lxxxvii] #224, #455, #3157

the way for community-led responses for building and acting on the capacity and legal literacy needed to enforce these provisions.[lxxxviii] Other sources show how legalising harm reduction and decriminalising sex work have enabled or can enable community-led responses for improving community wellbeing and capacity as well as advocating for reforms to other laws, policies and practices.[lxxxix] There are more indirect effects described in the sources such as how generally open civil society spaces characteristics of democracies may promote organisation among people living with HIV and allies with associated increases in knowledge of status.[xc]

The sources included under aim two illustrate a number of similar pathways through which negative laws policies and practices can and do frustrate community leadership and ally civil society. We also see in the sources the ways that negative legal environments inspire and necessitate community-led responses with one source suggesting that this empowerment can inspire more brutal official practices including increased violence.[xci] Some of the most common barriers are laws and policies that directly prohibit or burden community-led organisations and ally civil society organisations.[xcii] This prohibition and non-recognition is frequently deeply entangled with the criminalising, discriminatory and punitive laws and policies applied towards members of key and vulnerable populations.[xciii] In certain cases, prohibition and non-recognition is alternatively or additionally attributable to a broader opposition toward civil society activities construed as political.[xciv]

An example of the negative impacts of non-recognition of a civil society organisation on a broader community-led response can be seen in a study by Arps and Golichenko.[xcv] It concerned a community-led response aimed at benefiting sex workers, helping prevent HIV, and working towards better sexual and reproductive health. To better perform these activities, they needed legal recognition of their CSO, Silver Rose, since this would grant access to financing, the courts, and other benefits. The application was declined due to a discriminatory administrative determination connected with the punitive ban on sex work. In this case, the CSO was the intended vehicle for aspects of the planned community-led response and the refusal

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[lxxxviii] #2672
[lxxxix] #58, #118, #561, #3264
[xc] #58
[xci] #3226
[xcii] #224, #589, #2783, #2821, #3019, #3012, #3084, #3155, #3249
[xciii] #224, #589, #2783, #2821, #3019, #3084, #3155
[xciv] #2783, #2821, #3012, #3249
[xcv] #3084

to grant it legal recognition frustrated the response.[xcvi] As a result of only being allowed unregistered association, their purposes of providing education and information for sex workers, promoting safer and healthier work practices, and offering legal help and conflict resolution were frustrated.

Related to these more direct forms of prohibition and non-recognition, are the indirect barriers created by generally applicable laws and policies designed with paternalism toward or lack of regard for the needs of key and vulnerable populations. Examples include the structuring of funding application criteria and processes toward actors with more resources and capacity than community-led organisations typically have.[xcvii] This is usually attributed toward a neglect of the need to fund responses led by the communities most affected.[xcviii] In other cases, this is instead attributed to a more actively paternalistic and discriminatory attitudes and norms towards relevant populations.[xcix]

Criminalising, punitive and discriminatory laws and policies aimed or used against key and vulnerable populations, rather than specifically their efforts to organise, also frustrate community-led responses. For example, “anti-drug drive operations” in Dhaka not only caused harm directly to people who use drugs by causing police to engage in extrajudicial violence and provoking risk injection practices but also by frustrating community-led responses by exposing outreach workers to police violence and obstructions as well as by dispersing those seeking they were seeking to help.[c] Many of the other sources also explore how criminalising, discriminatory and punitive legal environments pose barriers to community-led responses and can erode or inhibit community capacity.[ci] Less direct impacts can flow on from the discourse and stigma produced by criminalisation in institutional distrust from affected communities that prevents or undermines their cooperation with official actors, including healthcare providers.[cii] An example of discriminatory policies and how they

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[xcvi] A similar example of punitive and discriminatory laws, policies and practices aimed at civil society can be seen in a report by Adrian Jjuuko and Linette du Toit that explores the effect of various laws preconditioning any group activities on registration with approval conditional on a security agency recommendation and acceptance of an ongoing requirement to cooperate with local authorities (#3249).
[xcvii] #32, #224, #2696, #3019, #3128
[xcviii] #32, #3696, #3019
[xcix] #224, #3128
[c] #3126
[ci] #161, #305, #589, #2811, #2928, #2983, #3001, #3064, #3019, #3140, #3155, #3247, #3250
[cii] #2983, #3001, #3038

degrade community capacity can be seen in a source that describes the fragmentation of collective identity, possibilities for mutual aid and access to community and civil society provided services that resulted from the discriminatorily targeted, undercompensated and intrusively implemented demolition of the area in which most sex workers of a minority ethnicity lived and worked.[ciii]

Negative laws, policies and practices impacting on community-led responses observed in the literature are not, however, always criminalising or outright discriminatory. For example, the successful community-led response by GROOTS in Kenya aimed at protecting vulnerable women and responding to HIV by upholding property rights was also frustrated by fragmented land laws and a lack of integration between community-led mechanisms for securing land tenure and the formal legal system.[civ] Similarly, another source shows how failure to respect confidentiality and rights can prevent or impede the scale up of civil society initiatives intended to advance sexual and reproductive rights.[cv]

DISCUSSION

Conclusions

We aimed to delimit the evidence on resource requirements and benefits of community-led responses for sexual and reproductive health and rights (aim one) while also contextualising this evidence on community-led responses with a mapping of the literature on the benefits or costs of good or bad laws, policies and practices (aim two). In this way, we intended to both explore the sources on each point independently while also bringing them into dialogue with one another in the hope that this would provide access to evidence on the mutuality of failure and success that exists between the 30-80-60 community leadership targets and the 10-10-10 societal enabler target.

We approached these aims with a systematic scoping review of scientific and grey literature supported by engagement and consultation with community partners and experts.

Our main findings relevant to both aims can be summarized as follows: 1. There is a large body of literature relevant to both aims which is growing rapidly in the case of aim one and is more stable in the case of aim two; 2. These sources cover various settings but have for both aims sufficient coverage of country settings the same as or similar to the Love Alliance

[ciii] #3064
[civ] #148
[cv] #3012

countries; 3. For both aims, there is less literature that speaks to the concerns and situations of transgender people and people who use drugs.

Our main findings relevant to aim one alone are as follows: 4.The included sources substantiate the already well evidenced benefits of community-led responses but are disproportionately focused on short-term and small-scale interventions; 5. The types of community-led responses described in the literature vary significantly in terms of the community ownership over these responses and the degree of community ownership appears to affect the priorities and aims of these responses; 6. As community ownership increases, the types of community-led responses seen become more diverse and less narrowly focused on service delivery; 7. The literature focuses on responses with less community ownership and, therefore, provides only a partial evaluation of community leadership's potential; 8. Few sources are describing resulting benefits in terms of cost-effectiveness or according to measures, such as QALYs and DALYs, amenable to economic evaluation; 9. There are few studies providing precise measures of the financial resource requirements of community-led responses and those that do exist vary substantially as to be expected given the wide variances in types of response and settings under consideration. 10: Reliance on underpaid or unpaid labour from volunteers within the community, as well as their financial and other resource contributions, was identified as a common resource for community-led responses; 11. A large number of the sources describe resource requirements in terms of the challenges of unreliable, insufficient or overly prescriptive funding.

Our main findings relevant to aim two alone are as follows: 12. The sources more commonly feature laws, policies and practices that negatively impact sexual and reproductive health and rights; 13. The most common pathway for negative impact is discrimination and criminalisation and the most common pathway for positive impact is anti-discrimination and decriminalisation. 14. Negative laws, policies and practices are characterised in the literature as undermining access, availability and quality of health services and also undermine health promoting behaviours with various direct harms to health consequent to this. 15. Positive laws, policies and practices vary but highlight in particular the limitations of isolated reforms and the need for concerted approaches of mutually supportive legal reforms as well as broader societal interventions.

Our main findings relevant to our aim of identifying cross-cutting results are as follows: 16. There is a reasonably high degree of mutuality between the two sets of sources; 17. The aim one sources that speak to community leadership for improving legal determinants show that a large proportion of sources on community-leadership touch on this dynamic with various pathways and outcomes identified; 18. These aim one sources indicate that community-led responses are often aimed toward improving legal

determinants of health and in many cases meet with success; 19. Although relatively fewer as a proportion of the total number of included sources, the studies of cross-cutting relevance within aim two show that the legal environment can be both a barrier to and enabler of community leadership; Taken together these sources coded with cross-cutting observations indicate a literature that explores, albeit infrequently overtly, the mutuality of the 10-10-10 targets and the 30-80-60 targets.

We recognize some limitations of this report. We produced this report with a small team and over a relatively abbreviated span of time. We did not have as much opportunity for recursive searching and consultation as we would have liked. We did not have the ability to consult on our search protocol with community partners or have the search strategy peer reviewed by others in our field. We hope to remedy some of the effects of these limitations ahead of the final draft. But our methodology was systematic and our search comprehensive, we are, therefore, confident that we included the range of research on this topic written from a health perspective. We may have missed research written from a political science or economic perspective not included in our target databases. The limits to our search in terms around population groups may also have left out important studies relevant to both aims.

Policy and advocacy implications

The included sources demonstrate the urgency of addressing the harms of criminalisation and other negative laws as well as the benefits of implementing laws to protect against discrimination and to decriminalise people and their behaviours. At the same time, it has also shown the limitations of isolated reforms which target only a single component of complex and intersectional forms of legal, extra-legal and societal marginalisation and discrimination. In the absence of action, health is harmed, health services impaired and the community-led responses are obstructed and frustrated. Accordingly, this review demonstrates how fundamental attention to the legal determinants is for realising the full potential of community-led responses and ensuring progress on ending HIV and preventing deaths from AIDS. This should inform both advocacy and the efforts of policymakers.

Our review of the literature confirms the interrelationship between investment in community leadership and realisation of progress on the societal enablers. Our findings of the mutuality of studies relating to the two sets of targets can be cited to confirm the premise of the “60” target that communities need to lead on delivering programming for the societal enablers. Additionally, the included sources also show that community-led responses are of impact in improving the legal determinants and such improvements are a common aim and outcome of community-led responses.`

This review also supports investment in and advocacy for community-led responses to HIV and related sexual and reproductive health challenges. All sources cite benefits to health and they are shown to have impact in delivering health services, ensuring prevention and moving the needle on critical legal determinants and related societal enablers. Community ownership also benefits the prioritisation and design of responses by ensuring they target areas of greater community need and, in particular, grapple with the challenges posed by preventing, mitigating and reforming bad laws. Global and national responses that aim to meet the challenge of HIV with sufficient ambition, thus, need to have community leadership at their heart and promote the highest level of community ownership attainable.

Meeting this challenge requires financial investment from countries and from global funders. We have found the research on community-led responses to be characterised by frequent reporting on the challenges and pitfalls of uncertain and inadequate funding. These funding challenges making delivering the services or programming needed challenging, difficult or impossible. More subtly, they can also warp the character of the community-led response by requiring communities fit the prescriptions and reporting requirements of funders rather than the needs and processes preferred and most suited to the communities themselves. High-quality and high-ownership community-led responses require capacitation and organisational development over the long-term which makes sustained and predictable funding essential. In agreeing to the 30-80-60 targets, the countries of the world also agreed to sustainably financing community-led organisations and networks. There is a pressing need to hold countries and funders to account in fulfilling this commitment to funding community-led responses generally and responses with high community ownership especially.

A related challenge is the overreliance on community voluntarism. Shifting funding and programming to community-led responses as a means of exploiting their passion to extract free labour and other resource commitments from already marginalised populations is wrong. The benefits of community leadership should, instead, be located in the “leadership” of the communities: the immense added value of directing resources to people who know their needs and their capacities best creatively advance responses to HIV and related sexual and reproductive health challenges. Community-led organisations need to be resourced well enough so that roles which merit compensation and wages should receive them. It is up to countries and funders to close the gap and help ensure fairness in this respect.

Research implications

The determination, design and implementation of all research agendas, programmes and studies should be community-led. This is needed to ensure appropriate and effective decision-making over the priorities for further research. As this review has established, the priorities of interventions shift depending on the degree of community ownership over them. The same will apply for community-led research. As such, the below implications sets out only potential areas of research based on the research gaps identified in the literature and also identification of related areas of research that were outside the scope of this review's research questions. Determining the need for and relative priority between these research items should be decided by the relevant community-led organisations and networks.

The literature is disproportionately focused on limited, time-bound and low community ownership responses that do not and cannot capture the benefits and value of community leadership. Further, although various included sources explore Love Alliance and other settings in comparable African regions the highest quality and most well researched long-term community-led responses are based in India.

There is a need for community-led research delineating a typology of community-led responses. Such research could extend and formalise this review's distinction between responses based on community-led ownership. It could also categorise responses based on longevity, scale, type of issues being addressed, interventions encompassed, and the structures of the community-led organisations or networks involved. This will be of assistance in assessing future and past community-led responses with greater granularity. This will help identify the characteristics—such as low community ownership, short duration, small scale—that may hinder the effectiveness of a response.

There is a research gaps on the financial and other resource requirements of community-led responses as well as the overall share and character of community-led responses within the HIV response. This should be targeted by further review of existing datasets and investigation of past and present community-led responses. This type of research could help to determine the proportion of services and programming for the HIV response being delivered as part of community-led responses in line with the 30-80-60 targets. It at least will help establish for different types of community-led responses the unit costs, financial resource requirements and other resource requirements that are typical. This research could be advanced with both greater transparency and disaggregated reporting by funders and implementers on the financial resource requirements and share of programming delivered by community-led responses.

Research on and investment in large-scale, long-term, and maximally community owned responses to HIV and related sexual and reproductive health challenges based in diverse regions, including those of Africa, will help determine the relative cost-effectiveness of community-led responses. By facilitating these responses and ensuring their process and final outcomes are well documented, the actual cost-effectiveness and value for money of programmes of work delivered according to community priorities, needs and preferences will be revealed. As part of this, preliminary research will be needed to establish the minimum scale and duration needed to estimate cost-effectiveness for different types of community-led responses. This evidence can, then, found further investment globally and related legal reforms needed to unlock the full potential of community leadership in settings that criminalise or permit discrimination against key and vulnerable populations.

The aforementioned research priorities could be packaged together in a mixed methods study comprising a systematic review and meta-analysis as well as econometric evaluations, cost analysis and qualitative interviews to determine the financial resource requirements, barriers and facilitators of community-led responses to sexual and reproductive health challenges as well as their health impacts, beneficial process outcomes, and positive externalities. Such research could also encompass broader positive externalities of community-led responses than were within the scope of this review's research questions—which were limited to health outcomes and determinants of health—and, in this way, more fully demonstrate the potential benefits of community-led responses.

There is also a need for further research on how positive legal determinants enable and strengthen community-led responses and how negative legal determinants undermine and frustrate community-led responses. Law reform advocacy could be strengthened by further evidence substantiating the connection between an effective HIV response, community leadership, and circumstances of non-discrimination and decriminalisation. Such research could, in addition to identifying causal links and overall effect sizes, delineate the types of legal determinants and overall frameworks that enable and support community-led responses. This programme of research could take the form of independent studies of existing and emerging community-led responses but could also be integrated within broader studies on the impact and effectiveness of community-led responses—such as those proposed above.

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APPENDICES FOR SEARCH STRATEGY

Appendix 1.1: Aim 1 Search Strategy and Results

- (HIV AND ("community led" OR "community leadership" OR "peer led" OR "population led" OR "population leadership" OR "community delivered" OR "peer delivered" OR "population delivered")) +1980-2022 February 18 2022 = **360 results in MEDLINE via Ovid**
- (HIV AND ("community led" OR "community leadership" OR "peer led" OR "population led" OR "population leadership" OR "community delivered" OR "peer delivered" OR "population delivered")) + 1980-2022 February 18 2022 = **547 results in Embase via Ovid**
- (HIV AND ("community led" OR "community leadership" OR "peer led" OR "population led" OR "population leadership" OR "community delivered" OR "peer delivered" OR "population delivered")) + 1980-2022 February 18 2022 = **482 results in Web of Science via Clarivate**
- (HIV AND ("community led" OR "community leadership" OR "peer led" OR "population led" OR "population leadership" OR "community delivered" OR "peer delivered" OR "population delivered")) + 1980-2022 February 18 2022 = **43 results in Sociological Abstracts via ProQuest**
- HIV AND ("community led" OR "community leadership" OR "peer led" OR "population led" OR "population leadership" OR "community delivered" OR "peer delivered" OR "population delivered")) + 1980-2022 February 18 2022 = **200 most relevant results selected from Google Scholar**

Total results: 1,632
Number of duplicates: 922
Total original results: 710

Appendix 1.2: Aim 2 Strategy and Results

MEDLINE via Ovid		
1.	((criminaliz* OR criminalis* OR ban* OR prohibit* OR decriminaliz* OR decriminalis* OR legaliz* OR legalis* OR discrimination OR anti-discrimination OR non-discrimination OR punitive laws) adj5 (marginaliz* communit* OR vulnerable population* OR key population*)).af	123
2.	((criminaliz* OR criminalis* OR ban* OR prohibit* OR decriminaliz* OR decriminalis* OR legaliz* OR legalis* OR discrimination OR anti-discrimination OR non-discrimination OR punitive laws) adj5 (people living with HIV OR persons living with HIV OR PLHIV	359

	OR HIV status OR transmission of HIV OR HIV transmission OR expose to HIV OR HIV exposure OR exposure to HIV)).af	
3.	((criminaliz* OR criminalis* OR ban* OR prohibit* OR decriminaliz* OR decriminalis* OR legaliz* OR legalis* OR discrimination OR anti-discrimination OR non-discrimination OR punitive laws) adj5 (sex education OR condoms OR abortion)).af	1410
4.	((criminaliz* OR criminalis* OR ban* OR prohibit* OR decriminaliz* OR decriminalis* OR legaliz* OR legalis* OR discrimination OR anti-discrimination OR non-discrimination OR punitive laws) adj5 (consensual sex OR consensual adult sex OR same-sex relationship* OR same sex activity OR sodomy OR men who have sex with men OR MSM OR male-male sex OR gay OR homosexual* OR sexual minorit* OR LGB OR LGBT OR LGBTQI OR gender expression OR cross-dressing OR transgender people OR transgender OR trans people OR transwomen OR transmen OR gender minorit*)).af	1643
5.	((criminaliz* OR criminalis* OR ban* OR prohibit* OR decriminaliz* OR decriminalis* OR legaliz* OR legalis* OR discrimination OR anti-discrimination OR non-discrimination OR punitive laws) adj5 (sex work* OR prostitut*)).af	361
6.	((criminaliz* OR criminalis* OR ban* OR prohibit* OR decriminaliz* OR decriminalis* OR legaliz* OR legalis* OR discrimination OR anti-discrimination OR non-discrimination OR punitive laws) adj5 (people who inject drugs OR persons who inject drugs OR PWID OR individuals who inject drugs OR illicit drugs OR opium dependence OR morphine dependence OR heroin dependence OR harm reduction)).af	200
7.	((criminaliz* OR criminalis* OR ban* OR prohibit* OR decriminaliz* OR decriminalis* OR legaliz* OR legalis* OR discrimination OR anti-discrimination OR non-discrimination OR punitive laws) adj5 (people in prison OR people held in prisons OR people confined in prisons OR prisoners OR detainees OR inmates)).af	75
8.	((criminaliz* OR criminalis* OR ban* OR prohibit* OR decriminaliz* OR decriminalis* OR legaliz* OR legalis* OR discrimination OR anti-discrimination OR non-discrimination OR punitive laws) adj5 (women	3886

	OR girls OR sex offences OR gender-based violence OR gender based violence OR GBV or sexual violence OR intimate-partner violence OR intimate partner violence)).af	
9.	1 OR 2 OR 3 OR 4 OR 5 OR 6 OR 7 OR 8	7781
10.	exp HIV/ OR exp HIV Infection/ OR HIV.mp OR AIDS.mp	487622
11.	9 AND 10	1284

Embase via OVID		
1.	((criminaliz* OR criminalis* OR ban* OR prohibit* OR decriminaliz* OR decriminalis* OR legaliz* OR legalis* OR discrimination OR anti-discrimination OR non-discrimination OR punitive laws) adj5 (marginaliz* communit* OR vulnerable population* OR key population*)).af	194
2.	((criminaliz* OR criminalis* OR ban* OR prohibit* OR decriminaliz* OR decriminalis* OR legaliz* OR legalis* OR discrimination OR anti-discrimination OR non-discrimination OR punitive laws) adj5 (people living with HIV OR persons living with HIV OR PLHIV OR HIV status OR transmission of HIV OR HIV transmission OR expose to HIV OR HIV exposure OR exposure to HIV)).af	424
3.	((criminaliz* OR criminalis* OR ban* OR prohibit* OR decriminaliz* OR decriminalis* OR legaliz* OR legalis* OR discrimination OR anti-discrimination OR non-discrimination OR punitive laws) adj5 (sex education OR condoms OR abortion)).af	1079
4.	((criminaliz* OR criminalis* OR ban* OR prohibit* OR decriminaliz* OR decriminalis* OR legaliz* OR legalis* OR discrimination OR anti-discrimination OR non-discrimination OR punitive laws) adj5 (consensual sex OR consensual adult sex OR same-sex relationship* OR same sex activity OR sodomy OR men who have sex with men OR MSM OR male-male sex OR gay OR homosexual* OR sexual minorit* OR LGB OR LGBT OR LGBTQI OR gender expression OR cross-dressing OR transgender people OR transgender OR trans people OR transwomen OR transmen OR gender minorit*)).af	1509

5.	((criminaliz* OR criminalis* OR ban* OR prohibit* OR decriminaliz* OR decriminalis* OR legaliz* OR legalis* OR discrimination OR anti-discrimination OR non-discrimination OR punitive laws) adj5 (sex work* OR 63rostitute*)).af	457
6.	((criminaliz* OR criminalis* OR ban* OR prohibit* OR decriminaliz* OR decriminalis* OR legaliz* OR legalis* OR discrimination OR anti-discrimination OR non-discrimination OR punitive laws) adj5 (people who inject drugs OR persons who inject drugs OR PWID OR individuals who inject drugs OR illicit drugs OR opium dependence OR morphine dependence OR heroin dependence OR harm reduction)).af	265
7.	((criminaliz* OR criminalis* OR ban* OR prohibit* OR decriminaliz* OR decriminalis* OR legaliz* OR legalis* OR discrimination OR anti-discrimination OR non-discrimination OR punitive laws) adj5 (people in prison OR people held in prisons OR people confined in prisons OR prisoners OR detainees OR inmates)).af	65
8.	((criminaliz* OR criminalis* OR ban* OR prohibit* OR decriminaliz* OR decriminalis* OR legaliz* OR legalis* OR discrimination OR anti-discrimination OR non-discrimination OR punitive laws) adj5 (women OR girls OR sex offences OR gender-based violence OR gender based violence OR GBV or sexual violence OR intimate-partner violence OR intimate partner violence)).af	4391
9.	1 OR 2 OR 3 OR 4 OR 5 OR 6 OR 7 OR 8	8084
10.	exp HIV/ OR exp HIV Infection/ OR HIV.mp OR AIDS.mp	637887
11.	9 AND 10	1615
Web of Science		
1.	TS=((criminaliz* OR criminalis*OR decriminaliz* OR decriminalis* OR discriminat*) NEAR/5 (key population*))	194
2.	TS=((criminaliz* OR criminalis*OR decriminaliz* OR decriminalis* OR discriminat*) NEAR/5 (people living with HIV OR PLHIV OR HIV status))	424
3.	TS=((criminaliz* OR criminalis*OR decriminaliz* OR decriminalis* OR discriminat*) NEAR/5 (sex education OR condoms OR abortion))	1079

4.	TS=((criminaliz* OR criminalis*OR decriminaliz* OR decriminalis* OR discriminat*) NEAR/5 (men who have sex with men OR MSM OR sexual minorit* OR transgender OR gender minorit*))	1509
5.	TS=((criminaliz* OR criminalis*OR decriminaliz* OR decriminalis* OR discriminat*) NEAR/5 (sex work* OR prostitut*))	457
6.	TS=((criminaliz* OR criminalis*OR decriminaliz* OR decriminalis* OR discriminat*) NEAR/5 (people who inject drugs OR intravenous drug* OR harm reduction))	76
7.	TS=((discriminat*) NEAR/5 (prisoners OR detainees OR inmates))	44
8.	TS=((criminaliz* OR criminalis*OR decriminaliz* OR decriminalis* OR discriminat*) NEAR/5 (women OR girls OR gender-based violence OR GBV or sexual violence OR intimate partner violence))	4579
9.	1 OR 2 OR 3 OR 4 OR 5 OR 6 OR 7 OR 8	6304
10.	TS=(HIV OR human immunodeficiency virus OR AIDS OR acquired immunodeficiency syndrome)	994,261
11.	9 AND 10	887

Sociology Abstracts		
1.	(criminaliz* OR criminalis* OR ban* OR prohibit* OR decriminaliz* OR decriminalis* OR legaliz* OR legalis* OR discrim* OR "anti-discrimination" OR "non-discrimination" OR "punitive laws") NEAR/5 ("marginaliz* community" OR "vulnerable population*" OR "key population*")	35
2.	(criminaliz* OR criminalis* OR ban* OR prohibit* OR decriminaliz* OR decriminalis* OR legaliz* OR legalis* OR discrim* OR "anti-discrimination" OR "non-discrimination" OR "punitive laws") NEAR/5 ("people living with HIV" OR "persons living with HIV" OR PLHIV OR "HIV status" OR "transmission of HIV" OR "HIV transmission" OR "expose to HIV" OR "HIV exposure" OR "exposure to HIV")	86
3.	(criminaliz* OR criminalis* OR ban* OR prohibit* OR decriminaliz* OR decriminalis* OR legaliz* OR legalis* OR discrim* OR "anti-discrimination" OR	2136

	"non-discrimination" OR "punitive laws") NEAR/5 ("sex education" OR condoms OR abortion)	
4.	(criminaliz* OR criminalis* OR ban* OR prohibit* OR decriminaliz* OR decriminalis* OR legaliz* OR legalis* OR discrim* OR "anti-discrimination" OR "non-discrimination" OR "punitive laws") NEAR/5 ("consensual sex" OR "consensual adult sex" OR "same-sex relationship*" OR "same sex activity" OR sodomy OR "men who have sex with men" OR MSM OR "male-male sex" OR gay OR homosexual* OR "sexual minorit*" OR LGB OR LGBT OR LGBTQI OR "gender expression" OR "cross-dressing" OR transgender OR "trans people" OR transwomen OR transmen OR "gender minorit*")	2386
5.	(criminaliz* OR criminalis* OR ban* OR prohibit* OR decriminaliz* OR decriminalis* OR legaliz* OR legalis* OR discrim* OR "anti-discrimination" OR "non-discrimination" OR "punitive laws") NEAR/5 ("sex work*" OR 65prostitute*)	719
6.	(criminaliz* OR criminalis* OR ban* OR prohibit* OR decriminaliz* OR decriminalis* OR legaliz* OR legalis* OR discrim* OR "anti-discrimination" OR "non-discrimination" OR "punitive laws") NEAR/5 ("people who inject drugs" OR "persons who inject drugs" OR PWID OR "individuals who inject drugs" OR "illicit drugs" OR "opium dependence" OR "morphine dependence" OR "heroin dependence" OR "harm reduction")	140
7.	(decriminaliz* OR decriminalis* OR legaliz* OR legalis* OR discrim* OR "anti-discrimination" OR "non-discrimination") NEAR/5 ("people in prison" OR "people held in prisons" OR "people confined in prisons" OR prisoners OR detainees OR inmates)	33
8.	(criminaliz* OR criminalis* OR ban* OR prohibit* OR decriminaliz* OR decriminalis* OR legaliz* OR legalis* OR discrim* OR "anti-discrimination" OR "non-discrimination" OR "punitive laws") NEAR/5 (women OR girls OR "sex offences" OR "gender-based violence" OR "gender based violence" OR GBV or "sexual violence" OR "intimate-partner violence" OR "intimate partner violence")	8222
9.	noft(HIV OR "human immunodeficiency virus")	15,179
10.	(1 OR 2 OR 3 OR 4 OR 5 OR 6 OR 7 OR 8) AND 9	419

	EconLit via EBSCO	
1.	((criminaliz* OR criminalis* OR ban* OR prohibit* OR decriminaliz* OR decriminalis* OR legaliz* OR legalis* OR discrimination OR anti-discrimination OR non-discrimination OR punitive laws) N5 (marginaliz* communit* OR vulnerable population* OR key population*))	9
2.	((criminaliz* OR criminalis* OR ban* OR prohibit* OR decriminaliz* OR decriminalis* OR legaliz* OR legalis* OR discrimination OR anti-discrimination OR non-discrimination OR punitive laws) N5 (people living with HIV OR persons living with HIV OR PLHIV OR HIV status OR transmission of HIV OR HIV transmission OR expose to HIV OR HIV exposure OR exposure to HIV))	6
3.	((criminaliz* OR criminalis* OR ban* OR prohibit* OR decriminaliz* OR decriminalis* OR legaliz* OR legalis* OR discrimination OR anti-discrimination OR non-discrimination OR punitive laws) N5 (sex education OR condoms OR abortion))	154
4.	((criminaliz* OR criminalis* OR ban* OR prohibit* OR decriminaliz* OR decriminalis* OR legaliz* OR legalis* OR discrimination OR anti-discrimination OR non-discrimination OR punitive laws) N5 (consensual sex OR consensual adult sex OR same-sex relationship* OR same sex activity OR sodomy OR men who have sex with men OR MSM OR male-male sex OR gay OR homosexual* OR sexual minorit* OR LGB OR LGBT OR LGBTQI OR gender expression OR cross-dressing OR transgender people OR transgender OR trans people OR transwomen OR transmen OR gender minorit*))	77
5.	((criminaliz* OR criminalis* OR ban* OR prohibit* OR decriminaliz* OR decriminalis* OR legaliz* OR legalis* OR discrimination OR anti-discrimination OR non-discrimination OR punitive laws) N5 (sex work* OR prostitut*))	43
6.	((criminaliz* OR criminalis* OR ban* OR prohibit* OR decriminaliz* OR decriminalis* OR legaliz* OR legalis* OR discrimination OR anti-discrimination OR non-discrimination OR punitive laws) N5 (people who inject drugs OR persons who inject drugs OR	13

	PWID OR individuals who inject drugs OR illicit drugs OR opium dependence OR morphine dependence OR heroin dependence OR harm reduction))	
7.	((criminaliz* OR criminalis* OR ban* OR prohibit* OR decriminaliz* OR decriminalis* OR legaliz* OR legalis* OR discrimination OR anti-discrimination OR non-discrimination OR punitive laws) N5 (people in prison OR people held in prisons OR people confined in prisons OR prisoners OR detainees OR inmates))	10
8.	((criminaliz* OR criminalis* OR ban* OR prohibit* OR decriminaliz* OR decriminalis* OR legaliz* OR legalis* OR discrimination OR anti-discrimination OR non-discrimination OR punitive laws) N5 (women OR girls OR sex offences OR gender-based violence OR gender based violence OR GBV or sexual violence OR intimate-partner violence OR intimate partner violence))	990
9.	1 OR 2 OR 3 OR 4 OR 5 OR 6 OR 7 OR 8	1302
10.	AB, TI, SU, SO (HIV OR "human immunodeficiency virus)	2062
11.	9 AND 10	18

Google Scholar (first 200 most relevant results): Discriminatory and criminalising HIV laws and HIV policies targeting “people living with HIV”, “transgender people”, “men who have sex with men”, “sex workers”, prisoners, women, girls

An additional 40 studies found through other searches and consultations were added.

Total results: 4463
Duplicates removed: 1661
Total original results: 2802

APPENDICES FOR ELIGIBILITY CRITERIA

Appendix 2.1 Definition for community-led organisations and responses

From the technical consultation on social enablers, 19 – 21 June 2019, Montreux Switzerland[82]

Community-led organisations
Community-led organizations, groups, and networks (Including collectives, coalitions, and other ways that people self organize), irrespective of their legal status, are entities for which the majority of governance, leadership, staff, spokespeople, membership and volunteers, reflect and represent the experiences, perspectives, and voices of their constituencies and who have transparent mechanisms of accountability to their constituencies. Community-led organizations, groups, and networks are self-determining and autonomous, and not influenced by government, commercial, or donor agendas. Not all community-based organizations are community led.

Key population-led organisations
Key population-led organizations and networks are led by people living with HIV, female, male and transgender sex workers, gay men and other men who have sex with men, people who use drugs, and transgender people. Key populations share experiences of stigma, discrimination, criminalization, and violence and shoulder disproportionate HIV disease burden in all parts of the world. Key population-led organizations and networks are entities whose governance, leadership, staff, spokespeople, members and volunteers reflect and represent the experiences, perspectives, and voices of their constituencies. Key population led organizations and networks and their expertise are anchored in their lived experiences, which determine their priorities. They speak for themselves and are an intrinsic part of the global HIV response. This definition of key populations is not meant to preclude the ways that people describe themselves, including related to sexual orientation, gender, and gender identity.

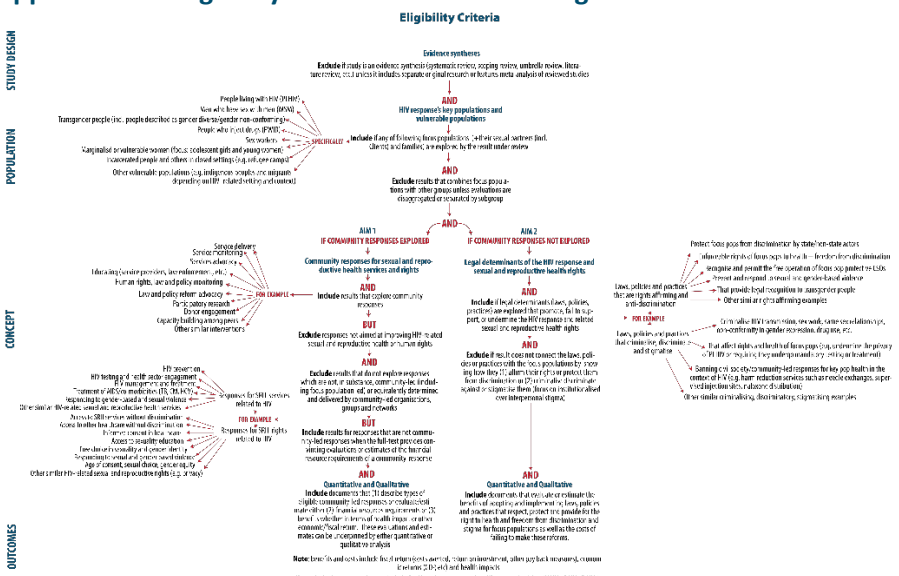
Community-led responses
Community-led responses are actions and strategies that seek to improve the health and human rights of their constituencies, that are specifically informed and implemented by and for communities themselves and the organizations, groups, and networks that represent them. Community-led responses are determined by and respond to the needs and aspirations of their constituents. Community-led responses include advocacy, campaigning and holding decision-makers to account; monitoring of policies, practices, and service delivery; participatory research; education and information sharing; service delivery; capacity building, and funding of community-led organizations, groups, and networks. Community-led

responses can take place at global, regional, national, subnational, and grassroots levels, and can be implemented virtually or in person. Not all responses that take place in communities are community led.

Key population-led responses

Key population-led responses. Key populations are primary actors in, and intrinsic to, the global HIV response. Their responses are transformational, based on their priorities, needs and rights. Key populations should be included, on their own terms and with consideration to varying social and structural determinants, at all levels of the global HIV response. Key population responses aim to strengthen the capacities of their communities and are committed to action, irrespective of resource availability. Key population communities are overlapping and thus their responses strive to be intersectional. Key populations choose their own representative and how they engage in HIV-, gender-, human rights-, and development related processes.

Appendix 2.2: Eligibility Criteria Decision-Making Tool



Appendix 2.3: Eligibility Decisions

Under preparation.

APPENDICES FOR DATA EXTRACTION

Appendix 3.1 Data Extraction Tool

We used a modified version of the Covidence extraction tool as set out below.

General information

- Author(s): [free text]
- Year of publication: [free text]
- Title: [free text]
- Relevance to which aims [single choice]:
  - (1) aim one;
  - (2) aim two;
  - (3) aim one and two
- Aims or purposes: [free text]
- Methods [checkboxes]:
  - (1) Meta-analysis;
  - (2) Cross-sectional/observational;
  - (3) Prospective/longitudinal;
  - (4) Randomised control trial;
  - (5) National program monitoring;
  - (6) Quasi experimental;
  - (7) Evaluation;
  - (8) Economic evaluation/modelling;
  - (9) economic evaluation or modelling;
  - (10) Other quantitative research;
  - (11) Qualitative research;
  - (12) Other [free text]
  -

Context

- Focus countries: [free text]
- Focus country income groups [single choice]:
  - (1) HICs;
  - (2) LMICs;
  - (3) All/mixed country income groups
  -

Population

- Focus populations [checkboxes]:
  - (1) People living with HIV;
  - (2) Men who have sex with men;
  - (3) Transgender people;
  - (4) People who inject drugs;
  - (5) Sex workers;
  - (6) Adolescent girls and young women;

- (7) Other vulnerable women;
- (8) Incarcerated people;
- (9) Other people held in closed settings;
- (9) Indigenous peoples;
- (10) Vulnerable migrants;
- (11) Other [free text]
-

Concepts: Aim 1 (if applicable)

- Interventions [checkboxes]:
  - (1) Key population-led;
  - (2) Community-led;
  - (3) Peer-led;
  - (4) Community-based;
  - (5) Other [free text]
- Types of community response [checkboxes]:
  - (1) Service delivery;
  - (2) Service monitoring;
  - (3) Services advocacy;
  - (4) Educating (service providers and others);
  - (5) Human rights, law and policy monitoring;
  - (6) Law and policy reform advocacy;
  - (7) Participatory research;
  - (8) Donor engagement;
  - (9) Capacity building among peers;
  - (10) Other [free text]
- Focus HIV-related services (if any) [checkboxes]:
  - (1) HIV prevention;
  - (2) HIV testing and health sector engagement;
  - (3) HIV management and treatment;
  - (4) Treatment of AIDS/comorbidities: TB, CM, HCV;
  - (6) Other [free text]
- Focus SRH Rights [checkboxes]:
  - (1) Access to quality SRH services without discrimination;
  - (2) Access to other quality healthcare without discrimination;
  - (3) Informed consent in healthcare;
  - (4) Access to sexuality education;
  - (5) Free choice in sexuality and gender identity;
  - (6) Responding to sexual or gender based violence;
  - (7) Age of consent;
  - (8) Sexual choice;
  - (9) Gender equity;
  - (10) Privacy;
  - (11) Other [free text]

-

Concepts: Aim 2 (if applicable)

- Positive legal determinants [checkboxes]:
  - (1) Anti-discrimination measures for focus populations;
  - (2) Measures to prevent gender inequality;
  - (3) Enforceable right to health for focus populations;
  - (4) Focus population access to legal services;
  - (5) Health literacy among focus populations;
  - (6) Recognise focus population supportive civil society organisations;
  - (7) Respond to sexual and gender-based violence;
  - (8) Other [free text]
- Negative legal determinants [checkboxes]:
  - (1) Criminalising focus populations or their behaviour;
  - (2) Discriminatory treatment of focus populations;
  - (3) Permitting discrimination against focus populations;
  - (4) Contributing to or permitting gender inequality;
  - (5) Banning focus population supportive civil society organizations;
    (6) Banning services needed by focus populations;
  - (7) Defunding services needed by focus populations;
  - (8) Other [free text]
  -

Outcomes: Aim 1 (if applicable)

Resource requirements of community responses

- Measurement approach [checkboxes]:
  - (1) Modelling;
  - (2) Evaluations;
  - (3) Other
- Findings on financial resource requirements: [free text]
- Other resource requirements: [free text]

Benefits of community responses

- Type of benefit reported [checkboxes]:
  - (1) healthy life years gained or HALYs/QALYs/DALYs;
  - (2) Other health impact;
  - (3) Fiscal return (costs averted, ROI);
  - (5) Economic return (GDP, etc);
  - (6) Non-quantifiable impact (capacity, equity, etc);
  - (6) Other
- Health impacts [checkboxes]:
  - (1) Prevention;
  - (2) Service demand/utilisation/linkage/retention;
  - (3) Service access/quality;
  - (4) Adherence;

    - (5) Viral load/suppression;
    - (6) HIV incidence
- Quantitative findings on benefits [checkboxes]: [free text]
- Qualitative findings on benefits: [free text]
- Findings on cost-effectiveness [single choice]:
    - (1) Yes – cost-effective;
    - (2) No – cost-ineffective;
    - (3) Mixed;
    - (4) N/A
    -

Outcomes: Aim 2 (if applicable)

Costs and benefits of legal determinants

- Type of benefit reported:
    - (1) healthy life years gained or HALYs/QALYs/DALYs;
    - (2) Other health impact;
    - (3) Fiscal return (costs averted, ROI);
    - (5) Economic return (GDP, etc);
    - (6) Non-quantifiable impact (capacity, equity, etc);
    - (6) Other
- Health impacts [checkboxes]:
    - (1) Prevention;
    - (2) Service demand/utilisation/linkage/retention;
    - (3) Service access/quality;
    - (4) Adherence;
    - (5) Viral load/suppression;
    - (6) HIV incidence
- Quantitative findings on costs or benefits: [free text]
- Qualitative findings on costs or benefits: [free text]

Appendix 3.2 Data Extraction Note: Community Ownership

Our definition of community-led responses encompasses a diverse set of interventions carried out at varying scales and levels but that are all informed, implemented and determined by communities for their own members.[83] We have tried to ensure we do not debase the terms “key population-led” and “community-led” by including all responses involving communities or key populations. We have tested sources even when they describe interventions community or key-population-led. At the same, given that usage has varied by place and over time, we have also tried to find community or key population-led responses even in sources where responses are not termed as such with, for example, certain interventions and programmes described as “peer-led” or “community-based” still

characterised by a sufficient element of community leadership and ownership.

In general, we see true key-population and community-led responses as those not only go beyond tokenism. That is to say, we would distinguish those response with an element of co-creation that, even if meaningful, is limited to determining methods and means rather than priorities and goals or otherwise occurs within the bounds of strict externally prescribed criteria.[84,85,86,87] At the same time, we acknowledge that less ambitious forms of community-ownership may be valuable and, in certain cases, may even be necessary or appropriate, at least over the short-term, given the potential need for resourcing and community-system strengthening as well as the constraints imposed by negative legal determinants. The truth or otherwise of this claim is not answered within this review.

To allow for us to comprehensively map the literature on community-led responses while being attuned to the nuances in varying community ownership of these reasons, we have in our extraction also characterised the degree to which the responses described in our sources have been community owned:

- We have rated a response as having a “high” degree of community ownership when priority populations and community-led organisations have been initiators, designer and implementers of the responses and other actors have always been in supportive roles or transitioned into merely supportive role after a start-up phase.
- We have rated community ownership as “medium” when there is community-led co-creation in design and implementation but in response to external initiative and with significant involvement from other actors.
- We have rated community ownership as “low” when community leadership is a limited component within a top-down framework—for example when their room for initiative is limited to shaping implementation in service delivery. It would be reasonable to consider the responses we have coded as having “low” community ownership as being neither key population-led nor community-led.

In extracting for this data variable, we are rating the community ownership of the responses in questions and not of the organisations and other actors involved. We have judged community ownership based on the description of the response and those organisations and people involved provided by the applicable the source. In general, we did not look behind the source’s description and fact-check it or draw additional information from elsewhere.

In general, we were less inclined to code responses which enrolled individual members of priority populations into a programme as “high” and more inclined to code responses that involved one more community-led organisations or networks as “high”. An underlying assumption is that unorganised individuals brought into larger response will be less able to represent and assert their community’s priorities, needs and rights than a similar number of people drawn from one or more existing or newly created organisations able to draw on collective energy, coordination and decision-making. This presumption was rebuttable in certain circumstances and was shaped by the particular facts.

One of the most complex issues was raised in respect to community ownership for responses that involved community-led organisations and networks operating across large areas—globally, regionally, transnationally, nationally—but initiating one or more responses in more confined geographic settings. In these cases, we had to consider whose ownership should be centred: the overall multinational organisation (e.g. global, regional or national community-led organisations or networks) or any individual priority population members and local community-led organisations involved. Determinations depended on the context and dynamics within the source.

APPENDICES FOR DATA EXTRACTION RESULTS

The full-text files of all included studies may be found at this link.

A spreadsheet containing the extraction results may be found at this link.

Appendix 4.1 Data Extraction Results: Full References

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APPENDICES FOR BACKGROUND DOCUMENTS

Appendix 5.1: Background on Reviewers

This is a brief summary of the institutions and people involved in designing, and delivering on this review.

The review team: This review was led by Juliette McHardy and supervised by Sharonann Lynch. Their core review team was composed by Maïmouna Bah, Agrata Sharma, Rory Kearns, Sunny Light, Rachel Sadoff, Lia Karen Magtibay, Jacqueline Lamas and Quincy Jones. C. Scott Dorris from the Dahlgreen Memorial Library at Georgetown University guided the development and execution of the review's search strategy. Alana Sharp provided crucial oversight and insights for the project's data analysis. Michaela Clayton assisted in original scoping research and refinement in the methods for implementing this review. Mara Pillinger and Ngozi Erondu both also provided high-level advice in the earlier stages of the review.

Juliette McHardy, LLB, LLM: is a fellow with the O'Neill Institute for National and Global Health Law at Georgetown University Law Centre. Prior to joining O'Neill, McHardy spent two years with the World Health Organization's Fiscal Policies for Health Unit focused on advancing health-promoting taxation and building national capacity for designing, passing, implementing and defending health tax measures. She has previously worked on issues of national and global health law, alongside those of human rights and international public law, as a legal research assistant with the O'Neill Institute, the University of Auckland, and the University of Hong Kong. She holds a Masters of Global Health Law and International Institutions from Georgetown University and the Graduate Institute of International and Development Studies, as well as a conjoint Bachelor of Laws and Arts (majoring in politics and international relations) from the University of Auckland.

Sharonann Lynch: is a senior scholar at and the acting director of the Global Health Policy and Politics Initiative at the O'Neill Institute for National and Global Health Law and a senior visiting fellow at the Yale Global Health Justice Partnership. Lynch has worked for more than 20 years in the global health. Prior to joining Georgetown, Lynch worked with Médecins Sans Frontières (MSF) for 15 years, including four years in MSF projects in southern Africa, primarily focused on introducing innovative models of care and changing national policies to support improved HIV and TB care. Starting in 2009, she served as the senior HIV and TB policy advisor of MSF's Access Campaign, influencing the policies of national governments and global health actors. Prior to joining MSF, Lynch was a founding member of Health Global Access Project (GAP) and its director of international

advocacy. She serves on the UNAIDS Advisory Group, the board of Health GAP, and the board of TB Europe Coalition. In the 1990s, Lynch was an active member of the AIDS Coalition to Unleash Power (ACT UP) New York and started the Memphis chapter of ACT UP and the New York group Fed Up Queers.

Alana Sharp: is a senior associate with the Global Health Policy and Politics Initiative at the O'Neill Institute for National and Global Health Law In previous roles, she has worked as a public health policy researcher and technical specialist in the Global Fund to Fight AIDS, Tuberculosis and Malaria, amfAR, the University of Michigan, and the U.S. Agency for International Development. Her research has focused on accountability in global health programs, HIV and tuberculosis, domestic opioid use, and novel uses of routinely collected data. Sharp is trained as an infectious disease policy researcher and holds a Master of Public Health in global health policy and management from the University of Michigan and a Bachelor of Science in biology from the University of New Mexico.

The HIV Policy Lab: The review team is composed by those working within the HIV Policy Lab (HIVPL) team of the Global Health Policy and Politics Initiative at Georgetown University Law Center's O'Neill Institute for National and Global Health Law.

The HIVPL gathers data on key HIV-related laws/policies around the world—including policies related to SHRH, criminalization/stigmatization, and gender-based violence—and tracks whether countries are adopting evidence-based policies. Believing that data is only valuable if used to support change, we produce empirical research, policy briefs, and, in partnership with civil society organizations, advocacy materials to hold governments accountable for adopting and then implementing the policies needed to end AIDS as a public health threat and promote the right to health.

We have a particular focus on monitoring the adoption of social enabler policies, promote advocacy in support of the 10-10-10 targets, and analyse the impact that law/policy reform has for the broader HIV/AIDS response. Specifically, we are deeply engaged in producing evidence that can be used to advocate for adopting and maintaining the social enablers. This has resulted in research published *in BMJ Global Health* which demonstrates that countries which have adopted social enabler policies have made more progress towards achieving the 95-95-95 targets than countries which continue to criminalize and stigmatize PLHIV and key and vulnerable populations. Our experience conducting this type of analysis and our deep familiarity with the existing literature makes us well-suited to conducting

this scoping review. We also produced and our producing policy briefs and research papers tracking progress and the drivers of progress towards the 10-10-10 targets.

We also draw on O'Neill's broader legal expertise in sexual and reproductive health rights. The O'Neill Institute is also be supported, as needed, by cross-disciplinary experts in health economics and human rights at the Georgetown University Medical Center and the Georgetown University Law Center.

The O'Neill Institute: The O'Neill Institute believes that the law is a fundamental tool for solving critical health problems. We see national and global health law as a frontier for collaborative, international, and rights-based approaches to health and well-being for all. Housed at Georgetown University Law Center in Washington, D.C., the O'Neill Institute draws upon Georgetown's considerable intellectual resources, including the School of Nursing and Health Studies, the School of Medicine, the McCourt School of Public Policy, and the Kennedy Institute of Ethics. Beyond the Georgetown community, the O'Neill Institute maintains partnership with other academic and research institutions, including the Geneva Graduate Institute, with which O'Neill maintains a joint masters programme and strong research ties.

Appendix 5.2: The 10-10-10 and 30-80-60 Targets

This is a reproduction of the targets as adopted by UNAIDS Member States in the Global Aids Strategy and the 2021 UN High Level Meeting Political Declaration.[88]

10-10-10 Targets and Sub-Targets

Less than 10% of countries have punitive legal and policy environments that lead to the denial or limitation of access to services.

- Less than 10% of countries criminalize sex work, possession of small amounts of drugs, same-sex sexual behaviour, and HIV transmission, exposure or nondisclosure by 2025
- Less than 10% of countries lack mechanisms for people living with HIV and key populations to report abuse and discrimination and seek redress by 2025
- Less than 10% of people living with HIV and key populations lack access to legal services by 2025
- More than 90% of people living with HIV who experienced rights abuses have sought redress by 2025

Less than 10% of people living with HIV and key population experience stigma and discrimination.

- Less than 10% of people living with HIV report internalized stigma by 2025
- Less than 10% of people living with HIV report experiencing stigma and discrimination in health care and community settings by 2025
- Less than 10% of key populations (i.e., gay men and other men who have sex with men, sex workers, transgender people and people who inject drugs) report experiencing stigma and discrimination by 2025
- Less than 10% of the general population reports discriminatory attitudes towards people living with HIV by 2025
- Less than 10% of health workers report negative attitudes towards people living with HIV by 2025
- Less than 10% of health workers report negative attitudes towards key populations by 2025
- Less than 10% of law enforcement officers report negative attitudes towards key populations by 2025

Less than 10% of women, girls, people with living with HIV and key populations experience gender-based inequalities and all forms of gender-based violence.

- Less than 10% of women and girls experience physical or sexual violence from an intimate partner by 2025
- Less than 10% of key populations (i.e., gay men and other men who have sex with men, sex workers, transgender people and people who inject drugs) experience physical or sexual violence by 2025
- Less than 10% of people living with HIV experience physical or sexual violence by 2025
- Less than 10% of people support inequitable gender norms by 2025

30-80-60 Targets and Indicators

30% of testing and treatment services are community delivered.

- 30% of testing and treatment services to be delivered by community-led organizations, with focus on: enhanced access to testing, linkage to treatment, adherence and retention support, treatment literacy, and components of differentiated service delivery, e.g. distribution of ARV (antiretroviral treatments).

80% of HIV prevention services are community delivered.

- 80% of service delivery for HIV prevention programmes for key populations to be delivered by community-led organizations.

- 80% services for women, including prevention services for women at increased risk to acquire HIV, as well as programmes and services for access to HIV testing, linkage to treatment (ART), adherence and retention support, reduction/elimination of violence against women, reduction/elimination of HIV related stigma and discrimination among women, legal literacy and legal services specific for women-related issues, to be delivered by community-led organizations that are women-led.

60% of programmes supporting the achievement of societal enablers are community delivered.

- 60% of the programmes supporting the achievement of societal enablers, including programmes to reduce/eliminate HIV-related stigma and discrimination, advocacy to promote enabling legal environments, programmes for legal literacy and linkages to legal support, and reduction/elimination of gender-based violence, to be delivered by community-led organizations.

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