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# Collaboration between key populations in a global partnership for health and human rights: Lessons learned from ‘Bridging the Gaps’

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## ABSTRACT

Because HIV and AIDS key populations share common social-cultural factors challenging their sexual health and rights (e.g. stigma, criminalisation), there is an assumed benefit of collaborative programmes where various key populations work in solidarity. In this paper, we reflect on how partners collaborated in a complex alliance of over 100 different NGOs, representing and supporting three key populations – lesbian, gay, bisexual and transgender (LGBT) people, sex workers and people who use drugs – working across 16 countries. We used a multiple-method approach of participant observation, qualitative interviews, and a survey to explore the benefits, facilitators and challenges of collaboration. Results show that motivators for collaboration included being part of the larger funding structure with applied impacts, a repressive human rights context, and intersectionality. Barriers for collaboration included identity politics, stigma, and constraints regarding the appropriate timing of new collaborations. Finally, facilitators include practical support for engagement, the framing of human rights in a medical agenda, and recognition of implicit differences. We conclude that for building the capacity for collaboration among socially marginalised groups it is important to develop trust and the ability to recognise strength in difference beyond the initial identification of shared norms and common goals.

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Key populations; HIV and AIDS; collaboration; partnership; stigma

## Introduction

Sex workers, men who have sex with men, and people who use drugs are key populations for HIV prevention and treatment because they are disproportionately affected. While 40–50% of all new HIV infections occur among key populations and their partners (World Health Organization, 2017), key populations have the least access to prevention, care, and treatment services due to social and structural barriers, such as stigma, discrimination, violence and criminalisation. In many countries, there are laws, regulations or policies in place that diminish access to health and legal services for key populations. For example, 79 states criminalise same-sex sexual relations (Carroll & Mendos, 2017). In this context, a common assumption in programmes and published literature is that it is most effective for civil society organisations advocating and representing key populations in health and human rights to collaborate. Facing similar human rights abuses and

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social-economic challenges, collaborative programmes between key populations may benefit from the pooling of resources, experience and knowledge.

When key population programmes are discussed in the published literature, findings are typically provided for single key populations (Brown, O'Donnell, & Crooks, 2014; Brown, Luna, Ramirez, Vail, & Williams, 2005; O'Donnell, Grulich, Garsia, Parkhill, & Browne, 2010; Shannon et al., 2015). To some extent, this is to be expected. For one, it is precisely the targeting of programmes to specific community needs, which makes health promotion more effective. Furthermore, key population movements, in particular, the LGBT movement already consist of complex partnerships of actors (Binnie & Klesse, 2012; Devor & Matte, 2004). In addition to this, only a limited number of governments are willing and able to provide significant funding to integrate several stigmatised and criminalised populations. Literature describing collaborations between key populations is virtually non-existent. Within the scope of this study published literature was scanned (medline, web of science, sociological abstracts) for programmes including at least two key populations. Within the 1.165 results, we found twelve relevant articles, of which none addressed the challenges of collaboration. Outside the published literature solutions to the problem mostly bypass collaboration as a strategic option, despite giving emphasis to local, community organisations and common structural determinants (cf Baggaley, Verster, & Hirnschall, 2018). In this paper, we describe the findings of a programme that has brought partners from three key populations together in order to investigate the potential benefits of collaboration.

In 2011, the Dutch Ministry of Foreign Affairs funded one of the largest programmes in the world on key populations, called Bridging the Gaps, focused on five goals:

- (1) Contribute to an increased quality of and access to HIV prevention, treatment, care, support and other services for key populations
- (2) Contribute to the human rights of key populations
- (3) Contribute to a better integration of specific services for key populations in the general health system
- (4) Increase of the capacity to work on HIV and key populations
- (5) Contribute to the development and strengthening of an approach to HIV and AIDS in key populations with other organisations.

Currently, in its second phase, the first phase of this programme ran until 2015 and is the focus in this paper. With a total 4.5 year budget of 46.7 million Euro, with 35 million Euro coming from the Ministry and the rest consisting of co-funding, the Bridging the Gaps programme addressed human rights violations and health challenges faced by sex workers, people who use drugs, and LGBT people. This programme worked with around 100 local and regional partner organisations which collaborated with four Dutch non-governmental organisations: Aidsfonds, AFEW International, Federation of Dutch Associations for the Integration of Homosexuality (COC), and Mainline, and with five global networks: the Global Network of People Living with HIV (GNP+), the International Network of People who Use Drugs (INPUD), the International Treatment Preparedness Coalition (ITPC), the MPact (formerly MSMGF), and the Global Network of Sex Work Projects (NSWP). Local partners included 36 organisations representing the LGBT community, 44 representing people who use drugs, 25 representing sex workers, and eight partners whose main focus is on HIV and AIDS, including the lead agency. In total, the programme worked across 16 different countries.

This programme provided a unique opportunity to gain insights into the benefits and challenges of collaboration between key populations in a global partnership context. This study, therefore, focuses on factors that influenced the capacity of different partners to collaborate. Generally, collaborative capacity is associated with long-term problem-solving processes of coalitions and is an important component of collective action (Kendall, Muenchberger, Sunderland, Harris, & Cowan, 2012). In the case of Bridging the Gaps, collaborative capacity is tested when different groups work together to counter dominant systems of authority. In such 'contentious' political contexts (Leitner, Sheppard,

& Sziarto, 2008), solidarity between key populations may rise from the recognition of common struggles, and serve as basis for relationships among diverse communities (Bacchetta, 2001; Binnie & Klesse, 2012). In addition, knowledge about collaborative context helps to further understand how the globalisation of solidarities unfold (Corrêa & Parker, 2004; Faist, 2010; Scholz, 2007) in the context of the numerous partnerships that increasingly populate the global health programmatic landscape (World Health Organization, 2009). Such coalitions range from existing organisations pooling resources, to new coalitions jointly working on particular activities, or, in the most advanced stage, even representing each other's interests (Hardy, Phillips, & Lawrence, 2003).

Following Thomson, Perry, and Miller (2009), collaboration refers to a process in which (semi-) autonomous actors interact through formal and informal negotiation, jointly creating rules and structures governing their relationships and ways to act or decide on the issues that brought them together. Collaboration obviously is a process in which the development of shared norms and mutually beneficial interactions is central. Thomson et al. (2009) also found a number of elements which motivate collaboration:

Mutuality in collaboration is manifest in partner organizations that (1) combine and use each other's resources so all benefit, (2) share information to strengthen each other's operations and programmes, (3) feel respected by each other, (4) achieve their own goals better working with each other than alone, and (5) work through differences to arrive at win-win solutions (p. 42).

The authors also concluded that trust is crucial, in that there is a belief that people who represent partner organisations in collaboration are trustworthy, that partner organisations can count on each other to keep their obligations, and that partners are committed to the idea that it is more worthwhile to stay in the collaboration than to leave. Finally, they emphasise that collaboration deals with a core tension between individual- and collective interests. Barriers here include partners not reaching their own missions, perceptions of losing independence, and conflicting expectations between their own constituency and partner organisations.

This suggests that the capacity to collaborate involves dealing with tensions rooted in differences and trust. Bantham, Celuch, and Kasouf (2003) has labelled such capacity as an issue of 'mind-set', or an awareness of dialectical, relational tensions that are inherent in relationships, complemented by willingness to address these. Additionally, communicative skills are essential, such as non-defensive listening, active listening, self-disclosure, or the sharing of needs, feelings, and specific requests. Another element of collaboration concerns levels of formalisation and centralisation. Gulzar and Henry find that effective inter-organisational collaboration is more formalised, as formalisation appears to bring a measure of reassurance (Gulzar & Henry, 2005). On the other hand, they find that most staff believe that highly centralised authority is unsuitable for providing acceptable, innovative, and timely community-based services.

Building on these themes, we designed a study that focused specifically on uncovering the way in which 'collaborative capacity', or the 'conditions needed to promote effective collaboration' (Kendall et al., 2012, p. 2) developed in Bridging the Gaps. We asked what major benefits and challenges were faced in this alliance consisting of a multitude of in-country and regional partners, and nine alliance partners. Data were gathered by the Centre for Social Science and Global Health at the University of Amsterdam, supported by the Bridging the Gaps partnership team at the Aidsfonds in Amsterdam and funded by Sharenet-International (De Vries, Brenman, & Tang, 2015).

## Methods

We used a multiple method case-study approach using a concurrent triangulation design for collecting data. This consisted of ethnographic observation, focus groups and interviews, plus a social network analysis and survey. We initiated the study with ethnographic observation as basis for the design of both the qualitative and quantitative instruments which were then implemented concurrently. The study was designed and developed after several meetings with the Bridging the Gaps lead

team at the Aidsfonds. A literature study led to the development of a conceptual model on collaborative capacity building that guided the development of a qualitative and a quantitative instrument. Both instruments were pre-tested. To test the qualitative instrument, we conducted interviews with key stakeholders in Amsterdam, and we held a quantitative survey during a meeting with representatives from country partners in March 2015. Part of the development of the instruments was an internal ethics review, held with support from the University of Amsterdam Institute for Social Science Research.

### **Qualitative methods**

Qualitative methods included a multi-sited ethnography in Amsterdam, Kyrgyzstan and Kenya, as well as international events, namely a Bridging the Gaps partner forum and one research workshop held between March and July 2015. Data collection methods included a total of 45 qualitative interviews with stakeholders at all levels of the programme, from local staff to the Ministry of Foreign Affairs, including 14 with local partner organisations in Kyrgyzstan and seven in Kenya. 'Stakeholders' typically were representatives of key populations who worked professionally for a partner organisation, particularly at country and global levels. A semi-structured qualitative interview instrument was developed and pretested at a key stakeholder meeting in Amsterdam where country representatives were present in March 2015. In addition to interviews, two one-hour focus group discussions were held, each consisting of five participants representing various country partners (Vietnam, Indonesia, Pakistan, Costa Rica, Kenya, Uganda, South Africa, Georgia, Kyrgyzstan). These key population representatives had flown in for a partner meeting in Amsterdam. Both interviews and focus groups generally covered question about: (1) linkages with different key populations, (2) linkages with organisations at another level in the partnership, (3) preconditions for the alliance as a whole, (4) structure and processes for collaboration (formal, informal), and (5) outcomes of collaboration. Finally, observations were made at the Bridging the Gaps lead agency and during management meetings by the study manager, who was present at the lead agency one day per week, participating in team and management meetings, and day-to-day work. In addition, the lead researcher had previously worked with Bridging the Gaps as evaluation researcher for nine months, and both researchers were present as participant-observers at meetings where local and regional partners were present. Ethnographic field notes were kept throughout and analysed.

All interviews and focus groups lasted approximately one hour, were semi-structured, and included a qualitative mapping exercise, in which respondents drew their perception of the Bridging the Gaps programme on paper. This mapping echoed the quantitative social network analysis described below, but was used as a tool for engagement during the interview, rather than a raw data source in itself. Ten in-country (Kyrgyzstan and Kenya) interviews were conducted with a translator. In total, 35 interviews were held in English, 10 with the assistance of a Russian translator, and recorded and transcribed by research assistants. Written consent for this was obtained from all respondents prior to the interview or focus group discussion. Qualitative data analysis software (NVivo 12) was used to take an inductive approach to the written transcripts for thematic analysis.

### **Quantitative methods**

Quantitative data was obtained through a survey sent to 92 partners of the programme. The survey was conducted online, after it had been introduced to the local partner organisations with letters in Russian, English or Spanish. In total, 115 individuals from 62 partners (67% of partners) across 17 countries responded (Africa: 23; Central Asia/Eastern Europe: 34; Latin America: 6; South/South-East Asia: 12; Global/Alliance partners: 9; Cross-country networks: 8). [Table 1](#) shows the human rights situation on a few indicators for these countries, with the exception of the global or regional networks based at non-country specific locations.

**Table 1.** Legal situation of selected key population activities for country of partners participating in this study.

Country	Same sex relations <sup>a</sup>	Sex work <sup>b</sup>	People who inject drugs <sup>b</sup>
Botswana	Criminalised (up to 14 years prison)	Partial criminalisation	No data
Costa Rica	Criminalised but no penalising law	Partial criminalisation	No data
Ecuador	Recognition (partnership)	No data	No data
Georgia	Criminalised but no penalising law	Buying sexual services criminalised	No data
Indonesia	Criminalised but no penalising law	Issue determined/differs at a subnational level	High application of death penalty
Kazakhstan	Criminalised but no penalising law	Partial criminalisation	No data
Kenya	Criminalised (up to 14 years prison)	Partial criminalisation	No data
Kyrgyzstan	Criminalised but no penalising law	No data	No data
Nepal	Criminalised but no penalising law	No data	No data
Netherlands	Recognition (marriage)	Not subject to punitive regulation/Not criminalised	No data
Pakistan	Criminalised (death penalty)	Selling and buying sexual services criminalised	Low application of death penalty
South-Africa	Recognition & marriage (24 states)	Selling and buying sexual services criminalised	No data
Tajikistan	Criminalised but no penalising law	No data	No data
Uganda	Criminalised (14 – life in prison)	Selling and buying sexual services criminalised	No data
Ukraine	Criminalised but no penalising law	No data	No data
Vietnam	Criminalised but no penalising law	Selling and buying sexual services criminalised	High application of death penalty
Zimbabwe	Criminalised (up to 14 years prison)	No data	No data

<sup>a</sup>Source ILGA 2017.

<sup>b</sup>Source UNAIDS Key Population Atlas: <http://www.aidsinfoonline.org/kpatlas/#/home>.

The survey included a mapping and analysis of the partner social network, asking all the participants with which partners they collaborate now, and with whom they already collaborated before the programme. Additionally, the participants were asked to rate various issues, including contextual issues and perceived goal achievement. Using quantitative software (R), collaboration between different key populations was calculated using a ratio of cross-key population collaborations to all collaborations between partners. We did this by dividing the collaborative relationships (incoming ties) an organisation received from organisations serving other key populations by all received collaborations. This measure only included the organisations serving LGBT, people who use drugs or sex workers. A few organisations that serve people living with HIV/AIDS or multiple key populations were excluded because these organisations did not allow for the exploration of cross-key population collaboration as a result of the program.

### **Informed consent**

Informed consent was part of the survey and interview instruments. All data were kept confidential. The survey data replaced the identity of respondents with anonymous identifiers. Only the data analysis team had access to the identity of the partners, and this was not otherwise shared with any of the study participants or reviewers. An ethics review procedure was followed and approved by the Amsterdam Institute for Social Science Research (AISSR) review board at the University of Amsterdam.

## Findings

### *Motivations for collaboration*

#### *An alliance level 'movement' with pragmatic impacts*

On a practical level, the majority of the partner collaborations in the Bridging the Gaps alliance were created because of the funding requirement to work in partnership. As an alliance level respondent told us: 'It forced us to work together. And of course that force came out of an idea that key populations are in the same position, they are vulnerable to HIV and other diseases and they should work together'. During interviews, respondents noted many examples that supported the idea that specifically working with other key populations had special benefits. With respect to the efficiency and scope of services, this included the development of referral systems between partners representing different key populations at the local level, and in some cases also improving their visibility. Another example provided was the joint sensitisation of state services, which in turn greatly increased the scope of awareness raising. Partners also noted that the alliance network provided opportunities for more extensive learning than they would otherwise have been able to, and that they frequently would invite each other during campaign and training events. The network of partners allowed for a broadening of their support to basic holistic care needs, such as the need for shelter and food of many clients, which otherwise would have been even more difficult to provide.

Next to improvements in key population-specific health services and advocacy, the described motivations for collaboration also included the increased sense of togetherness, increased trust, and decreased stigma between key populations that began to form once the structures were in place to forge links with other partners. As one respondent remarked:

What is great about that [Bridging the Gaps] is opening up of the mind to diversity. Really understanding the meaning and the beauty, maybe. Because I am not sure if it is about effectiveness at this point. Well, yeah you give a training with somebody else, but that is not going to change much. But just the fact that you are with each other.

Because of these ongoing changes, staff at all levels of the collaboration referred to the joint work of partner organisations as a 'movement', both as a function of Bridging the Gaps and as part of wider global activism. One global advocacy partner noted how Bridging the Gaps is a reflection of a wider HIV movement: 'It's reflecting in a sense the dynamics that are much larger than Bridging the Gaps, which has taken them and put them within one structure'. Although partners had differing ideas about what exactly the roots of this movement were, it does tell us that Bridging the Gaps motivated access to a larger collective, in the form of a project, which includes all key populations. How much of these benefits and changes can be attributed to Bridging the Gaps depends on the context. Bridging the Gaps can mean something very different for different partners: some partners are entirely dependent on the resources to continue business, some primarily seek the sense of belonging to survive in difficult contexts, while partners with more established roles serve as mentors and merely partner to meet some smaller programmatic needs.

During the interviews and throughout the ethnographic observations, members at all levels of the alliance commented that increased collaboration was necessary and valuable for the future of the programme, but that not enough collaboration had taken place over the course of the programme. One Dutch partner noted, 'It's really something that we had to work on. In year two, you know, we didn't really share that much information. So that really developed over time and that's ... I think that's really valuable now'. Another partner from the lead organisation noted how the development of collaboration within the partnership slowly moved from competition towards empathy:

It began very competitive among each other for money, who gets the best, who does what ... and in the run of the time I think people have learned to work together more. So the quality in the empathy between the different partners along the four years you see an improvement of the empathy.

Survey results showed an overall increase in the average number of collaborative relationships per partner increased from 5,9 before the programme to 8,6 collaborations at the time of the survey in

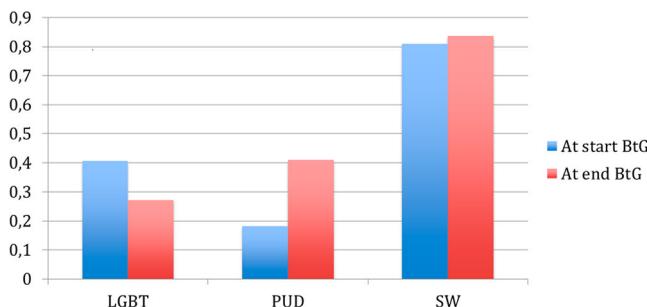
2015. Looking specifically at collaboration between partners representing a specific key population, the data, shown in [Figure 1](#), shows a particular increase for partners representing people who use drugs, contrasted to a slight decline for LGBT organisations (we could not determine the cause for this measured decline).

### Hostile human rights contexts

Next, to programmatic benefits and a sense of belonging offered by the larger alliance programmatic superstructure, another motivation for partners to collaborate with other key populations is the common experience of hostility. A global partner noted: ‘We will disagree if it’s a principle thing, but we have another thing where we stand together and we fight for global policy together. Because the similarity of stigma, of discrimination, of marginalisation of our communities is common’. Human rights advocacy needs in some partner countries, in particular, demanded cross-key population coalition building. In our survey outcomes, we saw this reflected by the finding that the organisations that had started to collaborate across key populations were also the ones who reported less progress on the Bridging the Gaps human rights goal because of extremely challenging circumstances or developments in this context. For example, in Kyrgyzstan several legal challenges to the human rights of key populations developed, due to a rapidly changing and unstable political environment, such as the Anti-LGBT legislation, a ban on ‘foreign agent’ organisations (providing care and services to key populations), and laws limiting the rights of sex workers. Besides being severe obstacles to the work of key population organisations, these challenges appeared to be key drivers for the partners to engage in joint action. As a local Bridging the Gaps partner from Kyrgyzstan stated: ‘Now we have found some joint interests and joint problems. Right now we are working on the anti-discrimination law, without indicating whether this is an MSM, a sex worker, or LGBT group ... there should be one movement to stop discrimination’. The Kyrgyz case study tells us how having partners focusing on several key populations in one country contributed to partner’s collaborative capacity development because it provided political solidarity and resilience in contentious political situations where laws or social discrimination threaten the human rights of one or more key populations. The case further confirmed benefits already mentioned, such as more opportunities for holistic, joined-up care for community members who are part of more than one key population (i.e. in need of referral between services tailored to different populations).

### Intersectionality

A third major influence motivating collaboration was common ground found through intersectionality. Intersectionality simultaneously considers the effects of multiple categories of social group membership (e.g. race, class *and* gender) that take place at multiple levels (Cole, 2008; Crenshaw, 1995). It highlights the ways key population identities overlap with each other, sometimes creating very specific or new issues for those who identify (or could be identified as) belonging to two or more key populations at the same time. Often, partner organisations had already established



**Figure 1.** Average ratio of crossover collaborations for each key population.

programmatic relationships with organisations from other key populations, even if there was not a lot of overlap. For example, a partner in Georgia noted that while Bridging the Gaps was the only funder for their (and the country's) people who use drugs programme 'under other programmes we do work with sex workers and with MSM as well, we see how that can benefit, even though in my country there is very, very little overlap between the key populations'. Partners recognised a range of common and defining experiences that were equally relevant for all three key populations across all levels of the programme. These included social/political positions, bearing the highest impact of HIV and AIDS, and the marginalised organisational experiences of key population NGOs in the global HIV and AIDS sector. All these mutually reinforcing disadvantages, when recognised as such, promoted joint understanding between key population partners and strengthened their voices in advocacy efforts. Particularly at local levels, these overlaps were easily recognised. An alliance partner noted that

The link between drug users and sex workers is more easy on the ground, because a lot of drug users engage in sex work and a lot of sex workers use drugs for different reasons. So that link is quite natural.

Whilst direct references to the concept of 'intersectionality' were more often made by partners at global and alliance levels, this quote demonstrates that at the local level, intersectional understandings amongst key populations were embedded in their lived experience of being a part of more than one key population.

## **Barriers to collaboration**

### **Identity politics**

Identity politics refers to the tendency to take on political positions that focus on the interests and perspectives of the social group with which people identify (e.g. 'their' key population community) (Bickford, 1997). Identity politics includes the ways in which people's politics are shaped by aspects of their identity through loosely associated social organisations. Many key populations have historically mobilised and de-stigmatised their communities by reclaiming their identities as social groups, to strengthen advocacy and a sense of community within these populations, and to compete for funds within well-defined territories. As groups do have individual needs, lumping them together under one label of 'key populations' can be seen to undermine the unique needs and identities of each individual social group. During the programme, tension could be seen between the advantages and disadvantages of partners explicitly identifying themselves with their specific key population 'identities', at the exclusion of others. For example, a focus group participant who was a sex worker in a local partner organisation told us:

I think the reason why people did not have the idea of working together was a lack of understanding of each other. Because I looked myself like a sex worker, and this is a problem I'm facing with my sisters. I did not look at that [MSM] brother who was behind them, because that brother did not matter at that time. What mattered to me were my fellow women.

Stereotypical identities that partners attributed to each other included the notion that LGBT partners are educated, well organised and good in lobbying, while sex workers partners are 'less academic'. These differences of the social groups had also been reinforced in the structure of Bridging the Gaps alliance, where from the initial programme proposal three separate key population projects had been identified, and not all countries hosted programmes for all three key populations. The initial governance approach tended to lean towards formalisation of processes rather than facilitating personal relationship building between the parties involved. A global advocacy respondent noted:

It was kind of like, ok, why are we creating these different silos? And that felt a little bit odd, weird. It felt like it was creating more tension than resolving them. And I talked to another guy who was at [partner name] who sits like all rolling their eyes like, here we go through another meeting that wasn't going to, you know bear any fruit

in terms of, how do we solidify this partnership? And you know, have this shared agenda as opposed to kind of just keep talking around this tension that exists?

In addition, during interviews, about half of the stakeholders participating in the management team and some local partners critically brought up the point that the funding structure limited collaboration between key populations in countries where only one project was funded. Survey results showed that for countries wherein Bridging the Gaps had funded partners from all three key populations, partners perceived to have reached more programmatic goals compared to countries where the programme focused on fewer key populations, particularly with respect to goals 4 & 5.

### *Stigma between and within key populations*

The history of identity politics is closely related to the mutual stigma which existed between the key population partners at various levels of the alliance. This was particularly so between people who use drugs and LGBT partners, whose communities across many contexts generally remain very separate from one another because of entrenched stereotypes and suspicion. Such perceived and anticipated stigma was most prominent in contexts where key populations were most isolated, discriminated and criminalised, and where a partner's activities took place mainly at a community level. One partner expressed:

Since some of the other key population's activities are illegal in our country and suffer from greater stigma than the key population we are working with, it is a challenge to advocate for other key populations towards religious leaders.

The impact of stigma appeared to go further than just mutual stigma. Even within groups, there was stigma, in particular with respect to intersectionality. For example, admitting that a sex worker is also using drugs can be difficult, as it includes further layers of marginalisation. As a respondent noted, in response to their policy to always include drug users' issues into sex work programming: 'No, we still get people that go 'we don't want to engage with that, as an advocacy thing'. Uhhh.. we get people that remain very silent on the issue'. Depending on context, mutual stigma also included the fear of association with persecuted or unpopular organisations. For local partners, some of whom had experienced mob killings and police raids during the course of our study, collaboration with risky partners was, therefore, lower on the priority list than security.

### *Cultural context, disclosure of links and timing*

Our case study in Kenya emphasised how premature implementation of collaboration between key populations may be a barrier to effective collaboration in culturally sensitive areas. In Kenya's coastal area, LGBT organisations attributed their reluctance to work with people who use drugs organisations to their Muslim orientation. However, explanations from the people who use drugs partners illustrated that this issue is part of the need to be sensitive to local customs first: 'The community works on Haram [sinfulness] reduction, while we work on HARM reduction'. According to them, it seemed too soon to confront the community with LGBT issues, because community ties to their own programme still needed strengthening. Because the development of trust with a key population's own community takes time, adding another key population to the mix in this context may not always be strategically desired. The consequence of too swift of a move towards collaboration and increased visibility also includes the risk of backlash. Another illustration of the importance of strategic timing is how in Kenya general migration of LGBT people from Uganda has made the local community more visible because of its increasing size. There was a concern that if this growth happens too quickly in a hostile environment, LGBT partners can get locked down and may have to go completely underground. This happened in Mombasa, where someone found out about a clinic and a mob destroyed the place, depriving the LGBT community from one of their few safe spaces. Often, by necessity, the integration of services between key populations is not made explicit, though they exist informally. In Kenya, organisations tend not to be explicit about including other key

populations, yet as service providers, they won't refuse any service user. Here, not disclosing what a partner is actually doing is a key cultural strategy to avoid such backlash.

### ***Facilitators (enablers) of cross-key population collaboration***

#### ***Practical support for engagement***

Opportunities for local partners to participate in global meetings and platforms bringing together several key populations appeared a key facilitator of collaboration between different key populations. The alliance further facilitated different ways in which the partners could meet locally, including round-tables, alliance meetings, and exchange visits, which allowed them to align their goals and develop common strategic agendas. Also mentioned was the special facilitating roles of more established partners who were able to bring smaller organisations together and act as a mentor, and of global advocacy partners such as GNP+ and ITCP, who work with all three key populations as part of their mandate. Partners also mentioned the importance of opportunities to sit in on working groups, such as permanent bodies advising police or medical professionals. Further, information and communication strategies for working with partners, and a permanent information and communication platform for continuous exchange of information and best practices was suggested. Other alliance facilitators recurrently mentioned were the increased openness and visibility of partners leading destigmatisation campaigns, learning to focus on mutual understanding and empathy, sensitisation or reduction of mutually negative stereotypes (particularly between the LGBT community and people who use drugs) and the minimisation of competition between partners. Finally, the development of good referral systems was an often mentioned facilitator for collaboration.

#### ***Medicalised framing of human rights issues***

The framing of human rights issues in a health perspective appeared another effective way to bring different partners together. The strategic focus on a health perspective acknowledges the intersectional overlap in the different communities (LGBT people who use drugs, people who use drugs doing sex work, etc.), motivating service providers to gain more knowledge on the needs of the different key populations and improve mutual referral processes. As one service provider for people who use drugs noted: 'As far as you have problems with drug use, you're one of us, we don't care whether you are MSM or sex workers'. In addition, the health perspective also seems preferable in terms of policy and advocacy. For example, in Kenya, there has been a technical working group at county level setup by the Ministry of Health which has facilitated integration, and has connection to similar structures in other countries as well that bringing key populations together. There also is the National level Kenya AIDS strategic plan. Overall, it is health that brings key populations together, as the HIV epidemic is a policy priority. Because Kenya's Ministry of Health is progressive on these issues, it also created space and framing to work with on a local level. A community-led LGBT partner stated:

... we decided that we go to approach the religious leaders, but we're going to do this on a health basis. So that is when they came, then we started the health approach, you know HIV and AIDS, how people get infected, and the prevention and stuff.

Providing a medical perspective can be used strategically to depoliticise on all levels of collaboration, including policy, advocacy & rights and the strengthening of existing networks. At the same time, it is clear that this strategy also has some major drawbacks. Some would argue though that such a strategy can undermine the legitimacy human rights as important in and of themselves, and that over-medicalisation can lend itself to quick fix medical 'solutions' to complex problems (e.g. opiate antagonist treatment) over solutions that require structural approaches, like decriminalisation and harm reduction.

**Recognition of implicit differences**

Finally, we learned that when individuals described their organisation’s linkages and collaborations during interviews and focus groups, they often talked about wearing ‘different hats’ in order to show themselves in different lights in different situations or contexts. Partners defined themselves in much more diverse and flexible ways than the explicit Bridging the Gaps structures suggested, such as shown in Figure 2.

In this model, in blue are the explicit differences identified in the programme, complemented by other, often implicit expressions of difference which were encountered through our analysis and are shown in red, and loosely framed as either a medical or human rights perspective. Note that none of these building blocks are mutually exclusive. While the resulting model is abstract and particular to Bridging the Gaps, it generally illustrates the way in which a partner’s positioning in a collaborative structure does not only act as a potential barrier to collaboration, reinforcing identity politics. It also provides potential for recognising shifting and complementary differences. The Bridging the Gaps

**PUBLIC HEALTH APPROACH**

PERSPECTIVE



MEDICAL



HUMAN RIGHTS

ORIGIN

PUBLIC SECTOR

CIVIL SOCIETY

NATURE OF ADVOCACY

HEALTH RIGHTS

SOCIAL JUSTICE

**ORGANIZATIONAL PROFILE**

LEADERSHIP



PROVIDER-LED



KEY POP.-LED

SERVICE PROVIDED



PREVENTION / TREATMENT



LEGISLATIVE / LEGAL



PERCEIVED ROLE



IMPLEMENTATION



ACTIVISM

POPULATION SERVED



PEOPLE WHO USE DRUGS (PUD)



LESBIAN / GAY / BI / TRANS (LGBT)



SEX WORKERS (SW)

ORGANIZATION TYPES



LOCAL



DUTCH ALLIANCE



GLOBAL

**Figure 2.** Bridging the Gaps conceptual model illustrating changing positionalities within the key population alliance. Note that none of these building blocks are mutually exclusive.

partners have made efforts to recognise the influence of other identities, or the different ‘hats’ they may wear depending on context. For example, the influence of different positions related to leadership (provider or key-population led partner) or the perceived roles (implementation versus activist) have become much more explicit throughout the evolution of the alliance. This has helped attune to their audience, emphasise complementary strengths, or where needed, commonalities.

## Discussion & conclusion

In this paper, we observed a complex alliance working with over 100 partners which aimed to bring together key populations and organisations working at global, alliance, regional and country levels. Triangulating the results from observation, qualitative interviews and a survey, this study identified the benefits, motivators, facilitators and challenges of collaboration between partners with different backgrounds, to identify opportunities to further strengthen collaborative capacity of key population organisations.

Together, the findings illustrate how in the contentious context of human rights to health among stigmatised groups such as key populations, the existence of a larger, international supportive framework such as Bridging the Gaps, is very valuable. Both survey and qualitative results emphasised an increase in collaboration overall and between key populations. We can see that in contrast to what was reported by Gulzar and Henry (2005), the most effective structures we observed in our case study were not highly formalised or centralised, but more supportive. A flexible funding approach and the realisation of being part of a wider supportive network encouraged many partners to continue their struggles. The study further confirmed how collaboration had pragmatic benefits for the improvement of health services and human rights advocacy. In contrast to the notion in the literature that recognition of commonality is a prime motivation for collaboration, we saw that in this case the funder’s initiative of bringing partners together under one human rights to health umbrella still led to a relatively slow recognition of the value of collaboration throughout the programme. It took time to develop trust internally, hindered by structural barriers in the programme, identity politics, and stigma between key populations. In addition, a number of implicit differences between the partner’s identities (e.g. community led versus provider led) simmered underneath the surface of the programmatic classification of differences by key population and organisational type (global, alliance, country).

Although generalisations are hard to make from a case study approach – one of the main limitations of this study – it can be concluded that collaboration between marginalised social groups is valuable particularly if common goals and intersectional dynamics exist. It also requires investment in time and resources at the beginning of a partnership to develop trust and counter identity politics and stigma between groups. We propose the mapping of implicit differences and commonalities, which may not be built into the official structures of a complex partnership, is a tool to build collaborative capacity. In addition, through regular interactions, diverse groups can learn to recognise both their similarities and differences and learn to turn such differences into valuable, complementary strengths.

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