

Addressing sexual and reproductive health and HIV needs among key populations

The challenge

30 years into the HIV epidemic, the sheer scale and dimensions of the challenge are still staggering. Progress has been made across the world: HIV treatment is increasingly available, health services are being strengthened, and access to linked sexual and reproductive health (SRH) and HIV services is being recognised as a priority.

Despite the global progress made in response to the HIV epidemic, however, people remain neglected or hidden and are disproportionately affected by HIV. These key populations - men who have sex with men (MSM), sex workers, people who inject drugs and transgender women - are less likely to access information and services, particularly because the availability of high-quality, stigma-free HIV and SRH services is extremely limited for key populations, despite their increased need to access them.

The response to generalised epidemics can frequently lead to neglect of the needs of key populations, who experience the epidemic at its most severe. This often coincides with stigma and discrimination, gender inequality, violence, lack of community empowerment, violations of human rights, and laws and policies that criminalise drug use and diverse forms of gender identity and sexuality. Together, these factors limit access to HIV and SRH services by key populations, constrain how these services are delivered, and diminish their effectiveness.

Our approach

BACKUP Health and the International Planned Parenthood Federation (IPPF) have collaborated over many years to foster greater and more rapid action on SRH and HIV linkages within the Global Fund to fight AIDS, Tuberculosis and Malaria (Global Fund). Recent collaborative work has highlighted gaps in addressing the specific needs of key populations within Global Fund programmes.

'Shadows and Light', a three-year project funded by BACKUP Health, aims to address the linked SRH and HIV needs of key populations within four IPPF member associations. The project involved the Family Planning Association of India and transgender people, Reproductive Health Uganda and sex workers, Family Health Options Kenya and people who inject drugs, and the Cameroon National Association for Family Welfare and MSM.

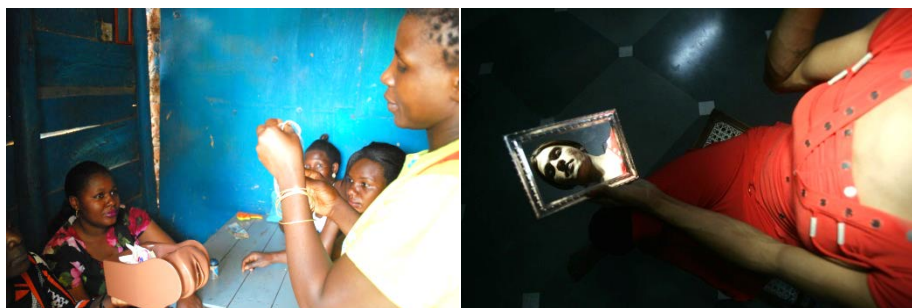
The project recognised that a comprehensive response to HIV must include initiatives that meet the needs of those who are marginalised, vulnerable, socially excluded and under-served. Based on these linkages, addressing SRH within HIV programmes and services funded by the Global Fund is a key opportunity to ensure sustainability in service provision to key populations.

The benefits

The overall aim of the project was to promote SRH and HIV linkages for key populations within Global Fund processes and programmes in Cameroon, India, Kenya and Uganda.

Major benefits were achieved through:

- Developing IPPF service capacity that addresses SRH and HIV linkages for key populations
- Increasing action on SRH and HIV linkages for key populations within Global Fund Country Coordinating Mechanisms (CCMs) in the four countries, and
- Increasing global recognition of linked SRH and HIV needs of key populations and of how Global Fund programmes can be a key avenue for addressing these.



L. to R.:
Demonstrating female condoms in Uganda.
A transgender woman in India.

Case study 1: men who have sex with men in Cameroon

In Cameroon, the SRH and HIV service needs of men who have sex with men are largely ignored because of political sensitivity to the issue and widespread stigma and hostility, as illustrated by the murder of prominent gay activist Eric Ohena Lembembe in 2013. Discrimination on the part of health service providers and a lack of information on SRH and rights mean that people of diverse sexual orientations and gender identities are unable to access health services, leaving them vulnerable to poor health. The HIV prevalence among MSM is very high in Yaoundé and Douala, with a reported HIV infection rate of 37.2% among this group (UNAIDS, 2012).

The Cameroon National Association for Family Welfare (CAMNAFAW) has scaled up its work in providing and campaigning for integrated services to MSM and, more broadly, to the lesbian, gay, bisexual, transgender and intersex (LGBTI) community. As a Principal Recipient (PR) under the Global Fund - Round 10 HIV Project, CAMNAFAW has a track record of making a significant contribution to the Global Fund strategy to reduce the transmission of HIV among most-at-risk populations. However, this focuses solely on HIV prevention with MSM, sex workers and truck drivers, and activities with MSM are limited to educational talks, HIV testing, distribution of condoms, and syndromic management of sexually transmitted infections.

Addressing needs

CAMNAFAW worked in partnership with civil society and local organisations already working with men who have sex with men under the Global Fund-supported programme to ensure that the 'Shadows and Light' project complemented existing activities and filled the gaps. Yaoundé and Douala were selected as pilot sites based on the number of MSM living there, the available infrastructure for implementing a broad range of integrated services, and the opportunity to demonstrate the benefits of a broader and more integrated approach, particularly to the Global Fund. Close collaboration with Care Cameroon enabled CAMNAFAW to strengthen the continuum of care, particularly for MSM living with HIV, through the use of Care Cameroon's drop-in centre to provide psychosocial care and of mobile testing units offering HIV testing in key 'hotspots', including cruising sites for MSM.

Main achievements

Expanding the reach of the project beyond MSM to meet the needs of LGBTI and people selling sex. CAMNAFAW broadened the project scope to provide comprehensive and integrated services to other people of diverse sexual orientations and gender identities, including lesbians and other women who have sex with women, transgender individuals, and sex workers.

Involving key population representatives strategically in designing and implementing the project and in advocacy for their needs. The involvement of a consultant who self-identifies as MSM (who is also the Representative for Key Populations on the

CCM) has been highly beneficial in supporting the project, including leading advocacy activities with the CCM, providing mentoring to other key population representatives who participate in the key population Taskforce, and developing the MSM 'report card'.

Using resources strategically to fill the gaps identified by civil society in the Global Fund programme. CAMNAFAW implemented the 'Shadows and Light' project strategically to complement its large Global Fund project, of which it is the PR. The complementarity of the two projects has helped develop comprehensive integrated SRH and HIV services.

Ensuring key population representation and accountability through Global Fund processes. This was achieved through establishing a key population Taskforce (supported in part through 'Shadows and Light') and having a key population Representative on the CCM. The project provided training to members of the Taskforce on the benefits and strategies to integrate SRH and HIV services. As a PR, CAMNAFAW was heavily involved in drafting the new concept note and advocated for the Minimum Package of Activities for key populations, which includes the integration of SRH and HIV activities across three priority components: prevention; testing and screening; and care and treatment.

Improving key population participation in the country dialogue process. 12 representatives (in collaboration with the Global Forum on MSM & HIV) were trained and supported to participate in the Global Fund country dialogue. Three of these (two identifying as MSM and one woman from the sex worker community) went on to participate in the key population taskforce established by Affirmative Action to play a 'watchdog' role and ensure that key population needs were integrated into the concept note. 'Shadows and Light' provided training and mentoring to the three representatives to act as key population focal points, engage fully in CCM meetings and contribute to the development and review of the concept note.

Key challenges

Safety and security situation of MSM / LGBTI in Cameroon.

Following the murder of Eric Ohena Lembembe, a prominent gay activist, in 2013, a coalition of LGBTI community organisations circulated a memorandum announcing the suspension of all activities with partner organisations because of the dangerous environment and lack of security. CAMNAFAW responded by organising two meetings with LGBTI community members in Yaoundé and Douala. Through consultation and consensus, a commitment was made to resume cooperation with partner organisations on the Global Fund project, with regular risk management meetings to review the ongoing situation.

Policy-makers, including the National AIDS Council and the Ministry of Health, are reluctant to discuss human rights. They are more open to discussing issues from a public health perspective, so it is important to 'speak their language' while also encouraging them to understand the human rights impact on public health and acknowledge that improving human rights for key populations is an important part of the solution to improving health outcomes.



Demonstrating female condoms in Uganda.

Lessons learned

CAMNAFAW used modest project resources strategically to address current gaps in services and accompanied this with effective advocacy to ensure these approaches were scaled up. The project has created a deeper understanding of interventions within the larger Global Fund project and has helped to identify relevant gaps.

As Cameroon enters the grant-making phase for Global Fund, it is important to ensure that all activities agreed in the concept note are now implemented. Continued support is necessary to allow and ensure key populations participation in relevant meetings. Key population representatives recognise the value of CAMNAFAW as the PR and its strong relationship with key population organisations, but key populations also need to speak for themselves and articulate their own needs.

Genuine capacity building among key population leaders takes time and is incremental. Community leaders also need training on national health systems, so that they are able to understand the concepts, engage fully with government representatives and speak confidently to CCM members.

Case study 2: people who use drugs in Kenya

The coastal region of Kenya has one of the country's largest populations of people who inject drugs, with an estimated HIV prevalence of 18.3% (UNAIDS, 2012). With an estimated HIV prevalence of 44.5%, women who inject drugs are particularly vulnerable. For many women, their main SRH concerns relate not only to HIV but also to other issues, such as access to contraception, family planning and safe abortion services. Family Health Options Kenya (FHOK) has identified high levels of sexual and gender-based violence among women who use drugs compared to men, with many experiencing violence and sexual exploitation for a 'dose' or when they were 'high'. This further increases their vulnerability to HIV, other sexually transmitted infections and unintended pregnancies.

Harm reduction services are limited in Kenya, as they are relatively new and face opposition from conservative and religious groups. It is estimated that only 15% of people who inject drugs are reached by services: the specific needs of women are often overlooked, and services are not adequately accessible to young people. This lack of relevance and access is compounded by fear of arrest, the high cost of treatment and high levels of stigma from service providers, all of which act as significant barriers to accessing the services required.

Addressing needs

FHOK, a leading service provider of SRH services in Kenya, focuses particularly on young people and marginalised and socially-excluded groups, including people who inject drugs and, more broadly, people who use drugs (PUDs). It has clinic sites in coastal areas of Kenya and is, therefore, well placed to respond to key population needs. FHOK initiated a comprehensive response for PUDs, particularly women, by integrating SRH, HIV, and harm reduction services across eight sites.

FHOK provided training to its own clinic staff as well as service providers from government facilities. In partnership with organisations working with PUDs, they provided integrated services through a static clinic, as well as through community-based outreach in selected areas. In partnership with other service providers, FHOK also supported outreach workers to distribute clean needles. Support group sessions, led by trained alcohol and other drugs counsellors, were also put in place, offering social support and harm reduction information for PUDs.

Given its experience in delivering youth-friendly SRH services, and with an established youth centre in Mombasa, FHOK began to reach out specifically to young people who use drugs. FHOK recruited 10 people under the age of 24 (six females and four males) who had experience of using drugs and trained them as community mobilisers. This team contributed to planning and implementation of project activities, based on their knowledge of the routines and needs of young people who use drugs.

Main achievements

Providing more than 5,000 people who use drugs with SRH, HIV and harm reduction services through a combination of clinic-based and outreach services. 54% of women using drugs who were using FHOK's programme accessed a comprehensive SRH package including various reproductive health services and HIV and other sexually transmitted infections screening and treatment. In most cases, sterile needles were provided directly, while other harm reduction services were provided through referral.

Comprehensively addressing the needs of service users with multiple and overlapping vulnerabilities. Young people using drugs are largely neglected in terms of service provision and many also sell sex, particularly in the tourist coastal areas. Reaching women who use drugs remains challenging, although there was a significant increase over time in the numbers accessing community outreach sessions and the static clinic.

Sensitising and training 15 service providers in public and private facilities in Mombasa to provide integrated harm reduction, SRH and HIV services for PUDs. Service providers were initially reluctant, fearing they would be seen as ‘accomplices’ because of the criminalisation of drug use. FHOK focused on the right to access stigma-free services and built tolerance and respect towards PUDs. A project implementation committee made up of PUDs supported training events designed to support the development of key population-friendly clinics, ensured that clinics were equipped with the relevant supplies, and developed referral systems in collaboration with outreach workers.

Ensuring sustainability of the work with PUDs by integrating it within existing clinics. Continuity of community-based services has been ensured as service providers have been sensitised and trained and PUDs have developed skills as outreach workers and have built close links with other organisations working with PUDs. Efforts to make this strategy sustainable include equipping the public health facilities with the necessary equipment and personnel, bridging the gap between services and service users, and crucially involving the community.

Working with law enforcement and police to increase their understanding of the issues and ensure project ‘buy-in’. This was critical to ensuring that outreach workers could conduct their activities without fear of arrest.

Key challenges

The current hostile environment / security situation in Mombasa is preventing PUDs accessing critical services. A Presidential Directive against drug use (a ‘clean-up’ campaign) has led to arrests, violence and harassment for PUDs, some of whom have been detained without access to medical treatment, including methadone. There is a very real fear for people’s safety, including those suffering severe withdrawal. Needle and Syringe Programming has faced opposition in Kenya and remains closely regulated, limiting the number of clean needles distributed.

Not all referral points were able to offer the same range of services or respond to needs comprehensively. This was because of limited resources to purchase needles, methadone and more costly treatments, such as those for chlamydia and hepatitis B and C.

Lessons learned

Involvement of key populations is instrumental and ensures that programmes meet the real and comprehensive needs of PUDs. Their existing involvement as peer outreach workers and counsellors should be built on further, to facilitate and support PUDs to take roles as decision-makers and experts.

Developing strategic partnerships with key population networks, for example the Kenyan Network of People Using Drugs, would be mutually beneficial and would support a broader harm reduction, SRH and HIV response.

Need of proper representation of key populations within CCMs. Despite the country dialogue and related Global Fund processes being perceived as inclusive of key populations, there is currently

only one key population representative on the CCM. Continued advocacy – along with capacity building for key populations’ representatives to ensure their genuine participation – is required to increase engagement of key populations.

Case study 3: sex workers in Uganda

HIV prevalence amongst female sex workers in Uganda is very high and estimated at 34.2% in Kampala (UNAIDS, 2014). Despite this, both government and non-governmental organisations report that the majority of sex workers do not have access to risk reduction interventions. Even where these are in place, they often focus primarily on the distribution and promotion of male condoms. While this is clearly important, it fails to address the broader SRH needs of women, including access to a wider range of family planning information and contraceptive options, legal safe abortion and post-abortion care, and measures to address the high levels of sexual violence women face.

Reproductive Health Uganda (RHU) began providing outreach services in the slum areas around Kampala in 2008. Through their outreach, the team became concerned by the numbers of women with repeated sexually transmitted infections, reporting serious instances of sexual violence, and having repeated unsafe abortions. This project built on efforts providing services for sex workers through an established clinic and community outreach, and the existing relationships developed with sex workers.

Addressing needs

RHU works through its Bwaise Clinic, located in the Kawempe District in the urban slums of Kampala, to increase access, coverage and quality of SRH and HIV services for female sex workers. RHU operates a peer-led, community-based programme to provide a comprehensive package of SRH and HIV services. Sex workers were trained to provide peer outreach at 10 locations in the slum districts of north-western Kampala working through a ‘cluster’ model, in which outreach workers conduct activities in their own communities.

In Bwaise, RHU specifically aimed to cater for young people who sell sex, recognising their heightened vulnerability. Inexperience makes individuals more vulnerable to being assaulted and exploited by clients or more experienced sex workers and weakens their ability to negotiate safer sex practices. Peer educators have supported these young sex workers by providing information, supplies and access to a broad range of SRH services, and helped identify supplementary sources of income.

Recognising the needs of the increasing numbers of sex workers living with HIV, RHU added some further chronic care components, mainly supplies of cotrimoxazole to treat bacterial infections, and referred and linked to other HIV programmes that provide antiretroviral treatment related services, including CD4 and viral load monitoring. Children of sex workers and other key population groups are linked to other projects that provide specific services, including educational support, immunisations, and growth monitoring in addition to routine management of common illnesses.

Main achievements

Advocating for specific interventions and commodities to deliver tailored services that meet service users' needs. Monthly 'cluster' meetings were held with peer educators and service providers to provide feedback on services, discuss challenges, make suggestions for change, plan subsequent outreach activities and distribute condoms and family planning and other supplies. This increased the project's relevance and ability to respond appropriately to the needs of sex workers and MSM.

Reaching out for more than 2,000 sex workers with integrated SRH and HIV services including safe abortion, post-abortion care, family planning, sexually transmitted infections screening and treatment, and HIV testing. 90 sex workers (60 females and 30 males) were trained as peer outreach workers to deliver integrated services within their own communities through a 'cluster' model. The outreach strategy has not only made it possible to reach out to more sex workers and other key population groups but also enabled a more comprehensive package of services to be provided.

Intensifying comprehensive programming for male and female condoms for sex workers to prevent sexually transmitted infections, including HIV, and unintended pregnancies. The majority of the women had not seen or touched a female condom at the beginning of the project, but they are now in such high demand that peer outreach workers have insisted on the importance of distributing them through outreach instead of only making them available through the clinic. Having outreach workers involved in community-based distribution has greatly increased access to condoms by sex workers and other key population groups in Kampala.

Successfully linking key populations who test HIV-positive to care and treatment services. Through combined clinic and community-based activities, RHU was able to link all those diagnosed with HIV to appropriate HIV treatment and care, with only a small number lost to follow up. The Bwaise Clinic has since been approved by the Ministry of Health as one of six RHU clinics to offer antiretroviral treatment, which will offer further services to people living with HIV.

Successful advocacy for the inclusion of SRH and rights and HIV activities for sex workers within the final approved Global Fund concept note. This was the result of the combined advocacy of civil society, including key population groups. RHU is represented on the CCM and trained six active and experienced peer educators on advocacy and supported their involvement in country dialogue processes.

Key challenges

An Anti-Homosexuality bill is still planned and an Anti-Pornography Act has been passed, which has exacerbated existing

hostility to key populations. This has made RHU's work with MSM even more challenging and represents a serious threat to the safety and security of MSM and peer outreach workers more broadly. However, strategies take the security situation into account by enabling outreach workers to work close to their homes so that they can return quickly if they feel unsafe at any point.

There is currently no declared key population representative on the CCM in Uganda. This issue is reported as being highly political, although two CCM representatives (from the International Community of Women Living with HIV and Community Health Alliance Uganda) were acknowledged as advocates for the needs of key populations.

Lessons learned

There is a clear benefit for clinics to be able to provide comprehensive services through a 'one-stop' centre, especially in contexts where there is significant threat and hostility towards key populations. Though RHU provided supported referrals, service users could not be followed up because of reluctance to access unknown services or fear of discrimination or even arrest.

Migration of sex workers requires a broader coverage and better distribution of services tailored towards sex workers. There is a need to continue to expand services to new areas or strategic locations to respond to emerging needs.

Meaningful inclusion of key populations is necessary for successful programming. Partnerships between stakeholders, peer educators, key population communities and sensitised health care providers has helped to overcome barriers to accessibility and ensure that key population needs are met.

Case study 4: transgender women in India

India's estimated HIV prevalence remains concentrated among key population groups, with the highest HIV prevalence among transgender women. In 2012, the HIV prevalence among transgender women in major cities like Mumbai and Delhi was nearly 25%. Vulnerability to HIV is often due to poverty, lack of family support, and absence of legal recognition and the ability to function productively in society. In 2009, the Delhi High Court decriminalised homosexual relations, but in December 2013, the Supreme Court overturned this decision and reinstated section 377 of the Indian Penal Code, which criminalises sexual activities 'against the order of nature'. This impacts on the considerable stigma and discrimination that prevails against MSM and transgender people, especially transgender women and the Hijra community. This stigma and discrimination, which is embedded in Indian society, plays out in health care settings. It leads to poor access for transgender people to services, further



Community outreach in Kenya

compounding their vulnerability to sexually transmitted infections, HIV and poor health. In April 2015, India's Supreme Court recognised transgender people as a third gender, a positive step towards respecting their rights.

Addressing needs

The Family Planning Association of India (FPAI) has extensive experience in working with men who have sex with men and the transgender and Hijra communities. Among their proven interventions are recruitment of staff from these communities, who are well placed to identify their specific needs, and development of partnerships with other service providers to address the particular needs of transgender people, such as gender affirming procedures.

FPAI chose four project locations, all of which are recognised as Integrated Counselling and Testing Centres by the National AIDS Control Organisation (NACO). At each location, organisations working with transgender people communities were mapped to ensure collaboration and to estimate possible reach. A community consultation meeting with local community-based organisations working with transgender people was held in all four sites to better understand the needs of transgender people and inform participatory project design and priorities. FPAI trained clinical staff and built their capacity to provide sensitive and appropriate services to transgender people in line with their specific needs. Since the inception of the programme, FPAI has expanded services across an additional six sites.

Main achievements

Facilitating participation by transgender people in project planning and delivery. Consultations with transgender women at the beginning of the project informed project design and priorities and ensured that training and services were appropriate to their needs. Transgender women were also recruited as outreach workers and counsellors. Effective community mobilisation for transgender people has built their capacity to take ownership of the programme.

Using 'feminising services' as an innovative entry point to HIV services. Through community consultations, transgender women identified the services they most wanted, such as hormone therapy, sex reassignment surgery, breast augmentation and laser therapy for facial hair removal. FPAI used the opportunity to provide access to hormone therapy as an entry point to HIV and SRH services. Ensuring high quality counselling is important in terms of the support for transgender people in their decision whether to begin a gender reassignment process.

Developing effective partnerships and referral pathways. All four locations have developed partnerships with local organisations working with transgender people, and these organisations are now referring their service users to FPAI for SRH services, as they are confident that their service users will receive quality services and staff will maintain confidentiality. FPAI has now a reputation for providing SRH services to female partners and other family members of transgender women.

Ensuring the confidentiality of services provided to transgender people. Some community-based organisations

referring transgender people to FPAI are reported to put pressure on clinics to provide them with their service users' test results, and some have been reported to treat positively tested service users less favourable. A clear FPAI policy ensures service users' confidentiality.

Reaching out to young key populations. 45% of those reached were below the age of 25; many had left their families and were engaging in sex work. Most of the young transgender women were the 'chelas' (students) of a 'guru' (teacher), in their community's tradition of master-disciple relationship within. When the 'gurus' go to the clinics, they often bring along their 'chelas' and introduce them to the staff. The project also worked closely with families to address stigma and discrimination and promote family acceptance and support.

Key challenges

Transgender women face many challenges such as being highly vulnerable to HIV, engaging in sex work, undergoing violence – including sexual violence – and police harassment, and suffering family rejection. Transgender people living with HIV face a double stigma. As a consequence of these challenges, they are not likely to seek health measures and often do not see health as a priority.

The overturning of the 2009 Delhi High Court decision that decriminalised homosexuality has created a lot of problems for community outreach programmes, as staff fear harassment by police. In addition, although transgender people are now legally recognised as a third gender and protected under the Constitution, they still face the threat of arrest for having same-sex sexual relations.

FPAI were not able to get involved in Global Fund discussions at national level as it is not a CCM member. This has made it difficult for it to advocate for integrated services within Global Fund programmes despite other advocacy efforts.

Lessons learned

Knowing the community context. Community consultation and involvement of transgender women in project design and delivery underpin successful outcomes. Identifying and utilising innovative entry points, such as work within existing community structures (e.g. with 'gurus' and 'chelas'), and identifying gender affirming procedures, such as laser treatment or hormone therapy, as an effective entry point for SRH and HIV service delivery were key elements in the success of this project.

Employing transgender people as outreach workers and counsellors. This instils a feeling of trust and belonging and helps address high rates of unemployment and poverty among the transgender community.

Ensuring that services for transgender people are built-in within FPAI clinics ensures sustainability. Transgender women view FPAI clinics and staff as non-judgmental and trustworthy. Together with effective partnerships and referral pathways, this ensures that work with key populations is now built in and will continue beyond the end of the project.

Overall success factors

The success of 'Shadows and Light' relied on how well IPPF's Member Associations were placed in the four countries to respond to the needs of key populations and to campaign for their interests within Global Fund processes and programmes. General success factors of the member associations chosen were:

A history of working with key populations

All member associations have a history of seeking to work with key populations in their local context and a strong foundation in rights-based approaches for marginalised and underserved populations.

IPPF strategic support to develop capacity

All member associations were supported through IPPF's focused HIV capacity building strategies. These strategies led to targeted support from IPPF Regional and Central offices in developing and managing HIV focussed policy and programmes.

Relationships with networks of people living with HIV

All member associations have partnerships with local networks of people living with HIV, representing a commitment to support these networks in representing the rights of people living with HIV.

Overall recommendations

Planning and designing integrated SRH and HIV services for key populations

- Identifying appropriate and innovative 'entry points' is critical if key populations are to be engaged on SRH issues.
- Effective interventions must recognise and respond to the complex and often overlapping vulnerabilities of key populations, especially among young key populations.
- Sensitising / training staff to challenge values and stigmatising attitudes and work effectively with key populations is critical and needs to include all clinic-based staff.
- Key populations prefer being able to access services through a 'one-stop' centre, particularly in hostile environments.

Increasing key population involvement and building leadership

- Promoting the meaningful involvement and leadership of key populations – particularly in expert or decision-making roles – increases the appropriateness and effectiveness of programmes and reduces stigma.
- Engagement with key population networks (national and international) was limited in practice, and there is considerable scope to engage further with these networks as strategic partners.

- Genuine leadership development of key population representatives takes time, requires strategic investment and is not achieved through workshops alone.
- Continued advocacy is required at national level to increase key population representation on CCMs.

Campaigning for, and funding, integrated SRH and HIV services for key populations

- Using restricted project resources strategically to complement existing programmes and address gaps in services demonstrates impact and supports advocacy with donors to ensure these approaches are scaled up.
- Small pilot projects can demonstrate important lessons regarding the benefits of integration for key populations, from which larger programmes can develop.
- Flexibility on the part of donors can enable projects to respond more quickly and effectively to specific needs as they arise.
- There is an urgent need to prioritise investment in tailored and targeted services for young key populations.

Conclusion

The 'Shadows and Light' project has had a significant impact in each of the four target countries in terms of sensitizing MA staff and service providers and building their capacity to reach out to members of key populations. Integrated SRH and HIV services were provided through a combination of clinic-based and out-reach services.

As a result of actively involving key populations in designing and delivering the project, and the flexibility offered by BACKUP Health to respond to emerging needs and priorities, the initial scope of the project broadened considerably to reach additional key population groups, including young key populations as a priority population. Working closely with key population communities to identify appropriate and innovative entry points has proved critical to engaging them on SRH and HIV issues.

The provision of integrated SRH and HIV services for key populations – particularly through their expressed preference for the 'one-stop' clinic approach – remains inadequate in many countries. HIV prevention continues to be the main focus of key population programmes, with less attention paid to broader but related SRH issues. 'Shadows and Light' has demonstrated that IPPF's organisationally strong rights-based approach is a solid foundation on which to build and expand their existing work with vulnerable and socially excluded groups to provide integrated SRH and HIV services for key populations. This offers tremendous potential to scale up this approach and integrate services for key populations through IPPF's established global infrastructure.

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