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Gender, Sex and the Power of Solidarity:
THE IMPLICATIONS OF EMPOWERING WOMEN AT RISK OF HIV AND AIDS

Why Investigate Women's Empowerment and HIV & AIDS?

We know that empowering women is fundamental to ending poverty and protecting human rights and dignity. But as program implementers and advocates, we want to better understand how increasing women's empowerment influences women's vulnerabilities to HIV so that we can strengthen this work and scale it up. With this in mind, CARE set out on a global journey to explore this relationship between women's empowerment and vulnerability to HIV through a multi-country, comparative research study in Africa, Asia and Latin America. The study tested what a global body of knowledge suggests:

- An effective HIV and AIDS response must address drivers of power in women's lives, including gender, class, race and occupation.
- Many HIV interventions targeting women and girls fail to understand what motivates their choices and overlook the broader factors that shape women's vulnerability. These shortcomings perpetuate a disconnect between international aid and needs on the ground.

Our Research (June 2007 – December 2008)

CARE created a global team of women from communities in which we work alongside experts in public health, gender and women's rights, and policy and advocacy. Our global research partner, the International Center for Research on Women (ICRW), provided guidance on research methodology and analysis.

The study examined CARE's work with sex workers in Bangladesh, Cambodia, India and Peru; urban garment factory workers in Lesotho; and rural women in post-conflict Burundi. In each country, CARE's program interventions utilized solidarity groups or peer education groups, hypothesizing that these strategies would foster collective agency to support women's empowerment, which would, in turn, increase women's ability to protect themselves from HIV-related risks. We explored women's definitions of empowerment and associations between measures of empowerment (e.g. self-esteem, decision making) and HIV risk (e.g. condom use, HIV knowledge).

A global research framework was developed through a collaborative process. Country teams led the research and analysis using interviews, focus groups and semi-structured questionnaires with more than 1,800 women.

Findings and Recommendations

Despite the diversity of contexts, similar patterns emerged. It is clear from our findings that bringing groups of women together to collectively address problems in their lives is beneficial. We also found ways in which we can more effectively foster that solidarity.

The power and potential of groups to impact women's lives differs greatly depending on the extent to which groups holistically approach women's empowerment. Too often, women's empowerment amounts to increasing women's agency, and overlooks structural and relational factors such as laws, social norms and power dynamics within women's key relationships that define so many aspects of their lives. A woman may have the knowledge and courage to request condom use with her partner, but if her partner is not also sensitized to understand the benefits of using condoms, then her efforts may be futile. Similarly, a woman living in a high HIV prevalence country may be well aware of the need to practice protective sex, but may engage in unsafe transactional sex because of economic dependence on others. Therefore, we cannot work solely with women, but must also engage with the key people in their lives – such as their husbands, lovers and family members. The most deeply rooted drivers of HIV are found in inequitable power structures and relationships in which women are at a disadvantage.

In addition to thinking holistically about our approach to women's empowerment, we similarly need to think of women themselves holistically. Our programs tended to target the public spheres of women's lives – intervening in their workplaces (garment factories, brothels), improving health services for vulnerable populations, building awareness of rights and skills to confront local institutions who were infringing on their rights (e.g. police, pimps). Though these may serve as initial entry points for programming, we need to expand the framing of our work with women beyond narrow categorizations such as "sex workers" or "garment factory workers". These women are also mothers, wives, daughters-in-law, and sisters; all these roles present different types of support and constraints in her life.

Highlighted Findings

- In Peru, 93% of sex workers who were members of a community-based organization (CBO) reported using condoms with their clients compared to 84.8% of those who were not associated with a CBO.
- In Bangladesh, 96% of brothel-based sex workers who were involved with the project reported using condoms with clients compared to 60% of those not associated with the project.
- Of the sex workers who were associated with a CBO in India, 97% reported consistent condom use with clients compared to 74% of those who had no CBO association.
- In Lesotho, within both the intervention group and comparison group, only 30% reported using condoms with their intimate partners.
- In Peru, of sex workers associated with a CBO, 37.3% reported condom use with an intimate partner compared to 19.4% of those not associated with a CBO.
- Within brothel-based sex workers in Bangladesh, 96% involved with a CBO reported condom use with intimate partners vs. 60% of those not associated with a CBO.
- In India, 13% of those associated with the project reported using condoms with their husbands vs. 16% of those not involved. With regard to "temporary husbands" (another type of intimate partnership), 54% of those involved in the project reported using condoms compared to 0% of those not involved.

In our programs, we found many improvements in the lives of women who participated in groups. Program participants reported higher utilization of STI and HIV testing and services compared to peers who did not participate in CARE's programs. They tended to carry less self-stigmatizing views of their social position in their communities, had higher self-esteem, had better knowledge of HIV, and reported being able to address powerful stakeholders through their group leadership. But, if our overall goal is to increase women's empowerment and reduce women's vulnerabilities to HIV, we did not complete our job, especially when we look at the private spheres of women's lives – namely sexual relationships with intimate partners. Almost universally, women explained that with their husbands and intimate partners, they seek love and trust, both of which they feel are undermined by the use of condoms. Yet many of the women reported abuse and infidelity in these intimate relationships, factors which increase vulnerabilities and risk of contracting HIV.

Recommendations

1. Design projects with a comprehensive approach to empowering women. Projects should aim to increase women's agency, help them engage more effectively with power holders and support them in challenging structures that make them vulnerable. A well-designed project can strengthen women as collective actors to challenge structural forces and ultimately create sustainable change.

2. Ensure that project design takes into account the diversity of relationships in women's lives. Implementers should avoid the tendency to categorize women in simplistic terms that might lead to a blind spot in the design of a project. The categorization may initially serve as an entry point but must eventually expand to a holistic view of the multiple identities of women. A thorough mapping and social analysis that explores women's roles and relationships as well as the many power holders in their lives is essential to the project design process. This process can be deeply personal and requires trust with communities; in these cases, this type of mapping may take place mid-way through a project.

3. Engage men as are part of the solution. In all research sites, women's relationships with men were instrumental in influencing women's sexual relations and HIV-prevention behaviors. With regard to men, women cited fear of violence or abandonment; elimination of needed resources; a desire for maintaining love, trust and familiarity; men's lack of information on HIV; and traditional gender roles as key factors that influence their decisions in regard to HIV prevention. Research from all six countries indicated that women's risk of HIV remained high despite their correct knowledge because their male sexual partners were neither involved in HIV interventions nor willing to adopt safer sex methods. It is unrealistic and short-sighted to put the onus of safer sexual practices solely on women. Their sexual partners need to be engaged as well.

4. Design flexible long-term funding cycles. Implicit in implementing these program recommendations is the need to address donor flexibility. Implementers need to ensure that donor education is not only focused on the issues, but also the processes needed to best meet shared goals. Current program funding, specifically U.S. government funds for HIV and AIDS, places heavy emphasis on narrow and specific project results without investments in broader programming that will make the results more sustainable and wide-reaching. A flexible program design allows for communities to identify programming priorities and interventions, thus engendering a sense of ownership and commitment from communities.

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