



Standing Together, Reducing Risk:
THE POWER OF GROUPS

SEPTEMBER 2009

“For us, it’s very difficult to negotiate the use of condom with our partners, because they are the men who go to bed with us, and wake up with us, the fathers of our children, the men we trust.”

— PROJECT PARTICIPANT, PERU

Acknowledgements

Contributing Authors: Leah Berkowitz, Theresa Hwang, Indira Sarma and Nadia Shadravan

We are especially grateful to the following for their contribution to CARE 's research study:

The CARE Global Coordinating Team

Madhu Deshmukh	Jodi Keyserling	Velina Petrova
Michael Drinkwater	Elisa Martinez	Nadia Shadravan
Theresa Hwang	Matthew Mathias	Diana Wu

International Center for Research on Women (ICRW)

Country Research Teams

Bangladesh

Victor Robinson
Andrea Rodericks
Fatima Jahan Seema

India

Nabesh Bohidar
Dr. Jose Sool
Sandhya Venkateswaran

Peru

Ximena Salazar**
J. Maziel Girón**
Clara Sandoval**
Victor Salazar**
Virginia Baffigo
(**Universidad Peruana Cayetano Heredia)

Burundi

Domitile Ntacobakimvuna
Jane Iredale
Tony Klouda

Lesotho

Mokhantso Makoae*
Zitha Mokomane*
Palesa Ndabe
Leah Berkowitz
(*Human Sciences Research Council)

Cambodia

Mercedes Logarta
Socheat Chi
Paula Gleeson

And mostly, we would like to acknowledge and thank the hundreds of women who helped shape and inform the research by participating in the design, implementation, response, and analysis of our research.

This study was made possible through support provided by the Ford Foundation.

Executive Summary

For over a decade, CARE’s HIV & AIDS programming and policy advocacy has highlighted the centrality of women’s empowerment within a broad rights-based approach to confronting HIV & AIDS. Implementers and women themselves have highlighted gender, class, race and other structural drivers of power as important influencers in determining sexual practices of at-risk populations. With funding from the Ford Foundation and in partnership with the International Center for Research on Women (ICRW), CARE sought to establish a fuller and more empirically grounded narrative about the impacts of CARE’s empowerment approaches for HIV prevention for women. This study was driven by CARE’s desire to strengthen our HIV and AIDS programming, engage constructively in policy debates on HIV & AIDS, and strengthen our accountability and internal learning.

This report is one product of CARE’s 18-month investigation assessing our women-focused HIV prevention projects in six different countries. The study explores how women’s empowerment approaches link to changes in women’s vulnerability to HIV. The projects under this study include those that work with sex workers in Bangladesh, Cambodia, India and Peru; garment factory workers in Lesotho; and rural women in post-conflict Burundi.

Group Methodologies and the Solidarity Spectrum

In all six sites CARE used group methodologies to bring together women whose marginalized status heightens their vulnerability to HIV¹. The group methodologies manifest in the form of peer education groups, solidarity groups and **community-based organizations (CBOs)**. In our global analysis of the six countries, we categorized the group methodologies along a “solidarity spectrum.” The spectrum traces the degree to which empowerment is incorporated into a project’s group methodology.

EXAMINING CARE’S INTERVENTIONS AND ITS IMPACT ON DIMENSIONS OF EMPOWERMENT



On the left-end of the spectrum, with the less comprehensive approach to empowerment, projects in Lesotho and Cambodia used peer education to provide women with information to make better choices in HIV prevention. In the middle, projects in Peru and Burundi used a group approach which emphasized solidarity within the group to collectively raise women’s self-esteem, self-confidence and awareness of their own human rights. At the far right of the spectrum, projects in India and Bangladesh that had the most comprehensive approach to empowerment engaged women’s groups not only to raise their individual self-esteem and self-confidence, but also to change societal structures identified as key drivers of their vulnerability to HIV.

Our research showed a range of outcomes associated with different types of group methodologies along this solidarity spectrum. For all six projects, women's participation in groups was associated with an increase in accessing HIV services and knowledge of HIV issues – essentially, increasing a woman's agency to protect herself from HIV. Group methodologies in the middle of the spectrum linked with changes in women's agency as well changes as in their relationships, for instance through an increased ability to discuss condom use with a partner or a client. Finally, those projects at the far right of the spectrum were linked to a change in women's agency, relationships and structural environment – for instance, in the increased ability of women to work with police to end police violence against sex workers. The more actively empowerment-focused projects that were able to build capacity and strength of the groups were also the ones with most promise for long-term sustainable impact.

We also observed that our interventions tended to be more focused in the public sphere than in the private sphere of women's lives. The evidence that, for instance, sex workers' condom use with a client is relatively high and consistent, but condom use with a lover is lower, calls for a greater understanding of the dynamics of women's private lives and how program implementers and policymakers can better respond to these dynamics.

While we see many benefits of women's empowerment to reducing vulnerability to HIV, it is clear that there is still room to do more. Recommendations include:

- 1. Design projects with a comprehensive approach to empowering women.** With the guidance of an appropriately designed and implemented project, the strength of women as collective actors can sustainably address drivers of HIV.
- 2. Ensure that project design takes into account the diversity of relationships in women's lives.** A thorough mapping and social analysis that explores women's multiple identities and relationships as well as the many power holders in their lives is essential to the project design process.
- 3. Engage men.** In all research sites, women's relationships with men were key in influencing, women's sexual relations and HIV-preventative behaviors. Men are also part of the solution.
- 4. Design flexible and long-term funding cycles.** Effective and sustainable improvements in empowering women and preventing HIV require fundamental shifts in power in key relationships such as between women and men, sex workers and institutions (e.g. police, health providers) – all of which require engagement in communities over a longer period of time.





Table of Contents

List of Acronyms 9

Introduction 10

Research Context 10

CARE's Empowerment Framework and Vulnerability to HIV 11

Group Methodology and the Women's Empowerment 13

Research Findings 14

Intervention Design: Examining CARE's Group Methodologies 16

Intervention Examined: Engaging with Power Holders 21

Intervention Impact: Failing to Reach the Private Sphere 23

Conclusions and Recommendations 27

Appendices 30

Endnotes 42



List of Acronyms

ABUBEF	Association Burundaise pour le Bien-Etre Familial (<i>Burundi Association for Family Welfare</i>)
AIDS	Acquired Immune Deficiency Syndrome
BBSW	Brothel-based Sex Worker
CBO	Community-based Organization
HIV	Human Immunodeficiency Virus
HBSW	Hotel-based Sex worker
ICRW	International Center for Research on Women
NGO	Nongovernmental Organization
PMTCT	Preventing Mother-to-Child Transmission
PSCAAL	Private Sector Coalition against AIDS in Lesotho
SAFE	Cambodian Sex Workers HIV/AIDS Risk Reduction Advocacy, Facilitation and Empowerment project
SAKSHAM	Strengthening Awareness, Knowledge and Skills for HIV and AIDS Management Project
SBSW	Street-based Sex Worker
SHAKTI	Stopping HIV and AIDS through Knowledge and Training Initiatives
STI	Sexually Transmitted Infection
TB	Tuberculosis
VCT	Voluntary Counseling and Testing for HIV

Introduction

In the world of HIV programming, empowerment approaches have emerged over the years in response to the ineffectiveness of health promotion efforts that ignored drivers of power in women's lives: gender, class, race and occupation. Further, growing communities of women – sex workers, migrants and even young married women – began to demonstrate how their own organizing efforts could empower them to better protect their health, and also to realize a fuller range of their human rights.

As an organization committed to addressing the underlying causes of poverty and social injustice, CARE values women's empowerment as both integral to our commitment to human rights and as a pathway to dismantling the deep structures that sustain poverty. CARE's HIV programs have drawn on these principles, integrating biomedical strategies for preventing the spread of HIV (such as condom promotion, VCT and PMTCT) with social, political and economic approaches that foster women's abilities to identify, pursue and protect their rights. Within a funding landscape that is often shaped by polarized debates around sexuality, reproduction and choice, there is a need for grounded evidence from empowerment-based HIV projects.

Research Context

In April 2006, CARE held a global conference on women, HIV & AIDS and human rights entitled *Carpe Momento! Seize the Moment!* As an outcome of the conference, CARE committed to documenting evidence from our extensive global portfolio to provide guidance for actors seeking to reduce the vulnerabilities of women to HIV. Building on that commitment, CARE now offers the findings of this inquiry into six of our HIV prevention programs that incorporate empowerment in varying degrees.

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 – drawing from the perspectives of over 1,800 respondents. CARE, country research teams and our global research partner, the International Center for Research on Women (ICRW), collaboratively designed a three-stage research framework incorporating qualitative and quantitative methods that were adapted by each of the six countries to suit their specific contexts and projects. The design and analysis was built based on a literature review of women's empowerment and HIV & AIDS.

The following is a summary description of the six projects:

In **Bangladesh**, the *Stopping HIV/AIDS through Knowledge and Training Initiatives* (SHAKTI) program (1995-2005) encompassed several projects united by a collectivization approach to working with sex workers in Dhaka and Tangail, Bangladesh. The program initially established a health clinic for brothel-based sex workers (BBSW) in Tangail that soon became a self run clinic; another component trained street-based sex workers (SBSW) in Dhaka as peer educators for condom promotion and sexually transmitted infection (STI) prevention. Two sex worker self-help groups formed by the project came to serve as the platform for a range of programmatic interventions in health, human rights and advocacy.

In **Burundi**, the *Umwizero: Positive Future for Women in Burundi* project (2006-2013) was built around the core programmatic element of savings and loan groups. Through these groups, a number of objectives were achieved in

savings and credit, HIV awareness and testing, interpersonal and interfamilial relationships, human rights education, negotiating with authorities, and others.

In **Cambodia**, the *Sex Workers' HIV/AIDS Reduction, Advocacy, Facilitation and Empowerment (SAFE)* project (2004-2007) drew on the peer educator and solidarity model to create a network of sex workers and karaoke workers that developed their leadership skills, confidence and advocacy abilities, in addition to HIV awareness and service access, Khmer literacy, vocational training and savings activities. The network members also connected with the national union of sex workers for national advocacy on rights-based HIV programming.

In **India**, the *Strengthening Awareness, Knowledge and Skills for HIV/AIDS Management (SAKSHAM)* project (2001-2010) works to collectivize sex workers in Rajahmundry, India. Through the project, sex workers have formed CBOs that foster leadership and community solidarity, and registered a federation of these CBOs. In addition to the management of an STI and HIV clinic, the project provides on-going training for social change agents who provide information on risk reduction and access to services. A critical component involves community-based advocacy with the police and media to change harmful attitudes toward sex workers. The project has also helped form crisis intervention teams that work with police and pimps to stop trafficking of young girls into sex work, and respond to violence against sex workers.

In **Lesotho**, the *Private Sector Coalition against AIDS in Lesotho (PSCAAL)* project (2002-2006) – a CARE-led collaboration between private sector and nonprofit actors – focused on peer education for the workforce in the garment factories in Lesotho. The project utilized peer counseling to influence behavior change, formed groups for care, support and discussion about HIV and AIDS, educated and encouraged workers to know their serostatus, provided mobile voluntary counseling and HIV testing clinics, and helped companies with their workplace HIV and AIDS policies.

In **Peru**, CARE is the principal recipient of the Global Fund to Fight AIDS, Tuberculosis and Malaria, where we have been coordinating programming with sex workers since 2003. Training in rights and HIV emphasizes multiple themes: human rights as a fundamental basis for eliminating discrimination and social stigmatization; and community participation.

CARE's Empowerment Framework and Vulnerability to HIV

Drawing on over three years of discussions with women around the world through the Strategic Impact Inquiry process, CARE has developed a conceptual framework that defines empowerment as the sum total of changes needed for a woman to realize her full human rights. The framework identifies three mutually reinforcing, and at times overlapping, dimensions of change:

- **Agency:** The aspirations, resources, actions and achievements of women themselves. CARE sees empowerment as a journey through which poor women increasingly use their agency to expand their options and challenge inequities.

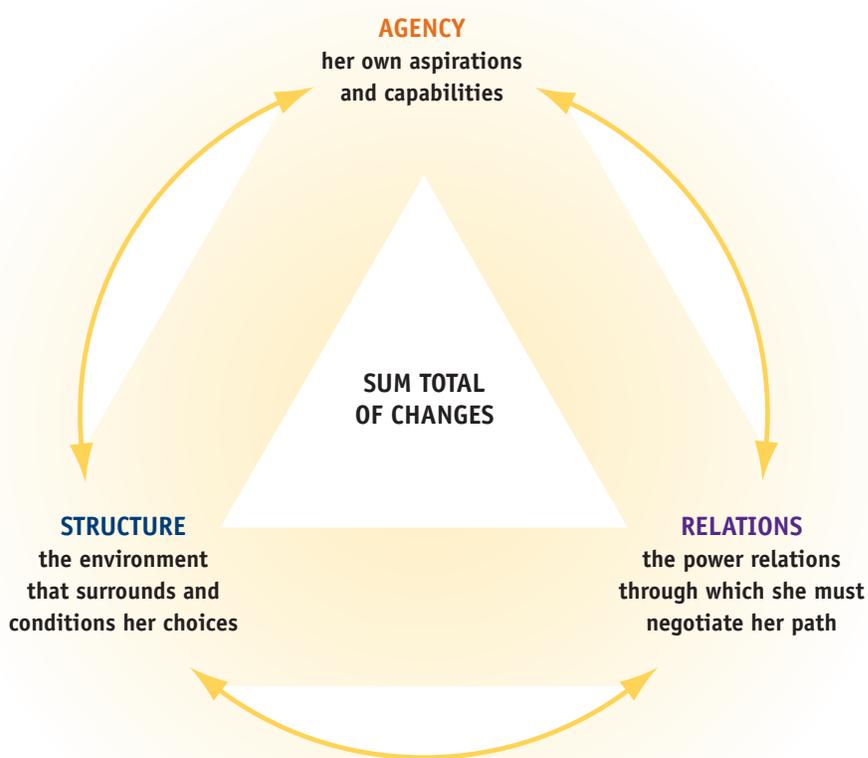
Strategic Impact Inquiry (SII)

CARE's SII is a three year study that seeks to evaluate CARE's impact on women's empowerment. It balances the goals of rigor, learning and organizational change, with the specific goal of fostering a culture of critical thinking in CARE, and with those we serve. Spanning nearly 30 countries, hundreds of projects, and the views of thousands of women, the SII draws key insights about women's empowerment work across different regions, and across different sectors and approaches that CARE engages.

- **Relations:** The social connections through which women negotiate their preferences, expectations and habits with other social actors. These include romantic/familial bonds, notions of love and marriage, as well as other relationships with family members, community members, other women in their groups, etc.
- **Structure:** The environment that surrounds and conditions a woman's choices. Structure includes routines, conventions and institutions that establish accepted forms of domination and agreed social order. Structures are so much a part of people's daily lives that most people hardly detect let alone question them.

DEFINING WOMEN'S EMPOWERMENT

CARE understands empowerment as the sum total of changes needed for a woman to realize her full human rights – the interplay of changes in:

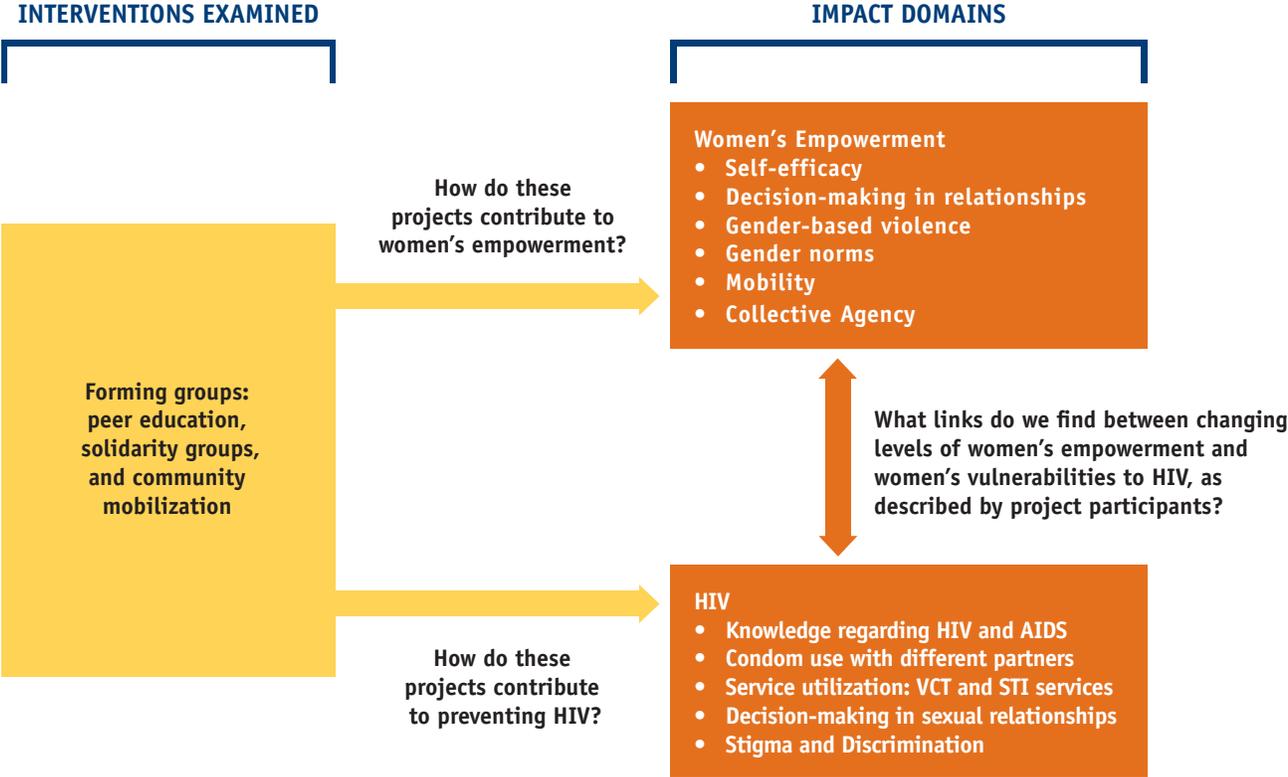


For instance, a woman might suggest condom use to her husband (agency), but she will need her partner to cooperate if she is to protect herself from HIV (relations). A woman may decide to join the self-help group (agency), and then she is able to put her children through school with the loan because the self-help group gets her access to the local bank (structure). A woman may decide to get tested for HIV (agency), but she continues to be at risk until her partner (relations) decides to go with her to the sensitized health care worker (structure) at the local VCT center to get tested.

CARE's theory of change is that reducing women's vulnerabilities sustainably requires change across each of these dimensions. In contexts where vulnerabilities involve risk of contracting HIV, we must ask how an intervention addresses women's risk of HIV vis-à-vis restrictions on individual agency, power imbalance in relationships, as well as structural risks or threats.

Our research sought to understand whether the empowerment strategy used in each project actually led to outcomes related to women’s empowerment and HIV risk, as noted in the figure below:

FIGURE 1: RESEARCH FRAMEWORK



In the absence of baseline data for the research domains, each of the domains were assessed across dose-response groups. We posited that women who are directly or closely involved with the project would experience greater effect of the project than those who were not involved.

Group Methodology and Women’s Empowerment

Despite contextual differences, each project in this study used a type of group methodology in working with participants, incorporating varying aspects of the empowerment framework. This range encompasses what CARE is terming a “solidarity spectrum.”

Group methodology refers to a collection of participants that belong to a similar social stratum – economic, social, professional or other² – formed primarily to enhance their own self-efficacy. For the purpose of this discussion, this enhancement can take place through increased information, social or economic support, or a combination, and is often facilitated by trained people who are also members of that stratum. In this research, CARE primarily examined three different group methodology types that we categorize as: peer education (Lesotho and Cambodia); solidarity groups (Peru and Burundi); and community mobilization (Bangladesh and India).

Research Findings

EXAMINING CARE'S INTERVENTIONS AND ITS IMPACT ON DIMENSIONS OF EMPOWERMENT



Our research showed a range of outcomes associated with different types of group methodologies along this solidarity spectrum. For all six projects, women’s participation in groups led to an increase in accessing HIV services and knowledge of HIV issues. Group methodologies in the middle of the spectrum linked with changes in women’s agency as well as changes in their relationships, for instance through an increased ability to discuss condom use with a partner or a client. Finally, those projects at the far right of the spectrum were linked to a change in women’s agency, relationships and structural environment – for example, in the increased ability of women to work with law enforcement to end police violence against sex workers. The more deliberately empowerment-focused projects were able to build the capacity and strength of groups, and were also the ones with most promise for long-term sustainable impact.

Overall, the following trends emerged:

- Knowledge of HIV prevention was found to be high for all the sites, both in intervention and non-intervention groups.
- Utilization of HIV/STI services was higher among intervention groups compared to non-intervention groups.
- In projects working with sex workers, condom use with clients was high, but condom use with intimate partners (lovers or husbands) was relatively lower.
- Use of condoms with an intimate partner was found to be low across the board, in all groups and projects.

The table on the next page presents a synopsis of the research findings.³ While the six countries shared a common global research framework, each

For this discussion, we characterize different group methodologies as:

Peer Education

Interventions that are comprised of discrete peer-to-peer information sessions attended by different individuals each time sessions are held. Individuals meet to share and discuss problems but do not actively engage power holders.

Solidarity Groups

Interventions that bring together the same group of women meeting on a consistent basis. The groups engage women who reside outside of mainstream society and are the most vulnerable to share and discuss problems and strategies to address HIV risk. The thematic focus of the groups include rights awareness and advocacy engagement.

Community Mobilization

Interventions that are designed and implemented in partnership with the target community to address structural issues in order to reduce individual vulnerability to HIV. The process emphasizes active participation and ownership building.

country research team adapted the framework to their context. Each country has its own data set. For the following table, we made qualitative assessments from multiple sources⁴ and categorized findings for each domain as high, medium and low. Shaded boxes indicate findings that showed a possible project effect, where respondents who had participated in the project had relatively higher levels than respondents who did not participate in the project.⁵

Findings Table

	Country	Lesotho	Cambodia ***	Burundi	Peru	India	Bangladesh
Women's Empowerment Dimensions	Key Intervention	<i>Peer education</i>	<i>Peer education; solidarity groups</i>	<i>Solidarity Groups</i>	<i>Solidarity Groups</i>	<i>Community Mobilization</i>	<i>Community Mobilization</i>
Agency	<i>Knowledge of HIV and prevention</i>	High	High	High	High	High	High
Agency	<i>Utilization of HIV/STI services</i>	High	NA	Low	High*	High	High
Agency	<i>Knowledge of HIV status</i>	Low	NA	NA	High	High	High
Agency, Relations	<i>Ability to discuss condom use with clients</i>	N/A - not a sex worker site	NA	N/A - not a sex worker site	High	High	High
Agency, Relations	<i>Use of condoms with clients</i>	N/A - not a sex worker site	NA	N/A - not a sex worker site	High	High	High
Agency, Relations	<i>Ability to discuss condom use with intimate partner</i>	High	NA	Low	Low	NA	High
Agency, Relations	<i>Use of condoms with intimate partner</i>	Low	NA	NA**	Low	Low	Medium
Agency, Relations	<i>Self-efficacy, confidence, self-esteem</i>	NA	NA	Low	Medium	High	High
Agency, Relations, Structure	<i>Perception of collective efficacy</i>	NA	NA	Medium	High	High	High
Agency, Relations, Structure	<i>Awareness of rights; desire/perceived ability to act on rights</i>	NA	NA	NA	Medium	High	NA

* Monthly check up are mandatory for sex workers in Peru.

** Discussing condom use is taboo in Burundi so few respondents answered the survey question on this variable.

*** This table focuses on quantitative research. Cambodia only conducted qualitative research.

Intervention Design: Examining CARE's Group Methodologies

Peer Education

Peer education communicates an informational message, such as a desired behavior change, through an actor with whom participants are able to identify because of similar ethnic, cultural or professional backgrounds. In Lesotho, CARE trained peer educators to conduct education sessions and provide peer counseling to fellow workers in order to avoid HIV risk and learn their HIV status; fostering empowerment was not an explicit goal of the project.

Peer educators from the Lesotho project echoed the same benefits that are in the literature regarding peer education strategies:

"I have helped a lot of people by encouraging them to do an HIV test and to accept their status, even when they are positive."

"We have lists of many people who wish to test because after talking to them, they now have understanding about the infection..."

"I know my HIV status, and many colleagues approach me for advice and guidance."

The quantitative data substantiated these observations: for instance, of the research participants who knew of at least one source of HIV services, 90.7 percent of those involved in the project had tested for HIV compared to 9.3 percent of those who were not involved in the project.

Although the Lesotho project was the only one without an explicit empowerment component, the findings indicate empowering impacts of peer education on the peer educators themselves. The Lesotho researchers noted that the peer educators' role had expanded through the course of the project to become lay counselors in the workplace, approached for guidance not only on HIV-related issues but also for advice in financial matters and domestic violence. Their knowledge as peer educators enhanced their status within their peer network; this sense of confidence and capability in turn affected their own lives. As one peer educator noted:

"When I was a young woman new in marriage, I practiced unsafe sex with my husband. We never used condoms since my husband hated condoms and I felt compelled to do what he wanted even though I knew it was unsafe. Now, I know better and I always insist on condom use... I know how to say 'no' and stand by my decision."

Yet these benefits did not necessarily extend to participants; the design of the project made any growth beyond the level of information dissemination improbable. Individual contact with the group was inconsistent; garment factory workers took part in peer education sessions on-site as they were able to attend. Consequently, participants varied from session to session, making ownership of the group and solidarity among participants difficult.

Similarly rooted in the peer education methodology, the Cambodia SAFE project is also the first along the spectrum to incorporate empowerment into project design. SAFE trained peer educators who worked in brothels and other entertainment facilities, who in turn mobilized their peers for HIV education, advocacy and life skills work. The qualitative results from Cambodia indicate that the peer education component of the project resulted in greater use of condoms and greater uptake of health services. To quote key informants:

“Through SAFE, I got a chance to meet other women and have fun. We also learned to protect ourselves from STI, hepatitis, things we never knew about when we left our hometown... HIV can be contracted through breastfeeding, sex, using the same needle... Condoms cannot protect 100 percent especially when it breaks. We have to check for the expiration date and make sure we press all the air out.”

“Although I was already using condoms before SAFE, I became more careful when I got involved with SAFE, like when the client refused to use condoms, I would tell them that I was not sure if I was infected so we better use a condom just to be safe. They then stopped refusing.”

In addition, many women’s responses begin to indicate smaller impacts from the project’s limited empowerment focus, in areas such as confidence and self-esteem. Unlike the Lesotho project, these benefits in Cambodia were seen not only within the peer educators, but also within the participants themselves. One participant observed the impact of the project on several spheres of her life. Notably, she comments on the shift in her own self-image and self-esteem, and the theme of increased confidence continues throughout.

“I used to feel I was bad / poor because I was a karaoke worker, but SAFE helped give me dignity. Now I know things and am aware of society... I get invited to different programs or activities – meeting the district and provincial governor and other powerful government officials. I am not afraid of anybody anymore. When I am sick I go to the hospital right away or if I have a problem, I run to the police immediately.”

Despite these strides, the researchers observed that the project successes seemed dependent on CARE staff and did not last beyond the life of the project. The design of SAFE did not cultivate participant ownership of project activities and processes. The duration of the project itself was also very limited.

Solidarity Groups

Whereas peer education groups mainly focus on providing information, solidarity groups are based on the concept that bringing women together enables them to develop their self-confidence, self-esteem and self-efficacy. Solidarity groups can provide a mechanism to raise women’s awareness of their human rights and also bring women together to use their collective strength to influence power brokers and stakeholders.

In Peru, the sex worker organizations formed through the projects were designed to serve as bases of support, aid and solidarity. While the projects used peer educators to disseminate information on HIV and STIs, the organizations also



explicitly emphasized the development of self-esteem and the awareness of rights through training workshops. As one peer educator observed:

“Well, what we want more than anything is that our rights are respected and instill this in the girls. We do workshops that we take to the different establishments: bars, hostels. We take the presentation to the girls about what their rights are, so they don’t go through what one has gone through, and become more aware of their rights.”

Sex worker testimonials indicate that membership in the organizations has not only given them information on health and well-being, but also has provided them with security and knowledge of their rights, particularly in interactions with their clients:

“Let’s say you go somewhere, to defend against something that has been done to you; I belong to an organization, right? Because sometimes when you go somewhere alone, it’s as if they don’t take you seriously. But, if you say you belong to an organization, like you’re not alone, it fills you with energy, with courage.”

Across the sites in Peru, over half of all sex workers interviewed stated “we fight harder for our rights” as a reason for affiliation to sex worker organizations. The belief in human rights was clearly linked to HIV-protective behavior. Analysis of the findings reveals a positive correlation between belief in one’s rights on the one hand, and consistent condom use with clients on the other: over 90 percent of sex workers who believed sex workers had rights reported always using condoms with their clients. In contrast, only half of sex workers who did not believe in sex worker rights reported always using condoms with clients.

In Burundi, the fundamental theory of change for the Umwizero project was that “being a member of a group can lead to improved social efficacy – that is, communication, self-confidence with others, taking decisions with others.”⁶ The project used savings and loan solidarity groups as an entry point for increasing the social and economic status of women through enhanced participation in the household decision-making process and, importantly, with increasing access and control of productive resources.

Women who participated in the project demonstrated increased self-esteem, increased freedom of movement – traditionally quite restricted in the region of Burundi where the project was implemented – as well as increased self-confidence. These attributes, combined with the increased income that they were earning from savings group activities, led to greater ability to speak in public as well as to make decisions in the household, group and community. A key feature of the Umwizero project was engagement with the men in participants’ lives:

“Prior to the intervention of the project, we were hidden in our houses; we could not participate in meetings or talk in public. We were afraid. Communication/freedom of speech with our husbands was very limited. But now, we speak at home, in meetings and our opinions are listened to and respected by the men.”

“We are happy to see that men see that we can give constructive opinions; they see that we are also intelligent and not small children, as they used to consider us.”

The researchers reasoned that the dramatic change in the relationships between the savings group members and their husbands provided some indication of greater ability of the women to negotiate sexual decisions in the household as well. However, this outcome was difficult to measure directly because of the taboo associated with discussing sex:

“We got married knowing that it is the husband who has to manage all the aspects of sex. It is embarrassing for a woman to talk about sex.”

Community Mobilization

Highly stigmatized by mainstream society, many sex workers also isolate themselves from fellow sex workers due to intense feelings of self-stigma, constant self-preservation and perceived competition with other sex workers. Both the Bangladesh SHAKTI project and India SAKSHAM project sought to create a sense of community among individual sex workers and to empower them not only as individuals but also as communities through a community mobilization approach.

In community mobilization, community members are viewed as prime actors rather than passive beneficiaries, an approach that gives them ownership over project processes and outcomes. The approach explicitly begins with a focus on the women themselves,

who define the issues in their lives and work on equal footing with program implementers to design appropriate interventions. Community mobilization approaches include identifying and addressing factors that make individuals and communities vulnerable to HIV; helping remove the barriers that impede access to relevant information and services; enabling individuals/communities to act based on their decisions and skills; and creating an environment to sustain changed behavior and safer practices.

Utilizing this approach, CARE's decade-long HIV program in Bangladesh gradually oversaw the handover of all project activities to the key sex worker organizations, Durjoy Nari Shongo (DNS) and Nari Mukti Shongo (NMS). In the early years of the project, the health clinic established in Tangail was the first key project activity to be taken over by sex workers. In time, street-based sex workers were trained for condom promotion and STI education, and drop-in centers were established. This work laid the foundation for the establishment of DNS and NMS, groups that came to play a critical role in mobilizing community action, and are now identified by the government and donors as key partners in the country's HIV prevention efforts.

The India project uses social change agents, whose role is not only to provide information on risk reduction and increase access to HIV & AIDS services, but to work as community facilitators to discuss problems faced in the community. Through these facilitated discussions, the project has created drop-in centers to foster the sense of community among the women; safe spaces that allow sex workers to meet, think, plan, mobilize and share safer sexual practices such as non-penetrative sex. Through the project, community-based organizations formed with an explicit goal to foster leadership, identify shared problems and solutions, and handle crises. The project also fosters community-led advocacy with the police and media to change harmful attitudes towards sex work, and has created crisis intervention teams to respond to episodes of violence and combat sex-trafficking of minors.

Sex workers in both sites spoke of empathy, sharing, compassion and a realization of sisterhood, indicating fundamental shifts in self-perception and a new recognition of the power of collective action. They discussed the benefits of belonging to a group – solving each others' problems, encouraging each other to access HIV/AIDS services, changing the way they dress and how they spend their money, a reduction in police violence through advocating and negotiating for their rights, and a general sense of unity.

Where previously the women might have felt competitive, they now saw benefits of unity:

"We realized that even if she is a sex worker in the same locality, what is the harm? We can live like sisters. First, they started believing it and then made other sex workers in the area believe in that."

"I cannot understand anything about empowerment in my life, but I protest against any injustices with other girls. That I think is my power."

"I find myself empowered because I can successfully perform any duty vested in me, I can convince people easily and I can make them participate in the meetings and rallies. I can bring any problem to the consideration of the legal authority and can convince them. I have enough strength, courage, confidence, ability and skill to work with the people of the outside world."

Most notable about the Bangladesh and India projects was the design decision to build the sense of collective efficacy among participants, and then to use this collective strength to engage with key actors whose exercise of power over the women increased their HIV risk. This engagement is explored in greater detail in the next section.

Intervention Examined: Engaging with Power Holders

In all of the project settings, the relatively weaker position of women to power holders in their lives contributes to their vulnerability to HIV. Poverty and extreme economic conditions often lead women to engage in unprotected transactional sex to fulfill basic livelihood needs. Though the women try to suggest condom use, the men usually refuse, citing pleasure or a denial of risk. A Lesotho factory worker commented on the nature of many of the relationships that women engage in the factory setting:

“A woman can have as many boyfriends as possible, and each would have a duty to perform like buying groceries, clothes, providing transport or paying rent, etc.”

The economics and power dynamics of the sexual relationships in these settings is also linked to violence that is often present in women’s lives. The words of another factory worker underscore the many levels of risk poverty engenders:

“Because of the little money we earn, most of the time we stay behind and work overtime. This is dangerous because when [we] finish at 6:00 p.m. we are raped, especially in winter [when it is dark].”

These power dynamics are also made explicit within sex work sites, as we consider the ways in which sex workers may be coerced into risky transactions by clients, madams and pimps, as well as others, such as the police. Women in India reported suffering physical abuse at the hands of rowdy clients, forced sex with police officers and coerced sex with multiple men despite having negotiated with only one client.

In Bangladesh, brothel madams often have complete power over the sex workers under them, particularly those who are tied to them through bonded labor. Madams and pimps may use various methods of coercion to force sex workers to take on clients despite their unwillingness to use a condom, or to take on more clients than they wish. One brothel-based sex worker in Bangladesh reported that madams were often known to be in close relationships with the police, particularly in the auctioning of new sex workers.

These power imbalances often leave women at a disadvantage to negotiate condom use and other safer sex practices. As a focus group member in Lesotho noted while discussing the relationships women often form with policemen, soldiers and taxi drivers:

“The problem is that if these men refuse to use condoms... the women cannot refuse them sex because they have received material support from them.”

Violence

The threat of violence can be a powerful disincentive that prevents women from accessing services to prevent, diagnose or treat health problems. Women may be prohibited by their husband or partner from visiting a doctor. Furthermore, they may also face violence if they are diagnosed as HIV-positive. This prospect may prevent a woman from seeking out health care or getting an HIV test, since a positive diagnosis could lead to physical abuse, abandonment, or to being thrown out of the house by her family or her partner.

The community mobilization approach, more so than the approach used in these peer education groups, was more effective in enabling women to engage with power holders in their lives in a manner unprecedented prior to the collectivization process. In Bangladesh, the activities of NMS have resulted in a shifting of power within the brothels. The researchers observed that some of the responsibilities formerly held by the brothel madam came over time to be held by NMS and that, while NMS has not fully replaced the traditional power structure there, it has inserted a more democratic element into the structure. Improvements were also made in regards to bonded girls. A sex worker recently released from three years as a bonded sex worker talked about explicit intervention by NMS that significantly changed the relationship between madams and bonded girls:

“Now the girls are much more independent. They are tortured less. The madams now abstain from torturing their subordinate sex workers as the leaders of [NMS] hold arbitration when any girl is so tortured.”

The researchers from Bangladesh remarked that the more positive relationship with the current local police superintendent may be at least a contributing factor in the reduced levels of extortion and violence by police against sex workers in the brothel. Ten percent of street-based sex workers who were affiliated with a CBO felt they could ask for help from the police in case of injustice, compared to less than one percent of non-participants.

In interviews, many sex workers identified the CBO as playing a major role in reducing stigma and discrimination, and in raising their own self-confidence and ability to resist exploitation by the police and others:

“People show better attitude toward this profession... They changed as we changed. Now we can go to different offices, can mix and talk with people. We can talk about the facilities in different offices and can attain our rights... The relationships have changed over time since the project of CARE and Durjoy Nari Shangathan have jointly been working for the sex workers, as well as government and nongovernment institutions, in order to ensure the sex workers a safe life by leading a life like other people in the society, accessing facilities and attaining rights.”

“Once there existed a strong relationship between the police and the madams, and it helped them torture the sex workers. But now that relationship is not strong enough. In the past, the new sex workers used to be put up on auction. The police used to take half of the bidding money. That system does not exist any more. As a result, the relationship between the madams and the police has changed now.”

Researchers in India reported that sex workers associated with CBOs for any length of time were two to three times more likely than those not associated with CBOs to have observed positive changes in the behavior of the police towards sex workers. In addition, a higher percentage of sex workers in home-based settings reported this change compared to street-based sex workers. The sex workers explain that observed change among the police has been the cumulative result of constant negotiation between sex workers and the police, as well as the ability of sex workers to address police violence by coming together and demanding their rights.

“There have been major changes in lives. In order to deal with violence either from a goon or gangster or police, we realized that we sex workers have to become united. Earlier we were scattered around and nobody listened to us. Now we have come together as sisters and things have changed.”

In India, where need for engagement with police was articulated by the women from the project outset, police initially were skeptical of the community's efforts to mobilize and advocate for change. Over time, however, this opinion came to change, as evidenced here in the words of a local police inspector:

"We used to think it was really silly that CARE was working on such a theme as sex workers. Later on, after learning about their activities, we started feeling that they were doing the right thing. We used to treat sex workers with contempt, thinking what they were doing was wrong. We never gave them importance. There is increased awareness of their rights and they have become strong by forming a society. One sub-inspector [SI] of police who came from Cuddapah was accused of manhandling sex workers as per human rights violation act. I think it was because of the awareness that CARE had brought that this case was revealed. The SI was warned and the SI also apologized, after which the cases were withdrawn."

In conclusion, the findings provide evidence that group methodologies can provide a platform where women can recognize the strength of their collective power to take on some of the most entrenched power structures that put them at risk for HIV. This outcome requires a comprehensive empowerment design that emphasizes the three dimensions of the empowerment framework – agency (e.g. self-esteem, awareness), relations (e.g. engaging power holders), structures (e.g. challenging gender norms and institutions that make women vulnerable to HIV). In order to implement strategies that comprehensively address women's empowerment, sufficient time frames for projects are needed. The more sustainable successes of the Bangladesh and India projects stand in contrast to the shorter-lived impacts of Cambodia and Lesotho projects.

Intervention Impact: Failing to Reach the Private Sphere

Condom Use

As demonstrated in the findings table (page 15), condom use with clients in the sex worker sites was not only high in each of the sites, but higher among sex workers who were involved in the intervention than those who were not. However, in the area of condom use with an intimate partner, the participants in all sites reported relatively low rates.

- In Lesotho, despite over 90 percent of participants knowing where to obtain essential HIV & AIDS information and services, condoms were not used widely. In the best case scenario where participants reported having the "final say" on condom use (49.3 percent), 67.6 percent of them always used condoms in the last six months.
- In Peru, high levels of HIV knowledge had a positive correlation to high condom use for all women with their clients. Eighty-nine percent of women in Lima-Callao and 98 percent in Chimbote reported using a condom with their clients, but this same trend did not carry over to their intimate partners. With a stable partner, condom use is relatively low (17 percent in Lima-Callao, 15 percent in Chimbote and 33 percent in Iquitos).
- In Cambodia, sex workers tended to shun condom use when they trusted their lovers. Respondents considered it a given that men, including their husbands or lovers, had sexual relations with women other than their wives or partner. Despite this knowledge, women still had unprotected sex with their partners because, according to them, women have the tendency to believe and trust men easily when they say they are faithful. Project participants saw this false sense of trust as one factor that puts them at risk for HIV.

These findings are consistent with emerging literature discussing intimacy as a determining factor of condom use.⁷ In Bangladesh, street-based sex workers reported a higher level of using condoms all the time with clients (54.8 percent) than with their husbands (22.2 percent). Similarly in India, despite the high rate of condom use with clients, condom use with temporary husbands (long-term partners) and husbands were lower for all women. In Bangladesh, the difference between brothel-based and street-based sex workers is interesting in this domain. Forty-seven percent of brothel-based sex workers reported that they always used condoms with their husbands compared with 22.2 percent of street-based sex workers. The research and program staff noted that Tangail brothel is unique in that the sex workers' families live with them in the brothel. The husbands are therefore exposed to sex education programs and materials, and may be more apt to use condoms. This observation has huge programmatic implications for the role of men in HIV prevention programs. Other evaluations similarly show greater impact in HIV interventions that engage both women and men.⁸

Data from some of the sites indicates that some of these decisions may be economically driven. Several studies have made the link between women's economic dependence on men as a risk factor for contracting HIV.⁹ In Lesotho, most informants indicated that the material nature of the relationships made it difficult for women to negotiate the condom use, even when they were aware that condoms were important in HIV prevention.

"We earn very little money here, this is what makes us easy prey and exposed to HIV infection. For example, if a man tells you he will drive on Mpilo Boulevard (an expression used to describe unprotected sex), just because you are at the mercy of this person, you agree to have unsafe sex in expectation that he will not withhold his money or other favors."

A similar sentiment – fear of abandonment and economic deprivation – was echoed in Peru:

"Well, at times for fear of losing our partners we don't use the condom. Then the fear, in many cases, the fear of being left, abandoned in many cases is a disadvantage."

"Sometimes, some of us, when we already had our partner, we go to work, and now, because of love, habit, sometimes we are afraid to be abandoned because we've already had years of living together with him. So we have this fear that he will leave us, will abandon us, or maybe even have another person out there and we accept this, sometimes also because of the economic aid (he offers)."

Almost universally, however, 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. In general, condom use was highly influenced by the extent of the emotional connection a woman felt or *desired* with her sexual partner. Among sex workers, for instance, the research revealed that women treated their clients differently from intimate partners with whom they shared an emotional bond.

"We, the majority of us who are here, it's very difficult to negotiate condom use with our partners, because he's the man who goes to bed with us, the man who wakes, the father of my children, the person in whom I trust... (Sex worker, Peru)"

Similarly, during an in-person research synthesis workshop with all of the country teams, each site affirmed this tendency of women to use condoms inconsistently or not at all with lovers; the explanation was that agreeing to



unprotected sex meant that they loved the man. In each of the sites, women related condom use with non-intimacy and unfamiliarity of a partner. Women in the research also acknowledged that whether they were in a short-term or long-term relationship, it was easy for women to trust men and be coaxed into not using condoms if the men used sweet and consoling words. Exacerbating this issue is the reality that many of the male partners do not receive the same HIV information to which the women are exposed.

The findings that messaging around safe sex has led to sex workers using condoms fairly consistently with clients but not nearly as consistently within their more intimate, personal relationships is not surprising; for most people, condoms signify a lack of intimacy. What is surprising is the way in which such programmatic blind spots can continue to exist despite years of programming with sex work communities, and the meager amount of discussion, research and programming that encourages sex workers to practice safe sex not only with clients, but also in their intimate relationships. This gap is all the more troubling since many sex workers revealed abuse by and likely infidelity of their partners. This reporting highlights the limited reach of our interventions in this private sphere of

women's lives, and reinforces the need for strategies that engage men and reach beyond the public sphere in which our programs currently operate.

Program implementers may inadvertently limit the impact of their work if they view a target group as "just sex workers" who have sex with clients, not as individuals who may have steady partners or husbands.

"By being sex workers we don't stop being mothers, we don't stop being sisters, cousins, whatever, and we feel the same for seller on the corner, for the female cop, even for you... We're the same, in the end we're all women and we feel the same."

There is also an underlying tension between supporting and engaging women's healthy desire for trust and intimacy in personal relationships, and challenging their framing of the abuse and infidelity in those relationships. Program implementers need to probe beneath the surface of this tension and understand how it is rooted in larger power structures and a very real and powerful desire to be in a loving relationship.

Stigma

Projects with group methodology approaches can provide effective vehicles for altering the negative perception and discriminatory attitudes of mainstream society. In this initiative, we looked at two types of stigma: (1) toward HIV and (2) toward sex work. Although the projects played a positive role in reducing both types of stigma, this success was limited to the public sphere and did not extend as effectively into the private sphere. For instance, when implementing an HIV prevention project within an occupational setting, the educational messages can create an environment which normalizes HIV, where participants experience less HIV stigma, and are therefore more likely to get tested and more likely to feel comfortable disclosing a positive status. However, the absence of the project within the private sphere of participants' lives – with their families, home communities and partners – may leave the participant vulnerable to stigma in her private life. Indeed, garment factory workers in Lesotho spoke about the ease of disclosing HIV status in the workplace (to peers and employers) but not in their home communities.

The dynamics are similar in considering the stigma associated with sex work. Projects seem to provide a sense of social acceptance among marginalized sex workers, as evidenced by the testimonies of police and doctors in the India site, as well as the successes of that project in influencing the language used by the media in reference to sex workers. Consequently, while sex workers in many of the sites felt able to disclose their line of work with the public with whom the project had interacted (NGOs, clinics, international forums), they felt much less able to do so with their families and close friends.

These findings highlight a major programming gap in an HIV prevention response. In Bangladesh, for example, researchers found an inverse correlation between HIV-related stigma and condom use among sex workers; the greater the HIV-related stigma, the lower the condom use. Overall, the research suggests that HIV-related stigma may be an important predictor of condom use. Studies in Botswana and Swaziland show similar trends, where holding discriminatory beliefs is associated with having more partners, unprotected sex and sexual risk taking.¹⁰ Though not a focus of the research, the data also suggests that it is very possible that HIV-related stigma is linked to sex work-related stigma. In our experience, these two types of stigma often interface and "layer" with other kinds of stigma (related to gender, ethnicity, religion, occupation etc.) to augment vulnerabilities.

Conclusion and Recommendations

CARE's programming across the six countries exhibits great diversity, but was implemented in environments that were not entirely dissimilar. We noted parallels in women's macro-social contexts across the six countries: poor access to education, markets or livelihood options; engendered, subordinate roles in the household and society; poorly enforced policies and laws to protect the vulnerable; and chronic cycles of poverty.

As we examined the findings against our women's empowerment framework, an overarching theme was that increasing women's agency (e.g. knowledge and self-efficacy) does not on its own lead to protective behavior. While the broad quantitative trends hinted at this chasm between knowledge and behavior, the qualitative data gave us further insight, as women expressed how influencing factors lay either within their relationships with others or in the broader environment. For example, condom use was highly influenced by the extent of the emotional connection a woman felt with her sexual partner. Sex workers, for instance, were at a high risk to HIV, violence, exploitation and abuse in roles that the project did not completely address: their role as a wife or intimate partner. In other instances, women's self-efficacy was highly influenced by how mainstream communities and powerful stakeholders thought of and treated them.

We conclude, then, within the confines of the research, that working solely to increase women's agency may limit outcomes. Too often, women's empowerment equates with increasing women's agency, but overlooks structural and relational factors. CARE's women's empowerment framework seeks to guide implementers to engage more comprehensively at the agency, relational and structural levels. Future programming within CARE might include the implementation of programs that focus on empowerment at the individual level, as evidenced through work with solidarity groups, as well as at the relational and structural levels in a woman's life, as evidenced through community mobilization. Examples of this include:¹¹

- Working with men to address violence, household norms, and HIV education and protection.
- Working with health care providers to address stigma as a barrier to testing and health care utilization.
- Working with the media to address stigma against sex work and HIV.
- Working with police and other power brokers in the community and local government to raise awareness and advocate for the rights of vulnerable women.

One important consideration is how programs engage with women. A project that views a woman only as a sex worker, for instance, ignores other identities which may place her at higher risk of HIV. A project that focuses on communication in relationships without addressing her partner's concurrent relationships can increase a woman's risk of HIV, violence, exploitation and abuse. Educating sex workers to use condoms with their clients may be insufficient if she is more likely to have unprotected sex with her lover. Showing garment factory workers how to use condoms is futile if they are unable to insist on condom use with their lovers because of economic dependence. Programs that use a holistic approach to address all of women's multiple roles and needs, as well as her key partners are better positioned to bring about sustained health and empowerment benefits.

Specific recommendations include:

- 1. Design projects with a comprehensive approach to empowering women.** Projects should aim to increase her agency, help her engage more effectively with power holders and support her in challenging structures that make her more vulnerable.

When a project limits itself to informational dissemination, the results will be similarly limited to an increase of knowledge, but not necessarily behavior change. The most deeply rooted drivers of HIV are found in inequitable power structures and relationships in which women are at a disadvantage. Using the strength of women as collective actors can, with the guidance of an appropriately designed and implemented project, challenge these forces and create sustainable change.

- 2. Ensure that project design takes into account the diversity of relationships in the women's lives.** Implementers should avoid the tendency to categorize women in simplistic terms – garment factory workers, sex workers – that might lead to blindspots 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. Our research findings on sex workers' differential use of condoms is indication that while programs may be “successful” in promoting high and consistent condom use with clients, lack of protective sex with intimate partners may still leave sex workers at risk.

A thorough mapping and social analysis that explores women's multiple identities 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 may require a trusting rapport with communities; in these cases, this type of mapping may take place mid-way through a project.

- 3. Engage men.** In all research sites, women's relationships with men were key 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 decision-making in regard to HIV prevention. Research from all six countries indicated that women's risk of HIV remained despite their correct knowledge because their male sexual partners were neither involved in HIV interventions nor willing to adopt safer methods. It is unrealistic and short-sighted to put the onus of safe 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.

Structural change is not a rapid process. Influencing the structural environment and powerful actors may require more time than the duration of many of these projects. Effective and sustainable improvements in empowering women and reducing vulnerabilities to HIV require fundamental shifts in power in key relationships, which requires engagement in communities over a longer period of time. In this study, the projects in India and Bangladesh that were able to influence structures operated for 10 years, as opposed to projects in Lesotho and Cambodia, which ran four to six years.

Women face different risks in all parts of their lives. Women often use whatever social capital and personal ingenuity they have to mitigate those risks. Yet, they are forced to weigh competing goals and desires each time they make choices in their daily lives. These findings drive home the need for comprehensive program approaches to empowerment and HIV and AIDS programming – ones that allow for safer choices in all aspects of their lives.



Appendices

Bangladesh: Gender, Power and Sex Strategic Impact Inquiry Research Summary

Context

Sex. Power. Stigma. AIDS. How do all of these factors interact in the thriving sex industry, its surrounding communities and the lives of sex workers in Bangladesh? While Bangladesh does not yet face a generalized HIV and AIDS epidemic, there are real risks for it to become widespread via sex workers and their clients. What does this mean for women engaged in sex work? And for the CARE programs working with them?

Snapshot of Findings

- **Stigma surrounding sex work:** Though stigma surrounding sex work is still relatively widespread, participation in CARE activities is associated with reduced stigma. Amongst brothel-based sex workers, 41% of participants involved in the project expressed a high level of stigma about sex work, compared to 86% of respondents not involved in the intervention. Similarly, 43% of street-based sex workers who participated in the project expressed a high level of stigma about sex work, compared to 62% of respondents not involved in the intervention.
- **Knowledge of HIV:** In Dhaka and Tangail, almost 100% of the sex workers identified “increased awareness about HIV” when asked about the perceived impact of the project on their lives.
- **Utilization of HIV services:** The data showed evidence that among street-based sex workers in Dhaka, a higher percentage of women closely involved with the project knew where to get tested for HIV and STI (100%), got tested (91.1%), and knew the result (93.1%) compared to women who were not involved at all (80%, 78%, 82.1% respectively). The opposite trend was seen among the brothel-based sex workers in Tangail where sex workers not involved with the intervention were more likely to have been tested in the preceding 12 months and knew their results. Possible explanations of this finding include that brothel-based sex workers in Tangail were older, more financially independent and reported engaging in fewer risky behaviors than their counterparts who were not involved in the intervention.
- **Condom use:** Respondents reported a very high level of condom use with clients with 57% to 66% reporting that they “always” used condoms with clients. Condom use with lovers and husbands had more mixed patterns. Among street-based sex workers, 43% of those who directly participated in CARE activities used condoms always or most of the time with husbands compared to 22% of those who had no participation in CARE activities. Similarly, in brothel-based settings, 71% of project participants used condoms always or most of the time with lovers compared to 54% of non-participants. Sex workers linked unsafe sexual practices, such as sex without a condom, to a variety of factors. Client preference and lack of negotiating power influences condom use with clients. Financial insecurity can also dictate condom use; a client may offer more money to forgo using a condom. Both the threat of and actual sexual violence are cited as reasons for unsafe sexual practices. The perpetrators of such violence are wide-ranging including madams, clients, police and thugs. Finally, the desire to please husbands and lovers, as well as a need for trust was cited as a reason for not using condoms in intimate relationships.

Implications

Context is Critical

- Program impacts between street-based and brothel-based sex workers exhibit some significant differences, emphasizing the critical importance of understanding context (structures of the work environment, power relations, norms) in program design and implementation.

The Importance of Intimate Relationships

- Programs should better understand links between empowerment/sexual practices in intimate partnership and empowerment/sexual practices in the sex trade; especially in relation to how violence and gender norms at home affect sexual practices in the workplace. In order to be effective, programs need to address the diversity of relationships in women’s lives.

The Power and Limits of Sex Worker Organizations

While sex worker organizations clearly contributed to sex workers’ empowerment, our analysis also raised a number of issues:

- Limits to sex worker organizations’ abilities to confront powerful actors within the sex worker community. While there are differences between the actors, structures and laws influencing street based and brothel-based sex workers, all sex workers struggle to exercise control while facing violence, stigma, extortion, and other forms of exploitation at the hands of these powerful actors in all spheres of their lives. Programs should use a comprehensive approach to

empowering women, helping women to increase their agency, engage more effectively with power holders and support them in challenging structures that make them more vulnerable.

- Dangers of co-optation as group leaders form closer relations with powerful external actors (e.g. police).
- Long-term issues of governance within groups.
- The power of sex worker organizations and other powerful actors to control access to sex workers, influencing flow of funds, program design and ability to critically examine sensitive topics such as the situation of bonded sex workers.

Bangladesh's Strategic Impact Inquiry (SII)

CARE explored the dynamics of gender, power and women's empowerment among marginalized women. The inquiry focused on how gender and power relate in the lives of sex workers. CARE framed the study around our HIV program work from 1995 to 2005, with a focus on the Stopping HIV/AIDS through Knowledge and Training Initiative (SHAKTI project). SHAKTI worked with sex workers (SW) and other high risk groups in Dhaka, Tangail and other parts of Bangladesh to:

- Help SWs manage sexually transmitted infections (STIs) and promote condom use to prevent HIV.
- Provide voluntary counseling/testing.
- Connect SW to services to treat HIV and prevent mother to child transmission.
- Build capacity of NGOs to manage programs and develop networks for people particularly vulnerable to HIV.
- Influence policies/programs on AIDS.

For the SII, the research team explored women's empowerment among street-based and brothel-based sex workers to better understand the context of power and empowerment and the impacts of the SHAKTI project on their lives. The study focused on:

- How do women who CARE's projects support define empowerment?
- How do these projects contribute to women's empowerment?
- What linkages do we find between changing levels of empowerment and HIV vulnerability, as described by project participants?
- What are the dynamics of power, empowerment and violence in the sex work environment in Bangladesh?

For the full report on Bangladesh, e-mail: pqlibrarian@care.org

Methodology

CARE coordinated with local researchers and sex worker self-help groups in Dhaka and Tangail. CARE research and design teams collaborated throughout the process of research design, data collection and analysis.

Research Design

- Mixed Methods Research Design: Design involved quantitative and qualitative of data collection and analysis to respond to an evolving understanding of research questions and triangulate across methods.
- Participant Selection: Participants were selected to provide representation of brothel- and street-based sex workers. The sample was based on different levels of participation in CARE projects.

Data Collection

- Overview: 449 participants, 2 sites, 2 months.
- Literature Review: Grounding Research in existing literature.
- Focus Group Discussions (9 groups: sex-workers, former staff): Examined themes such as context, power relations, and empowerment.
- Informal Interviews (9 respondents): Examined participants': Demographics, HIV/AIDS awareness, beliefs, violence, project participation and empowerment.
- Survey Research (316 respondents): Examined participants': Demographics, gender norms, empowerment, participation, health-seeking behaviors, violence.
- In-Depth Interviews (29 respondents: 12 sex workers, 6 project staff, 11 community members): Examined themes such as: Empowerment, HIV risk, interventions, relationships, self-help groups.

Data Analysis

- Reflective Process: Design and field research teams met regularly to share observations and challenges and engage in collaborative analysis.
- Analysis: Statistical analysis of survey data, triangulation across methods.

Limitations

- Bonded sex workers were not accessible.
- Findings not necessarily representative of sex worker population throughout Bangladesh.
- Participation of sex worker organizations may have introduced certain biases.

Burundi: Gender, Power and Sex

Strategic Impact Inquiry Research Summary

Context

After 12 years of civil war fueled by discrimination, marginalization and the denial of rights, Burundi continues to struggle in post-conflict recovery. Following the war, sexual and domestic violence has been on the rise. Women rarely report abuse or seek services because of rape-related stigma and a strong cultural taboo on discussing sexual relations.

Snapshot of Findings

- **Self Efficacy:** 66.7% of group members reported being able to discuss their problems with their husbands and members of the group, compared to 2.4% of non-members. When asked about the ability to manage conflicts on her own, 27% of members said they could compared to 6% of those who had left the solidarity groups and 19% of non-members.
- **HIV Knowledge:** Respondents had high levels of knowledge about modes of transmission and methods of prevention. Knowledge surrounding HIV services was also high; 80% of respondents know where to find health centers that offer services in relation to HIV.
- **Utilization of HIV Services:** Despite high amounts of knowledge regarding HIV services, overall use is low. Only 33% of respondents had been tested in the past 12 months and knew their result. However, there is an association between participation in solidarity groups and HIV testing; 61% of respondents (women and men) who were members of solidarity groups reported having gone for HIV tests compared to only 27% of non-members who reported being tested. Twenty percent of those tested were members, compared with 6% who had left solidarity groups and 7% who were non-members. The motivation for testing is not linked to self-esteem, but rather, group influence and awareness raising – particularly amongst couples – done by the program. Increased mobility; trainings on leadership, HIV prevention and life skills; and income led to knowledge of and greater use of HIV services, and knowledge of HIV test results.
- **Stigma:** Stigma around HIV & AIDS is high; 49.1% of interviewees have a perception that AIDS is a punishment for bad behavior and 28.2% think that it is a shameful disease and PLWHIV should feel embarrassed. This stigma affects HIV testing rates and knowledge of results. Women admit difficulty informing their husbands that they want to be or have been tested. Additionally, they struggle to convince their husbands to get tested.
- **Taboo and Communication around Sex:** Though 46% of women involved in the solidarity groups affirm having positive changes regarding sexual relations with their partner compared to 25% for non-members, apply to communication around sex remains a complex area that is often taboo. This limits women's ability to discuss or negotiate safe sex. As such, data on condom use was difficult to obtain; 36% of respondents refused to discuss condom use. Of those willing to discuss condom use, 64% said they never or rarely use condoms with their husbands. Only 23% of women stated that they can buy condoms without feeling embarrassed. Thirty-five percent of respondents said that they could not discuss condoms with their partners.

Implications

Inclusive Group Dynamics

The study found that women in solidarity groups can exclude or even exploit one another. Therefore, programs must:

- Promote inclusiveness among leaders and analyze how policies may affect members differently.
- Strengthen group management and transparency.
- Develop strategies to reach and work with women who have been previously excluded to have meaningful impact on the poorest, widows and Batwa minorities. This includes women who cannot read or write and younger women.
- Be aware of tensions arising from women's participation in groups and develop interventions to ensure stronger relations both within groups and with others.

Adopt 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 more vulnerable by:

- Ensuring groups work effectively with local authorities in meetings and are not exploited by them. This is particularly important given the prevalence of gender-based violence, low rates of reporting, and lower rates of actions taken against the perpetrator.
- Being aware of political situation and changing context to shape and leverage work. This includes capitalizing on the improvement in women's social status and the favorable political environment, e.g. the National Assembly's revision of the Burundian Penal Code to include 20 articles pertaining to violence against women, to improve the lives of women.

Engage Men

- Work with men through trainings and identify male role models to support women's empowerment and fight violence.
- CARE must foster communication between couples, particularly around issues of sexual relations.

The Project

CARE assessed the impact of Project Umwizero (positive future for women in Burundi), which began in 2006 in three provinces and is in its second phase (until 2013). Project Umwizero works to build solidarity and empowerment among women by:

- Mobilizing and supporting solidarity groups and their leadership to provide safe spaces for women to gather.
- Enhancing women's life skills through training on sexual/reproductive health, including HIV/AIDS and human rights.
- Providing microfinance services as an entry point to raise women's social and economic status in communities.

Burundi's Strategic Impact Inquiry (SII)

CARE's study focused on:

- How participants' lives have changed in terms of empowerment due to their participation in Umwizero.
- How the group process improved relations between men and women, women's roles in conflict resolution and relationships in the broader community.
- How the project impacted women's vulnerability to HIV.
- The relationship between empowerment and HIV risk.

For full reports on Burundi, e-mail: PQlibrarian@care.org

Methodology

Burundi's SII was rooted in qualitative, participatory research.

Research Design

- Formative Workshop: Developed research guides, empowerment indicators defined by participants and identified domains.
- Research Team: Program staff, partners.

Data Collection

- 110 respondents (24 men, 86 women).
- Closed Questionnaire (110 respondents): Examined participants': Knowledge of HIV and sexual behavior, availability and utilization of services, collective agency, gender based violence, HIV & AIDS stigma, gender norms.
- Semi-Structured Interview (85 respondents): Examined participants': Gender relations, conflict resolution, decision-making, impact of groups, life changes, group dynamics.
- Focus Group Discussions (6 groups of women members, former members, and non-members): Examined: Solidarity group functionality, concepts of inclusion, sustainability of groups.

Data Analysis

- Triangulation: Data validation across methods, locations and researchers.
- Reflective Process: Team reflected on initial observations and challenges in order discuss observations and research approaches.
- Participatory Analysis: Team participated in each aspect of qualitative analysis. The team also engaged community-based feedback and validation processes linked to reflective program implementation.
- Quantitative Analysis: Closed questionnaire results were analyzed using SPSS software.

Limitations

- Widespread taboo on discussing sex prevented collecting data on condom use.
- Small sample made some quantitative analyses impossible.

Cambodia: Gender, Power and Sex

Strategic Impact Inquiry Research Summary

Context

Cambodia, a post-conflict country, has the highest HIV prevalence in the region. The government has been proactive in combating the spread of HIV. Women, particularly sex workers, are vulnerable to HIV due to low rates of education, literacy, wages and social status. Gender-based violence (including rape) is prevalent and culturally accepted. As women migrate to cities, women have fewer income-earning opportunities and are made vulnerable to exploitation, abuse and trafficking.

Snapshot of Findings

Information

- Information on condom use allows women to make safer choices.
- Increased knowledge on HIV prevention and protection.

Love, Trust and Familiarity

- Women want to trust their intimate partners and do not use condoms though many believe their partners to be promiscuous.

Marginalization

- When drugged or forced, women have unsafe sex with clients despite awareness of risks.
- Low education and poverty lead women to sex work and inhibit their choice of protected sex.
- Sex workers and “indirect sex workers”¹² continue to face stigma by friends and family, and some have internalized this stigma.
- Sharing knowledge on HIV with the community raised the status of some women.

Violence

- In cases where sex workers had economic security and could choose whether or not to have sex, they often reported suffering violence.
- Violence, including gang rape, continues as society views it as a private affair.

Services

Sex workers use STI services, though indirect sex workers have less access to them. Sex workers find services inefficient and corrupt.

Impact on Empowerment

- Relations: Sharing knowledge on HIV with the community raised status of some women.

Implications

Broader Strategic Engagement

- Empowerment is an individual and collective process that requires time and resources.
- Unequal gender relations are structural; CARE must work to orient institutions and engage men in order to address male privilege.
- CARE must comprehensively incorporate advocacy into programs to address the context affecting HIV among sex workers.
- Savings programs should build on existing practices and be systematically implemented.

Organizational Management

- The multiple dimensions of empowerment/HIV risk require long-term financing and staff development.
- Donor support and its disruption must be taken into account for sustainable programming.
- Staff and partners require training to understand CARE’s empowerment approach and codes of ethics.

Cambodia’s Strategic Impact Inquiry (SII)

To respond to the HIV epidemic, CARE initiated the Sex Workers’ HIV/AIDS Reduction, Advocacy, Facilitation and Empowerment (SAFE) Project from 2004 to 2007. SAFE worked with sex workers (SW), entertainment workers (indirect sex workers) and men who have sex with men in the provinces of Bateay, Meanchey, Oddar, and Koh Kong to develop their leadership and confidence, reduce HIV risk and promote advocacy. To pursue its objectives, SAFE implemented:

- Peer Education: engage peer educators (PE) to facilitate trainings on computer and vocational skills, HIV and literacy.
- Formation of Peer Groups: provide space for workers to discuss HIV & AIDS.
- Socials: promote unity in community.
- Advocacy: inform government on rights issues facing SW.
- Service Delivery: reproductive health, support for rights cases and technical assistance for saving schemes.

For the SII, the CARE team explored:

- How SW view empowerment and their vulnerability to HIV.
- How SAFE understood gendered power relations and SW decisions.
- How SAFE's empowerment of SW reduced their vulnerability to HIV.
- How programmatic and organizational processes affected the above questions.

For the full report on Cambodia, please e-mail: pqlibrarian@care.org

Methodology

CARE and an independent consultant led the SII. Field staff participated in the research design and data collection. Throughout the process, the team carefully considered ethical issues related to stigma and trauma in respondents' lives.

Research Design

- Site Selection: CARE staff identified two project sites for the SII (Poipet in Banteay Meanchey province and in Smach Meanchey in Koh Kong province).
- Participant Selection: Convenience sampling.

Data Collection

- Overview: 17 respondents.
- Document Analysis: Reconstruction of project activities and implementation.
- Focus Group Discussions: Examined the perceived meaning of empowerment and vulnerability to HIV.
- Key Informant Interviews: Examined the context and HIV work insights.
- In-depth Interviews: Examined the project impact.

Data Analysis

- Triangulation: Data validation across methods, locations and researchers.
- Workshop: Respondent reflection on and validation of study findings.

Limitations

- Difficulty accessing the women involved in the projects led to a purely qualitative study with a very small sample.
- Difficult accessing project documentation.
- Government crackdown on brothels has drastically changed the SW context forcing many women underground.

India: Gender, Power and Sex

Strategic Impact Inquiry Research Summary

Context

An estimated 2.4 to 2.8 million people are infected with HIV in India. Female sex workers are particularly vulnerable to HIV because of the association of their occupation with poverty, their position relative to men in authority, lack of knowledge of their rights, the stigma surrounding sex work and threats of violence. Indian law regarding sex work is ambiguous and problematic. Sex work itself is legal, but a complicated series of laws and regulations confuse what is and is not permissible.

Snapshot of Findings

- **Knowledge of HIV:** Overall knowledge of HIV was high among both members (100%) and non-members (82%) of community-based organizations (CBOs).
- **Accessing HIV and STI Services:** Sex workers involved with CBOs were more likely than sex workers not associated with CBOs to access HIV and STI services. Over 80% of all respondents associated with CBOs for more than six months reported getting tested for HIV. In comparison, only 40% of those who are associated for less than six months or not associated at all had reported getting tested for HIV. Of women associated with a CBO, 100% reported seeking treatment compared to 60% of women not associated with a CBO. Many women referred friends to drop in centers and services. This may be linked to the study's finding that feeling that they have helped others is a key aspect of empowerment for women.
- **Condom Use:** Involvement with the program was associated with higher rates of condom use with clients; 97% of all those associated with the CBO for more than a year and a half reported "always" using condoms with clients. In comparison, only 72% of those not involved with the CBO reported "always" using a condom with clients. However, most women (regardless of CBO participation) did not use condoms with intimate partners, with almost half stating they felt there was no need to use condoms with husbands.
- **Collective Efficacy:** Group solidarity has enabled sex workers to pursue their rights and lessen vulnerability to HIV. Sex workers highly involved with a CBO had confidence in their ability to "handle" or manage customers and police, while those not associated with a CBO indicated a sense of helplessness and an inability to change the environment in which they work.

Implications

Programs should use a comprehensive approach to empowering women.

- Projects should aim to increase women's agency, help women engage more effectively with power holders and support women in challenging structures that make her more vulnerable.
- Understanding of empowerment must be based on both individual and group aspects; and take into account context-specific nuances.

Programs should take into account the diversity of relationships in women's lives.

- Approaches should view individuals in totality, e.g. viewing sex workers as women.
- Push for focus on addressing unequal gender relations in both private and public spheres of individual's lives.

Programs should continue to support CBOs groups of sex workers for better empowerment and HIV prevention outcomes.

- Facilitate transparent and democratic structures within CBOs groups, supporting groups to manage themselves effectively.
- Facilitate membership of harder to reach individuals to ensure inclusivity of groups and interventions.

CARE must be dedicated to achieving gender equity and social change.

- Affecting all aspects of the 'structure' requires long-term commitment.
- Build capacity of staff on gender and empowerment. Support staff to deal with changing work contexts.

India's Strategic Impact Inquiry (SII)

CARE assessed the impact of our SAKSHAM project for the Strategic Impact Inquiry (SII). SAKSHAM started in 2004 and operates in Rajahmundry, Andhra Pradesh, where it works with female sex workers in order to empower the sex worker community and reduce their risk to HIV through:

- Selecting and training peer educators to provide information on risk reduction
- Increasing access to resources by creating:
 - > Drop-in centers that enable the community to meet and mobilize.
 - > Community-based organizations (CBOs) of sex workers.
 - > Healthy committees (comprised of sex workers, doctors and NGO members) to oversee and monitor management of the STI clinic.
 - > Crisis intervention teams to respond to episodes of violence.
 - > Encouraging community-led advocacy with police and media.
 - > Distributing free condoms through the CBO.

India's SII: For the SII, CARE aimed to:

- Examine the contributions of SAKSHAM's approaches toward the empowerment of sex workers and HIV/AIDS prevention.
- Understand female sex workers' experiences, circumstances and aspirations for empowerment.

For the full report on India, please e-mail: pqlibrarian@care.org

Methodology

CARE coordinated our staff and a research consultant to conduct the study. The team took part in research design, data collection and analysis.

Research Design

- Research Team: Research coordinator, 2 social sciences post-graduates and 3 field researchers from community.
- Site Selection: Rajahmundry, a high HIV prevalence area where SAKSHAM worked.
- Participant Selection: Stratified random sampling of sex workers from project records.

Data Collection

- Overview: 240 respondents.
- Structured Questionnaire (240 women): Examined: Women's vulnerabilities and factors shaping them, impact of programs on HIV and empowerment, and the impact of empowerment on HIV risk.
- Focus Group Discussions (10 groups): Examined: Views on empowerment, SAKSHAM's contributions.
- In-depth Interviews (20 women): Examined: Impact of empowerment, cases.
- Key Informant Interviews (12 respondents): Examined: Views on project impact, changes.

Data Analysis

- Quantitative Analysis: The results of the structured questionnaire were analyzed using SPSS software.
- Reflective Process: Research team reflection on participant responses.

Limitations

- Sampling was random, but not representative of sex workers in terms of duration of involvement.

Lesotho: Gender, Power and Sex

Strategic Impact Inquiry Research Summary

Context

Lesotho has one of the highest HIV/AIDS prevalence rates (23%) in the world¹³, and 57% of people living with HIV in Lesotho are women¹⁴. The disproportionate number of females living with HIV results from both biological susceptibility as well as economic insecurity and patriarchal practices. Shifting economic patterns has driven female labor migration to the urban capital. Removed from their support networks and pushed by economic survival, some women are more vulnerable to practicing transactional sex.

Snapshot of Findings

- **Knowledge of HIV:** Both project participants and non-participants demonstrated high knowledge of HIV (99% and 96% respectively).
- **Utilization of HIV Services:** Of those who tested for HIV, participants were significantly more likely to have tested than those who were not participants (40.5%, 15.0%). The differences were more dramatic when asked about utilization of STI services (100% of participants, 0% of non-participants).
- **Sexual Decision Making:** Despite a high percentage (80%) of participants reporting confidence in discussing condoms and over 70% reporting that they could convince their partner and others to use condoms all or most of the time, only 40% of participants said they could refuse sex with a partner. Women cited economic dependence on, fear of being abandoned by, and fear of violent response by a boyfriend or intimate partner as reasons for the inability to refuse sex with a partner.
- **Poverty and Economic Disempowerment:** Poverty, the threat of poverty and familial obligations leave women vulnerable to sexual exploitation from partners and transactional sex; 76% of respondents had three or more dependents. The need to work overtime to augment low wages indirectly increased women's risk of being raped as they worked longer days and traveled in the dark.
- **Unequal Relationships:** Showing respect for husbands and their sexual preferences is linked to women's identity and self-esteem. Condoms are seen as barriers to women's access to material support or stability in marriage. Empowerment enables women to disregard stigma toward HIV and focus on her own health (condoms, HIV treatment).
- **Migration:** Lack of social support from a new environment can lead to risk-taking behavior and greater vulnerability to HIV.

Implications

Address women's broader needs and rights: Women are trying to negotiate sex in the context of skewed gender relations. These notions have implications for designing future programs.

- Women's responses reflect deeply entrenched gender norms where respect for a husband and humbling herself was a fundamental attribute of a woman's identity and self-esteem. Women value their relationships with their husbands and do not seek conflict or confrontation with their husbands.
- Communication about condom use may be difficult to realize without disturbing core values – trust, monogamy, and procreation. Women have tried to avoid conflict with their partners in order to secure their welfare and maintain a sense of identity. This avoidance occurs, despite the fact that in most cases, neither partner is practicing faithfulness and monogamy.

Adapting to Local Values and Realities: The project must work with contextual factors (socio-cultural and economic) that influence women's decisions in relationships.

- The project needs to address poverty and migration issues, which increase HIV risk.
- While women have very high levels of HIV knowledge and awareness, poverty and survival strategies of exchanging sex for material goods undermines many women's intentions to pursue safe sex practices.

Engaging Men and Local Power Holders

- For robust sustainable impact, the project must also work with men, households and communities to address relational and structural dynamics underlying women's vulnerability to HIV.
- Many women we interviewed said that the men need HIV education. Right now, the women are trying to negotiate condoms based on information about HIV that the men do not have. In epidemics where the main mode of transmission is through heterosexual transmission, programs focusing exclusively on women may have limited impact or place undue burden of responsibility on women who are already dealing with huge power inequities.

Lesotho's Strategic Impact Inquiry (SII)

CARE assessed the impact of its Private Sector Coalition against AIDS in Lesotho project (PSCAAL) for the SII. PSCAAL operated from 2002-2005 in collaboration with local employment associations and the International Organization for Migration. PSCAAL worked in factories with garment workers to increase HIV/AIDS awareness and response through:

- Peer Education: to raise awareness and increase demand for services for workers infected/affected by HIV/AIDS.
- Support Groups: to provide space for workers to discuss HIV/AIDS.
- Voluntary Counseling and Testing: to mobilize workers to undertake confidential HIV testing and provide services to garment industry workers.
- Trainings on workplace HIV/AIDS policies: to assist companies to institutionalize their response to HIV.

Lesotho's Strategic Impact Inquiry (SII): For the SII, CARE explored:

- The impact of PSCAAL on women's empowerment and vulnerability to HIV.
- The relationship between women's empowerment and vulnerability to HIV.
- Differences in program impact between those who were exposed to peer education and those who were not.

For the full report on Lesotho, please e-mail pqlibrarian@care.org.

Methodology

The SII was rooted in qualitative and quantitative methodologies, and participatory research. Given the sensitivity of the topic, CARE arranged counseling sessions for respondents.

Research Design

- Research Team: Human Sciences Research Council, CARE staff.
- Site Selection: CARE staff identified two factories for the SII.
- Participant Selection: Convenience sampling.

Data Collection

- Overview: 186 respondents.
- Focus Group Discussion: Examined the perceived meaning of empowerment.
- Semi-Structured Interviews: Examined: Demographics, HIV awareness, decision-making, gender equality, self-efficacy, and community.
- Key Informant Interviews: Examined: PSCAAL work and context.
- Policy Analysis: Examined: HIV workplace policy and implementation.

Data Analysis

- Triangulation: Data validation across methods, locations and researchers.
- Reflective Process: Research team reflection on impact of CARE's work.

Limitations

- No baseline for assessment on women's empowerment specified for the project.
- Few peer educators were available for the study as they had moved from the factory.
- Rapid developments have taken place in the HIV/AIDS environment since PSCAAL.

Perú: Gender, Power and Sex

Strategic Impact Inquiry Research Summary

Context

In the regulated context of sex work in Perú, HIV prevention has been fairly successful in the sex worker community. A national peer health educators program laid the foundation for rights awareness and basic access to knowledge and services, as well as the formation of sex workers' organizations. However, street-based sex workers, who are considered outside of the law, are often criminalized, younger and more vulnerable to trafficking and HIV. The diversity of experiences of sex workers, in the larger environment of gender inequality and economic insecurity, requires a closer examination of broad dynamics of gender and HIV/AIDS.

Snapshot of Findings

Group Membership organizing has paved the way towards the empowerment of sex workers on three main focal points:

- **Facing institutional abuse and mistreatment:** though in this aspect, greater changes at the structural level are lacking for empowerment to be consolidated. Almost 100% of sex workers belonging to organizations stressed the importance of being part of such groups, stating that it helps them to be strong and better defend their rights.
- **Negotiating condom use with the client:** With clients, 93.5% of sex workers belonging to an organization report using condoms with clients all of the time in the last six months compared to 84.8% of sex workers not belonging to an organization
- **Facing the clients' violence:** Sex workers in organizations expressed that their complaints were taken more seriously and follow-up was more likely as a result of being part of an organization.

Condom use with Intimate Partners: Membership in sex workers' organization is associated with higher rates of condom use with intimate partners. 37% of women who belonged to an organization reported condom use with a steady partner, compared to 19% of women who didn't belong to an organization. However, most women are unable to negotiate condom use with intimate partners because of dynamics around trust, love and familiarity.

Vulnerability: Unstable relationships, lack of community and the nature of the position leads to vulnerability to HIV in women's lives.

- Young sex workers, without networks or status, are more vulnerable to violence and express lower empowerment. It is likely that young sex workers are more vulnerable to violence because they have not built yet many social networks in their work, and they are on the streets and cannot pay for protection.
- Evidence suggests that the stigma sex workers face renders women in sex work vulnerable to rights abuses by state or private social actors.

Implications

Support Organizations and Help Them Expand Their Reach

- Sex worker organizations are protecting women's rights, not just sexual health or workers' rights – to ensure they have support in that work.
- Work with peer educators to ensure group inclusivity, avoid exclusion of any sex workers.
- Young sex workers tend to be less involved in groups – explore reasons why, and develop tailored strategies to strengthen their limited social networks/support.

Engage Men and Local Power Holders

- Men's participation is essential to challenge the gender norms that influence condom use with intimate partners and contributes to violence against women.
- Understand dynamics of power and engage local power-holders (police, pimps, brothel owners, health services) for human rights of sex workers.

Use a Comprehensive Approach to Women's Empowerment

- Support sex workers' financial empowerment within their own context/reality to ensure savings given the volatility of their lives.
- Build capacity of sex worker organizations to enable women to further exercise their rights.
- Support sex workers to pursue changes at the structural level.

Peru's Strategic Impact Inquiry (SII)

As a principle recipient for the Global Fund, and lead agency on monitoring and evaluation of national HIV/AIDS prevention efforts, CARE partnered with the Cayetano Heredia University to learn more about empowerment, sex worker organizations and HIV prevention, from the perspectives of sex workers themselves.

Because Global Fund ATM programming is carried out through support to partners and national systems, CARE looked at a number of interventions over time in which Global Fund support played a role in supporting the work of sex worker organizations, focusing on three regions: Iquitos, Lima/Callao and Chimbote.

Peru's Strategic Impact Inquiry (SII): The specific objectives of Peru's SII were to analyze the perceptions, aspirations and frustrations sex workers have, emphasizing HIV/AIDS prevention, in regard to:

- Organizations, themselves/lives as sex workers.
- Rights that benefit them, expectations of rights.
- Their relationships with men in general and as a couple in particular.
- Formal and non-formal networks.

In addition, the study analyzed activities that engaged the sex worker population and contributed to their empowerment in HIV/AIDS prevention.

For the full report on Peru, please e-mail: pqlibrarian@care.org

Methodology

Cayetano Heredia University led the multi-stakeholder research team.

Research Design

- Research Team: Project staff, sex worker organization leadership, Cayetano Heredia University.
- Sites: Three distinct areas of Peru (Iquitos, Lima/Callao and Chimbote).
- Participant Selection: Convenience sampling used to identify participants.

Data Collection

- Overview: 765 respondents.
- Survey Research (765 respondents): Examined: Demographics, HIV awareness, decision-making, gender equality, self-efficacy and community.
- Life Stories (19 respondents): Examined: Feelings about sex work.
- Participatory Exercises (7 activities, 153 people): Examined: Notions of empowerment, self-efficacy, and law.

Data Analysis

- Triangulation: Data validation across methods, location, people researchers.
- Discourse Analysis: Recognize sex worker interpretation of lives, analysis of specific situations and context.
- Reflective Process: Research team reflection on impact of CARE's work.

Limitations

- Study looked at a multitude of projects.
- Due to limited access, study covered sex workers accessing health services.
- Qualitative component only conducted with women affiliated with sex worker organizations.

- ¹ More detailed country-specific information is included in the appendix, with contact information for country-specific full reports.
- ² While groups are generally formed with similarity along one stratum, there may be differences along other strata that project planners can overlook in ways that cause disruptions to project implementation. This element is discussed in greater depth in Annex 1.
- ³ Please refer to Annex XX for more detailed site specific research findings.
- ⁴ Including: quantitative and qualitative data, country final reports and presentations, reflections from participants and program staff.
- ⁵ In the absence of baseline data, the research took a cross-sectional design. Respondents were categorized in two or three groups ranging on intensity (length of membership, or position held within the group) of involvement in the group.
- ⁶ CARE Burundi (2009) *Gender, Sex and Power: The Implications of Empowering Women at Risk of HIV& AIDS*. 5.
- ⁷ Murray, L., Moreno, L., Rosario S., Ellen, J., Sweat M., Kerrigan, D. (2007) *The Role of Relationship Intimacy in Consistent Condom Use Among Female Sex Workers and Their Regular Paying Partners in the Dominican Republic*. *AIDS Behavior*. 11:463–470.
- ⁸ Jewkes Rachel; Nduna, Mzikazi; Levin, Jonathan; Jama, Nwabisa; Dunkle, Kristin; Wood, Kate; Koss, Mary; Puren, Adrian; Duvvury, Nata. (2007). *Evaluation of Stepping Stones: A gender transformative HIV prevention intervention*. Gender & Health Research Unit, South Africa Medical Research Council.
- ⁹ Physicians for Human Rights. (2007) *Epidemic of Inequality: Women’s Rights and HIV/AIDS in Botswana & Swaziland: An Evidence-Based Report on the Effects of Gender Inequity, Stigma and Discrimination*.
- ¹⁰ Ibid.
- ¹¹ Many of these strategies are already being implemented by CARE, but not all in the same project.
- ¹² Indirect Sex workers refers to women who do not formally engage in the sex trade through formal structures such as brothels but through their work in entertainment establishments (karaoke bars etc.) often engage in sex work.
- ¹³ UNAIDS. *Global report annex: HIV and AIDS estimates and data, 2007 and 2001 [Data file]*.
- ¹⁴ UNAIDS. *Epidemiological fact sheet on HIV and AIDS: Lesotho 2008 update [Data file]*.



care

Defending dignity.
Fighting poverty.

CARE USA Headquarters
151 Ellis Street, Atlanta, GA 30303
404-681-2552 www.care.org

CARE is an Equal Opportunity Employer and Affirmative Action Employer (AA/M/F/D/V) dedicated to workplace diversity. CARE® and CARE Package® are registered marks of CARE. Copyright ©2009 by Cooperative for Assistance and Relief Everywhere, Inc. (CARE). All rights reserved. Unless otherwise indicated, all photos ©CARE. CARE®, CARE Package®, I Am Powerful®, She Has The Power To Change Her World, You Have the Power to Help Her Do It.® and Defending Dignity, Fighting Poverty.® are registered marks of CARE. Cover Credits: Cover and Page 6: © 2005 Phil Borges; Pages 5, 8 and 29: Theresa Hwang/CARE; Page 18: Ximena Salazar; Page 25: Nicole Cappelletto/CARE.