



Women's Empowerment

Introductionⁱ

Of the 1.3 billion people who live in absolute poverty around the globe, 70 percent are women. For these women, poverty doesn't just mean scarcity and want. It means rights denied, opportunities curtailed and voices silenced. Consider the following:

- *Women work two-thirds of the world's working hours*, according to the United Nations Millennium Campaign to halve world poverty by the year 2015. The overwhelming majority of the labor that sustains life – growing food, cooking, raising children, caring for the elderly, maintaining a house, hauling water – is done by women, and universally this work is accorded low status and no pay. The ceaseless cycle of labor rarely shows up in economic analyses of a society's production and value.
- *Women earn only 10 percent of the world's income*. Where women work for money, they may be limited to a set of jobs deemed suitable for women – invariably low-pay, low-status positions.
- *Women own less than 1 percent of the world's property*. Where laws or customs prevent women from owning land or other productive assets, from getting loans or credit, or from having the right to inheritance or to own their home, they have no assets to leverage for economic stability and cannot invest in their own or their children's futures.
- *Women make up two-thirds of the estimated 876 million adults worldwide who cannot read or write*; and girls make up 60 percent of the 77 million children not attending primary school. Education is among the most important drivers of human development: women who are educated have fewer children than those who are denied schooling (some studies correlate each additional year of education with a 10 percent drop in fertility). They delay their first pregnancies, have healthier children (each additional year of schooling a woman has is associated with a 5 to 10 percent decline in child deaths, according to the United Nations Population Fund)

and are far more likely to send their own children to school. Yet where women do not have the discretionary income to invest in their own or their children's education, where girls' education is considered frivolous, and where girls are relied on to contribute labor to the household, they miss this unparalleled opportunity to develop their minds and spirits. Their countries suffer too: the World Bank estimates that nations in South Asia and Africa lose .5 to 1 percent growth in per-capita income per year compared to similar countries where children have greater access to quality, basic education.

In India, a CARE project working with adolescent girls noted that *"they are often seen only as temporary people who will cease to be – at least for the father – once they have disappeared inside a marriage."*

In Zambia, a Lenje man with many wives told CARE, *"Women are like livestock,"* meaning many things. They can be bought and sold, as cattle can, and they are a productive asset, as cattle are. To this man, women were extremely important – his cattle certainly were – but they had the status of a commodity.

In many societies around the world, women never belong wholly to themselves; they are the property of others throughout their lives. Their physical well-being – health, security and bodily integrity – is often beyond their own control. Where women have no control over money, they cannot choose to get health care for themselves or their children. Where having a large number of children confers status on both men and women – indeed, where childbearing may be the only marker of value available to women – frequent pregnancy and labor can be deadly. World Health Organization data indicates that in Afghanistan and Sierra Leone,

for example, a woman's lifetime chance of dying in childbirth is one in seven; in the United States it is one in 3,418, and in Norway and Switzerland, one in 7,300. In any given year, 15 percent of all pregnant women will face a life-threatening complication, and more than 500,000 – 99 percent of them in the developing world – will die. Some 130 million girls and women, mostly in sub-Saharan Africa, have been subjected to genital cutting at the behest of their parents, and 2 million more face the blade every year, according to the United Nations Population Fund.

In Lesotho, an old adage says, *"A woman is the child of her father, her husband and her son."* The constitution treats women as minors, incapable of making decisions... Within the law, households [that do not have a "permanent" male in them] do not exist, which makes women even more vulnerable.

Around the globe, home and community are not safe havens for a billion girls and women: At least one in three females on earth has been physically or sexually abused, often repeatedly and often by a relative or acquaintance. By the World Bank's estimate, violence rivals cancer as a cause of morbidity and mortality for women of childbearing age. Even within marriage, women may not be able to negotiate when and what type of sex to have, nor to protest their husbands' multiple sex partners. Poverty and exclusion push some girls and women to engage in sex work, almost always the desperate, last choice of people without other choices. Further, the U.S. Department of State indicates that up to 800,000 people are trafficked across international borders annually: 80 percent of these are women and girls, and the majority are forced into the sex trade. And in the midst of conflict and natural disaster in countries around the world, women's risk of violence skyrockets. Systematic rape as a weapon of war has left millions of girls and women traumatized, forcibly impregnated, and/or HIV positive. These factors combined explain why today more women than men around the world are HIV positive. In sub-Saharan Africa, more than twice as many young women as young men are living with HIV, according to the International Labor Organization.

Which aspects of women's poverty, their lesser economic, legal and social status, are due to **sex** (the physical attributes and processes mandated by the cellular presence of XX or XY chromosomes), and which to **gender** (the economic, social and cultural attributes and opportunities that human societies have attached to being a woman or a man)? Gender differences pattern our identities, attitudes, roles, relationships and resources more deeply and persistently than class, race or other social constructs. In all societies, including our own, sex and gender are so tightly linked that we have great difficulty disassociating them. Gender roles perpetuated over time and space are normalized: they come to seem as much the natural order as sex differences. *Helping women and men uncover and uproot the profoundly unjust gender norms that keep so many women mired in poverty and bereft of dignity is surely CARE's most challenging undertaking to date.*

CARE's Evolving Approach to Poverty

Since our founding in 1946, CARE has been dedicated to helping poor people overcome suffering. Our earliest work was to send food and basic necessities – the CARE Package® – to families in Europe and Asia whose lives were shattered by World War II. We have since expanded geographically, and now work in some 70 of the world's poorest countries in Africa, Asia, Latin America, the Middle East and Eastern Europe. Our more than 900 projects deal with agriculture, health, education, natural resource management, economic development and emergency response. But most importantly, CARE has grown in our capacity to analyze poverty's complexity, to develop multifaceted programs and partnerships to address poverty, to advocate for broad-based support for the eradication not only of the symptoms of poverty but its underlying causes, and to critically evaluate our work in our constant quest to more effectively help people overcome poverty.

What is Poverty?

Poverty is hunger. Poverty is lack of shelter. Poverty is being sick and not being able to see a doctor. Poverty is not being able to go to school and not knowing how to read. Poverty is not having a job, is fear for the future, living one day at a time. Poverty is losing a child to illness brought about by unclean water. Poverty is powerlessness, lack of representation and freedom.

World Bank

CARE has moved from an early view of poverty as primarily an absence of necessary goods and services (food, water, health care), to one that also encompasses an absence of assets and opportunities (land to produce food, access to markets to sell and buy), and to an absence of skills and knowledge (basic education, vocational training), and finally to a position that poverty in most cases is rooted in human-made systems that exclude, marginalize and discriminate against certain groups of people. In effect, the absences listed above are but *symptoms of exclusion and social injustice*.

Since the early 1990s, CARE's household livelihood security framework has broadened our view of the multi-dimensional nature of poverty. The framework's focus not on poverty but its opposite – livelihood security – encompasses aspects of life not normally correlated with need or want. Thus, in addition to food, water, health, shelter and education, CARE includes participation in community, personal security and identity as prerequisites of a livelihood-secure household; similarly, a household's assets would include not only its physical, financial and natural resources, but also its social and political positioning, its collective knowledge and its human capacities. Our household livelihood security perspective also confirms that overcoming poverty cannot be the purview of any single actor: CARE must work in strategic partnerships, including with the poor. Perhaps most importantly, the framework clarifies that achieving household livelihood security requires attention to *power relations* within and among households, and particularly those rooted in gender.

An ensuing, important shift in our approach to understanding poverty came with what we call a rights-based approach. Viewing livelihoods through the lens of human rights, in contrast merely to human needs, has helped CARE explicitly focus on people achieving the *minimum conditions for living with dignity*. Rights violations represent important underlying causes of livelihood insecurity. In much of the world, a lack of access to assets and resources is symptomatic of underlying discrimination, exploitation and exclusion. In 2000, CARE adopted a rights-based approach to help us expose the roots of vulnerability and marginalization and delve more deeply into gender, governance and other manifestations of power relations.

A key breakthrough in CARE's evolving understanding of the underlying causes of poverty has been the explicit recognition of power as the currency of material and social well-being. Power has been defined by gender activities within the development arena as "the ability to get what you need, keep what you have and influence others to meet your interests."

Global Research Framework for CARE's
Strategic Impact Inquiry on
Women's Empowerment, 2005

A rights-based approach:

- Insists that poverty is neither natural nor inevitable, but has roots in political and economic decisions;
- Helps us identify the structural and societal causes of poverty and marginalization;
- Aims to address relations between those who wield power and those who do not;
- Provides a means of strengthening people’s capacities to claim and exercise their rights; and
- Clarifies authorities’ duties to those they serve.

Before we adopted this approach, CARE’s practical attempts to empower women often missed this simple starting point: Until women are accepted by men as equally human, attempts to help women change their lives will necessarily always result in achievements that are limited in scope and longevity. Women alone cannot empower themselves, nor should we expect them to bear that burden. Men too – especially in their status as power holders in the family, community and formal government – must act.



Most recently, CARE has developed what we call the unifying framework to bring together the salient aspects of our poverty eradication approaches. This framework is designed to help us – the thousands of CARE staffers around the globe and the people we serve – consistently look beyond the immediate and most evident causes of poverty to three categories of cause that shape the lives of the poor. These are causes related to: basic material or *human conditions*; influence and *social positions*; and the structure of laws, norms and institutions that constitute the *enabling environment* in which an individual lives. Our use of the framework as an analytical tool consistently underscores that women’s disempowerment is a universal factor in extreme poverty; in turn, a focus on women’s empowerment offers a pathway out of extreme poverty and toward dignity and security – for women, their families and whole communities.

CARE and Women’s Empowerment

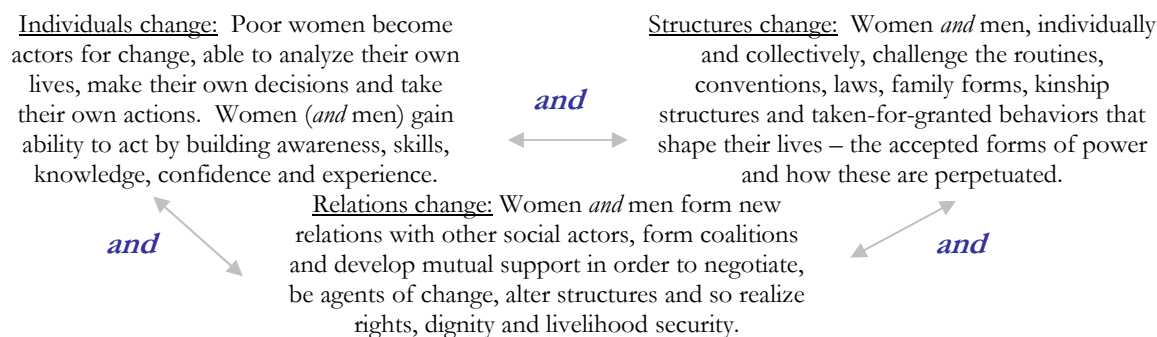
A Guide to Action



CARE has always worked with women and girls alongside men and boys in our poverty-fighting programs. But over time, we have shifted from understanding poverty as a phenomenon of unclaimed rights as well as of unmet needs, and now have a greater appreciation of the human-made, structural elements that underlie the poverty of entire groups of people. That’s why we are transitioning from working with women as victims of poverty to *empowering poor women* to challenge and change the contexts in which they live. In this shift, we join many colleagues in the international arena: global groups such as the

World Bank and United Nations, donors including the United States Agency for International Development, and our peer nongovernmental organizations. But CARE is also leading the way with our expanded understanding of empowerment that combines theory and practice to promote sustainable change.

CARE is using our understanding of empowerment both to improve our work and to assess the impact of our programs. Built upon social theory that recognizes the power of **individuals** (sociologists call this “agency”) and **structures**, CARE’s view of empowerment is unique: It also incorporates **human relationships**, which, research and experience indicate, are key factors in the construction and entrenchment of poverty, and must be judiciously altered if poverty is to be overcome. Our understanding of empowerment reminds us that change – in this case, improvement in the physical, economic, political or social well-being of women – will not be sustained unless:



Let us take a look at just two examples of how CARE might try to empower women to achieve an explicit goal, and how all three dimensions of empowerment must be addressed *in some way* if the goal is to be achieved and sustained:

<i>Sample Goal 1: Improve gender equity within the household</i>		
CARE and participants make changes to:	Individuals	A village savings and loan project improves women’s financial status; corollary training builds their savvy to earn more from income-generating activities. Women’s stature and say-so in household decision-making increases with income.
But impact is limited/unsustainable without changes to:	Structures	Marriage and inheritance customs still accord husbands ultimate ownership of his wife’s assets.
	Relations	Men, other women and customary leaders have not been drawn into dialogue about current structures; do not support change.

<i>Sample Goal 2: Eradicate female genital cutting</i>		
CARE and participants make changes to:	Structures	CARE trains women’s groups to advocate for a national law banning female genital cutting; the women successfully sway the government and a law is enacted.
But impact is limited/unsustainable without changes to:	Structures	Marriage norms and women’s social roles are unchanged: Most women have no livelihood options or social status outside marriage.
	Individuals	Non-group members’ awareness was not raised to support change.
	Relations	Religious leaders and women who earn a living performing cutting on girls were not consulted and do not support change; most men will not contemplate marriage to an uncircumcised woman.

This view of empowerment does not necessarily push CARE alone to enable changes in individuals, structures *and* relations in all our programs. Women’s empowerment, like poverty eradication, cannot possibly be the purview of a single organization. Rather, by designing our programs with this view in mind, we push ourselves and our project participants to more fully examine the environment in which we are working. We generate networks and partnerships to support change, and we harness parallel social movements in our efforts to affect underlying causes of poverty.

A Tool for Measurement

How can we be sure that our work is making distinct contributions to women’s empowerment? CARE places great value on *programmatic accountability* to those we serve, to our donors and to ourselves as a learning organization. By monitoring our progress and evaluating our achievements against the intended outcomes,

we can make adjustments to current work, learn from experience and build upon success. CARE weaves formal monitoring and evaluation processes into every project that we implement around the world. In addition, we maintain a global system that monitors high-level indicators (the number of people we reach each year, with what types of interventions and certain information about them such as sex, age and livelihood).

In 2005, to enrich our existing information systems, CARE launched a multi-year research process to examine our programmatic impact on the underlying causes of poverty and rights denial. The first three years of our research focus on *CARE's contribution to women's empowerment and gender equity*. We use carefully chosen and applied methodologies to conduct original research on the impact that CARE's work has on individuals, structures and relations in a given context. Additionally, we mine other data sources to better understand our contributions to poverty eradication.

A Common Core: What Elements are Crucial to Women's Empowerment?

An essential first step in CARE's field research into our impact on women's empowerment is to guide participants toward *their own definition* of an empowered woman. In all four countries where our first round of research was done, four elements were common to participants' definitions. What elements form this crucial core? According to our respondents in India, Ecuador, Bangladesh and Yemen, an empowered woman has:

- Notions of self-worth and dignity (individual).
- Bodily integrity; freedom from coercive forces over a woman's very body (individual and structure).
- Control and influence over household and public resources (structure and relations).
- Experience with or appreciation of the value of collective effort and solidarity among women (relations).

Though still incomplete, CARE's research into women's empowerment is shedding light on what CARE is doing right. The data is suggesting new directions for CARE, our project participants and our colleagues in the international development arena as we strive to empower women to change their world – our world – for the better.

CARE in Action

In this section, we provide examples from around the globe of our work with men and women to bring about changes – to individuals, structures and relationships – that point the way to women's empowerment. The projects highlighted here represent many of our classic program sectors, including education, health and economic development. They also represent cutting-edge arenas CARE has entered as a result of adopting a rights-based approach and targeting the underlying causes of poverty: addressing gender-based violence, confronting harmful traditional practices such as female genital cutting, and helping women attain positions in which they can alter structures and relations that perpetuate inequality.

Innovations in Education

Lack of education and poor quality of education combine with girls' and women's low status to create a particular human development problem. CARE's extensive work to promote access to high-quality education for all has shown that multiple factors must come together to overcome the problem. Schools must be built, books secured and teachers trained. Equally important, communities must confront the attitudes and assumptions that prevent girls from attending and excelling in school. CARE and our participants find creative ways to change people's views about the value of education, for both girls and boys, and to foster a social environment in which girls feel encouraged to attend school.

In northern **Benin**, CARE and two local nonprofits worked to increase girls' enrollment and retention in primary school, improve the quality of education, and promote community participation in and support for basic schooling for all children. The project, known as Pro-Base, surpassed all planned goals and objectives.

Girls' enrollment rose by 97 percent over four years, and 8,000 more girls were in school at the end of the project than at the beginning. Girls' dropout rates plummeted, and their academic achievement soared. Boys benefited as well, though changes were less dramatic because boys were in a better scholastic position when Pro-Base began. CARE and our partners undertook an array of activities – with children, parents and school workers – to achieve these results, and among the most successful was the formation of village-based groups to promote girls' education. Made up of dynamic men and women, the groups found novel ways not only to encourage parents to send and keep their girls in school but to:

- *Reduce child labor:* The groups encouraged families to join together to solve common labor problems so that boys and especially girls could be freed up from house and farm work to attend school; and
- *Reduce the incidence of forced marriage:* Before Pro-Base, the regularity of early, forced marriages and early pregnancies constituted a primary factor in girls' abandonment of school. The problem has considerably diminished, due in part to group outreach.



Southern Sudan, meanwhile, which in 2005 put an end to decades of war with the north, is struggling to create an education system where none has existed for years. CARE has played a major role in this process, through our Sudan Basic Education project. With a consortium composed of Sudanese and international groups, we have developed high-quality teacher training programs, devised curricula relevant to the area and culture, built hundreds of schools, and trained hundreds of staff in basic administration and management procedures. We have created not only primary education systems for children, but also accelerated learning programs for adults who never had the opportunity to attend school.

But parallel to this ambitious program, we needed to address local biases that relegated girls and women to the home and, implicitly, saw formal education as a benefit to be enjoyed by boys and men. We therefore used a new outreach method – role models – to ensure that exclusion of girls did not become normalized in the new school system. Simply put, most people in southern Sudan had never met an educated woman, nor any woman whose sphere was larger than home and village. CARE located such south Sudanese women and organized their travel to towns and remote villages, where they spoke with children, parents and school workers about the value of educating their girls. And to help make sure that new attitudes stayed in the classroom, CARE developed a series of schoolbooks whose characters – based on our interviews with dozens of south Sudanese girls – are smart, engaging and bold girls who challenge local notions of what a girl “should” be.

The Many Forms of Gender-Based Violence

Gender-based violence, which includes sexual, physical or psychological violence and harmful practices based on gender, is one of the most common human rights abuses in the world. It is also one of the least discussed and confronted.

CARE's first project dealing with gender-based violence began in the early 1990s at the **Somali** refugee camps in northern **Kenya**. Bandits roamed the camps' boundaries and raped and robbed refugee women who left camp in search of firewood. Initially CARE developed prevention strategies, such as provision of alternative fuel sources, and we joined with other aid agencies to

“If we're going to talk about women's empowerment, we have to talk about the problem of sexual violence. It's great if the head of the community development committee is a woman. But if she's going home and getting raped every night by her brother-in-law, is she empowered? No.”

Kassie McIlvaine, CARE's
Director in Burundi

provide better medical, psychological and legal services for rape victims. More recently, in recognition of injustices and rights-violations within the camps, we launched a large-scale campaign to guide men and women in discussing and addressing female genital cutting, rape and battery (including within households) and other forms of gender-based violence. And we have built upon this work in other places where women suffer the dual trauma of war-displacement and increased vulnerability to violence. In **Chad**, for example, where CARE is working with more than 100,000 refugees from Darfur, **Sudan**, our standard relief provision (food, shelter and other basic needs) is fully integrated with community services that bring refugees – men and women – together to learn about rights, debate views on violence, and develop activities to reduce and react to instances of violence against women. In each refugee camp, CARE has created women’s centers – welcoming, safe places where women and their children can gather to debate, learn or simply find respite from the stress of camp life.

CARE has formed a strong, multi-agency partnership to address violence against women on **Sri Lanka’s** eastern coast, an area where traditional gender roles hold women and girls at a severe disadvantage even in normal times. But gender-based violence here has been exacerbated by three decades of war between the government and Tamil separatists, and the chaos of the 2004 tsunami. CARE initiated the Stop Violence against Women Partnership to overcome a near-total lack of support services for girls and women who had endured violence in the home or in the context of the war. Early partnership members included local nonprofits, lawyers, local branches of government-run health and poverty alleviation services, and several U.N. agencies working in the area. Together, we developed services to assist survivors of violence in a dignified manner. Equally importantly, we seized the opportunity by working together to discuss, learn and test new ideas. As a result, the partnership reached out to key sectors of the government including the police, hospitals and judiciary, who now recognize and treat gender-based violence as a serious social problem rather than the natural lot of women. All partners – from nonprofits to the police – have prioritized *prevention* of violence, and are instigating changes in the structures and relationships that have historically situated violence against women as a normal and private aspect of male-female interaction.

Economic Development: A Woman’s Path to Self Mastery



In the early 1990s, CARE was determined to help extremely poor women in rural **Niger** accumulate money that they could then invest in income-earning activities – impossible for those who must devote every penny to daily survival. We devised a simple methodology in which groups of 20 or so women pool their savings and make the tiniest amounts – pennies per woman per week – grow into important sums. When group members borrow from the pool, they can start or expand small enterprises, from livestock rearing to market trading. Members repay their loans with interest, and the savings grow.

The formation of a women’s savings group is a months-long process. A CARE staffer trains members in all aspects of group governance and funds management, slowly building skills and confidence until women can manage their group independently. But we also include other types of training: Women gain new information on human rights, health and nutrition, childcare, food production and business skills.

The *Mata Masu Dubara* (“women on the move”) program today counts well over 150,000 Nigerian women as members and, as a vehicle for individuals’ economic security, MMD has been an unparalleled success. But the personal strength that grows as CARE trains women to collectively manage their resources and govern their groups, and the confidence that blooms as women accumulate assets and gain new knowledge, have been the parallel boons of MMD. It turns out that a savings group can be an ideal forum for women to identify and address other important issues in their lives. Women get the

opportunity to gain social, political and economic skills and savvy, which opens a greater field of action. Women report a new sense of mastery over their own lives.

Mata Masu Dubara: Preparing the Ground for Structural Change?

Clearly, Nigerien women who are members of MMD enjoy increased skills, knowledge and resources. But have they moved beyond individual change to challenge the legal, political and familial structures that surround them?

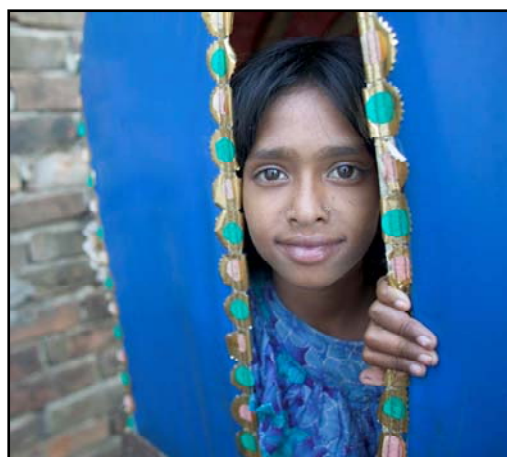
Over the years, participating women's role and status *within* existing structures has changed. However, members have generally not chosen to challenge the structures themselves. For example, women report that they have a greater voice in household decision-making – over use of resources, for example, or children's marriage prospects – but they have not yet banded together to challenge customary kinship and marriage structures that relegate them to subordinate positions in the home. Still, there are hopeful signs. Some MMD groups have created *mutuelles* – special savings that members can draw upon to purchase health care without first seeking their husbands' approval. Other MMD groups, with CARE's help, have applied for loans from formal banks, surely a challenge to the banking industry's view that poor, rural women are the greatest credit risk of all. And in the political arena, a surprise outcome of MMD is the number of members who have run for – and won – local offices in tandem with the government's decentralization process. Women are entering politics in tiny but unprecedented numbers, thanks in part to MMD. But it remains to be seen how they will use their new positions to alter the lives of Nigerien women – or perhaps even to challenge the very nature of the political structures in which they now participate.

But are individual-level changes the result of greater wealth alone? **India** is home to thousands of women's savings groups created with the help of numerous organizations – CARE among them. We recently concluded research into our own and a random control group of other women's self-help groups in Orissa State. Evidence shows that women who participate in our "Microfinance-Plus" projects (the "Plus" includes training in human rights, health and governance topics, similar to the training that MMD members enjoy in Niger) experienced higher levels of empowerment than women in a random control group. Women who received credit and who sustained social, political and business-development training for more than three years displayed greater independence, increased household decision-making, more control of resources, and more equality within the home. Further, evidence revealed that women in "Microfinance-Plus" projects spent 125 percent more money on the education of their children and 43 percent more on health care than women in the control group.

Indeed, our research in India showed not only benefits of "Microfinance-Plus," but serious potential drawbacks to microfinance services *alone*. A woman will have greater access to credit, but not necessarily control over the money. She may face increased violence in the home – for example, her husband may wrest control of borrowed money or force her to take loans for his use. She may take on a greater workload without concomitant increase in status or ability to make decisions for herself. CARE is advocating in India that *all* microfinance strategies for women address root causes of women's subordination and their systemic exclusion from development processes.

HIV and AIDS Thrive on Social Injustice

The scourge of HIV and AIDS has sharply raised the odds against people denied full control over their sexual and reproductive choices. This is especially the case for women in Africa, where the greatest number of people by far are infected, and in Asia, where infection is spreading most rapidly. CARE's work to help people protect themselves from HIV and manage their sexual health has brought us to some of the most challenging – and creative and successful – work in our history.



Since the mid-1990s, we have worked with the people most vulnerable to HIV in **Bangladesh**: sex workers. Initially our SHAKTI (meaning *strength* in Bangla) project strove to increase the women’s knowledge of safe sex practices. But we quickly understood that their vulnerability lay in factors far more complex than lack of knowledge. Women’s ability to negotiate safe sex and condom use was constrained by socially constructed factors, including gender inequalities and the tremendous stigma attached to their profession, which effectively rendered them powerless in the face of their clients. After long discussions with the women, SHAKTI embraced a rights-based strategy to help women gain strength and dignity, and empower them individually and as a community. Our activities included training (in literacy, vocational skills, microcredit group formation, human rights, leadership skills and self defense) and resources (school and board for the women’s children, drop-in centers where the women receive health care and counseling, find shelter, and meet and network). CARE staff and SHAKTI members held policy dialogues with the Ministers of Health and of Social Welfare, police and community leaders to increase tolerance and reduce harassment and assaults.

The women who participate in SHAKTI have surpassed their own and CARE’s expectations. Research after the project’s first phase found that condom use by brothel-based and street-based sex workers was up (73 and 51 percent respectively) from a baseline of 12 percent, and no increase of HIV prevalence could be detected among participants. Sex workers had formed self-help organizations and were themselves undertaking behavioral research among clients to better protect themselves. They were also spreading information on safe sex and sexual health to others. The SHAKTI project has inspired the Bangladeshi government and others to implement similar interventions elsewhere in the country. CARE continues our work with high-risk populations in Bangladesh.

At a drop-in center that CARE established in our SHAKTI project, sex workers discussed how they have challenged the discrimination heaped upon them by women and men. For example, they are less afraid to tell the police to stop harassing them, and confident enough to say, “Like you, we have an equal right to have an income.” They said that recognizing their innate equality with others has not reduced the risks they face, but has equipped them to deal with the risks more effectively. They had formed a self-help group and dubbed it *Durjoy Nari Shanga* – meaning “difficult to conquer women.” When asked how their lives had changed with SHAKTI, one woman said simply, “We realized we are also human beings.”

Dhaka, 2002

Water, Agriculture and Natural Resources: Women’s Work, Women’s Stewardship



Around the world, girls and women are primarily responsible for hauling water to meet their families’ needs. In some parts of Africa, women walk four hours to the nearest well, spring or river. Where water is carried over long distances, the quantity available for drinking, cooking and washing is limited. The result is poor hygiene, which drives much of the transmission of diarrheal and other diseases that are so deadly to children in developing countries. Poor women regularly cite water – accessible, clean and in sufficient supply – as a priority in their vision of a better future. Without effective water management, women’s capacity to achieve a healthy, secure and dignified life is substantially compromised.

Because women are so severely affected by water supply and sanitation, CARE makes sure they are involved in our water projects from the first moments of planning. Women are engaged in choosing sites for wells, public taps or cisterns, selecting appropriate technology (handpumps or motorized pumps), and learning to

manage new infrastructure. All our water programs include education in hygiene and disease prevention, and often extend to other relevant topics.

Throughout **southern and east Africa**, for example, CARE's work encompasses the new realities brought about by HIV and AIDS. Not only must we develop water systems appropriate and accessible to people who are weakened by illness, but we must embed HIV and AIDS topics – prevention, prolonging wellness among those who are HIV-positive – and gender inequities in all our activities, from service provision to service use. In **Sierra Leone**, meanwhile, our Watershed Project is an exciting example of how we bring empowerment and social justice to water and sanitation programming. Since the nation's gruesome war came to an end in 2002, CARE and Sierra Leoneans have engaged in rich conversation about underlying causes of the war, and our dialogues have revealed people's belief that the conflict stemmed from simmering frustrations over decades of corruption, injustice and the exclusion of young adults, women and poor people from decision-making processes by the government and traditional patronage networks. We are working together so that ordinary women and men can address these problems and build not only secure livelihoods but a sustainable peace in the country. Thus in Watershed, instead of simply repairing damaged wells, CARE worked to ensure that everyone – women, men, young and old – has a voice in decision-making, water system maintenance and repair. Some 29,000 people in 50 communities now enjoy access to and management of clean water sources through this project.

Women's tremendous role in growing the world's food supply means their participation should be central in any program to improve farming techniques or natural resource management. Yet much work in this arena involves technological approaches – mechanized farming, emphasis on cash crops over family consumption – assumed to be in the male realm. Women around the world are left to work harder to grow the crops and raise the animals that sustain their families. To reverse this trend, one CARE project is active in **Ecuador's** Amazon region, where the Shuar people's life has always depended upon careful interaction with their fragile and complex jungle ecosystem. The traditional *aja*, or family garden, has been the locus of intergenerational knowledge and connection: Women pass food-growing traditions and techniques for environmental preservation to their daughters. But the *aja* system has been weakened by the introduction of modern farming practices that are often harmful to the ecosystem. Modern techniques, typically taught to men, disrupt the oral transmission of farming knowledge that has helped ensure food security for Shuar families. This shift has also displaced Shuar women from one of their few sources of stature within the community. Today, CARE and Shuar women are working to regain the *aja* tradition. We are recording, preserving and spreading women's farming knowledge and skills, weaving in new methods adapted to the ecosystem and developing marketing linkages for the surplus food – tubers, vegetables, medicinal herbs, fruits and forest plants – that the women cultivate from their new or renewed *ajas*. The Shuar women have significantly improved their families' food security, while preserving their environment and renewing the value attached to the knowledge and tradition of the *aja*.

Sexual and Reproductive Health

Sexual and reproductive health encompasses a woman's ability to exercise her right to control what happens to her body; to make choices about whether, when and with whom to have intimate relationships, and if and when to have children; to protect herself from diseases associated with reproduction; and to have informed access to health services. As a prerequisite for sexual and reproductive health, quality health services must exist, and women and girls must live in environments that enable them to seek services and practice healthy



behaviors. CARE's 70+ sexual and reproductive health projects around the world are working to improve the social, political and cultural environments that limit women's health and well-being – and even threaten their survival. The examples below demonstrate our evolving work, from ensuring availability of quality services, to altering social structures to increase women's access to services, to guiding men and women toward an understanding of the social and cultural underpinnings of sexual and reproductive health.

Caution: Empowerment Work Carries Risks

In our projects and our research, CARE strives at all times to benefit people and to do no harm. We consistently question how our work might place an individual at risk. This is nowhere more salient than in projects that implicitly or explicitly question the balance of power within a community or family, and particularly between men and women. Unintended consequences of empowerment work may fall into one of two categories:

Backlash: Perhaps the most common consequences result from fear that empowerment is a zero-sum game; that for one person to gain, another must lose. In addition to the earlier India microfinance example, we have seen:

- Cases where emergency response prioritized women and children, whose needs were greatest, but left the women at greater risk of attack from men who would steal food and other aid items.
- Instances around the world in which women suffered abuse from husbands who feared that their participation in a project of any stripe would alter the *status quo*.
- A few cases in Niger where a woman's growing financial status via participation in a savings group actually puts her at risk of seclusion within the home: Some families see this as a symbol of wealth.

Gilding the Cage: Most people live within social structures so deeply normalized that they are seen as the natural way of things. An individual who benefits from some change in status or wealth may use that change not to alter structures, but to gain power within the very system that restricts her. For example:

- A woman in India may use increased income to purchase fetal screening and, per cultural preferences for sons over daughters, abort a female fetus.
- Discussions about female genital cutting may persuade a family not to drop the practice, but to perpetrate somewhat less severe forms on their daughters.
- In Bangladesh, a woman whose social status grows from improved financial security may use her new position to abuse the one socially-sanctioned power relation available to her: control over her daughter-in-law.

In a recent program called Foundations to Enhance the Management of Maternal Emergencies, or FEMME, CARE worked with 18 district hospitals in **Tajikistan, Tanzania, Peru, Rwanda and Ethiopia**. The aim was to improve women's access to quality services by building the capacities of health workers to effectively manage obstetric emergencies and save women's lives. In Peru, to cite just one result, our FEMME project in the mountainous Ayacucho district resulted in six facilities equipped and trained to handle obstetric emergencies. We developed protocols and guidelines for emergency obstetric care, which are now widely used to train nurses, midwives and doctors. In Ayacucho, 84 percent of patients' needs for medical services were met, up from 30 percent, and maternal mortality rates dropped.

In **India**, women's social position and the violation of their rights are rooted, among other factors, in decisions made at many points along a spectrum: within households, community leadership structures and national legislatures. Many of CARE's projects in India – including our reproductive health work – begin at the first point on the spectrum: relations within the household. Because husbands and their mothers typically exercise great power over wives and daughters-in-law, we developed a strategy in which we bring mothers-in-law, husbands and daughters-in-law together for a facilitated discussion on their shared goal of healthy pregnancies and healthy babies. With this common interest in the center of the discussion, all parties usually can agree that a pregnant woman must have the autonomy to seek health care and spend household resources to get it. In this way, women cease to be pawns in others' often-arbitrary use of power, and exercise their right to basic health care.

CARE's Inner Spaces, Outer Faces initiative in **Vietnam** and **India** originated in our commitment to broaden our health programming by exploring and altering the factors that limit health and well-being, especially of women and girls. To launch this innovative effort, CARE's own staff first identified, explored and challenged the social construction of gender and sexuality that underpins much poor sexual and reproductive health. The second step focused on the "outer spaces" – identifying, through research with project participants, how gender, power and sexuality interact to affect women's options and opportunities to gain access to health services, make healthy choices about their own bodies, and have a safe and enriching sexual life. CARE teamed with women and girls to use this new knowledge to design more powerful projects that challenge, for example, cultural norms that severely limit women's presence in public places – and hence their access to health clinics and even lifesaving obstetric care. The Inner Spaces, Outer Faces initiative helped CARE staff more comfortably address sensitive issues such as male-female disputes over the use of family planning, domestic violence, early marriage and preferences for sons rather than daughters. Our staff and our participants are now better equipped to identify and deal with all of these issues, and their clear implications for girls' and women's well-being.



Female Genital Cutting: a Valued Tradition and a Human Rights Abuse

CARE's shift from a needs- to a rights-based approach brought the practice of female genital cutting, or FGC, into clearer focus. No matter our individual reactions to the practice, a needs-based approach led our programs to treating FGC primarily as a health risk, one whose consequences can include hemorrhage, prolonged labor, maternal and neonatal deaths. But with a rights-based focus, FGC's human and social aspects came to the fore, and we saw new programmatic options. As a first step, we sought to educate ourselves about how people viewed the centuries-old practice, and to discover new ways in which they and we could address it. We began our research in communities in **Ethiopia** and **Sudan**, and among **Somali** refugees in **Kenya**.

In our one-on-one conversations, the great majority of men and women expressed their approval of FGC; for them, it was linked to religion, cultural preservation and parents' responsibility to ensure their daughters' marriageability. (Interestingly, in Kenya and Ethiopia, men stated they wanted FGC to continue because women did; women said they wanted FGC to continue because men did.) Next, given the shroud of intense secrecy surrounding the topic, we sought the help of leaders to arrange first-ever public discussions of FGC between ordinary women and men, religious and customary leaders. CARE created culturally-sensitive ways to address topics such as the erroneous association of FGC with Islam, and the notion that any social norm – "the way we've always done things" – is immutable. And we helped women and communities form new alliances, such as with national networks that support the abandonment of harmful traditional practices.

Over 18 months, what did we learn? In Sudan, one village declared that it would not submit its girls to FGC, and debated ways to ensure that daughters could be married even if not cut. In Kenya and Sudan, traditional leaders discussed with CARE how they might better protect women and children in their communities. In Ethiopia, religious leaders met to discuss FGC and Islam, and developed a persuasive argument to counter those who held that the religion requires females to undergo FGC. In all three sites, men and women expressed deeper understanding of the adverse health, social and psychological effects of FGC, and of how women's and girls' rights were compromised by the practice. But in Kenya, CARE's work stirred reaction: Some families who made a commitment to abandon FGC were forced to move from one refugee camp to another to flee threats from those who championed FGC.

Conclusion

CARE is deeply committed to improving the lives of poor women, men, girls and boys in some 70 of the least developed countries in the world. We choose to focus particularly on women, because in every society they struggle against gender norms that limit their resources and opportunities for improvement, and because we know that women's empowerment is a tremendous resource for social change and a prerequisite in the broader fight against global poverty. But most fundamentally, we work with women because women are important in their own right. Everything CARE has learned about fighting poverty tells us that the most profound changes arise when we work not only with the most disempowered, but with the people and structures around them that can support or undermine their struggle for a life with dignity. At CARE, we strive for a world in which a person's rights, responsibilities, opportunities and dignity are determined not by their status as male or female, but as a human being.

¹ Data in this section is drawn from organizations that collect and aggregate information at a global level, including the U.N. Millennium Campaign, the World Bank, UNICEF, UNESCO, the U.N. Population Fund, the World Health Organization, the U.S. Department of State and Department of Health and Human Services. Information in text boxes is derived from *'We are also Human: Identity and Power in Gender Relations'*; Drinkwater, M., CARE 2005.