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Stigma, gender and HIV: case studies of inter-sectionality

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Stigma, Gender and HIV: Case studies of inter-sectionality

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Introduction

In this chapter we use the theoretical lens of 'inter-sectionality' to examine the complex relationship between gender and stigma, and to consider the implications of this relationship for HIV/AIDS programmes. Our focus on HIV/AIDS, gender and stigma lies at the interface of two related interests. First, we believe that an understanding of stigma is required to deepen our analysis of facilitators and barriers for effective participatory HIV/AIDS programmes. Participation in HIV/AIDS prevention, treatment and care programmes has become somewhat of a mantra. HIV-related stigma serves to deprive people with AIDS of the confidence and agency they need to access treatment, participate in programmes and increase self-efficacy, all of which have positive health outcomes. Currently, much research into HIV-related stigma remains at the descriptive level, emphasising the impact of stigma on agency, rather than exploring the complex psycho-social roots of stigma.

Our second interest in the relationship between HIV/AIDS, gender and stigma relates to the way in which the HIV/AIDS pandemic is driven by gender inequality and exacerbates gender inequality (UNIFEM, 2004). We recognise gender as a socially constructed relationship that limits women's access to material and symbolic resources compared to men's access to these. The role of HIV-related stigma in supporting gender inequality is under theorised – but as we hope to make clear, this needs to be at the centre of any understanding of HIV-related stigma. Understanding the relationships between stigma, gender inequality and the continuing HIV/AIDS pandemic is crucial if this cycle it to be broken.

In this chapter we develop a social psychological reading of HIV-related stigma, which focuses on the relationship between the individual and society. The aim of social psychology is to understand how social imperatives become sedimented in the individual psyche (Joffe, 1999) and how this might best be resisted (Howarth, 2006). In relation to the social dimension of the individual-society interface, we are particularly interested in the inter-relationship between the symbolic and material dimensions of human life in shaping peoples' experiences of HIV/AIDS (Campbell, *et al.*, 2005a; Cornish, 2006). In relation to the individual psychological dimension of this interface, we are concerned with the way in which this social world shapes and sets the context for the

construction of social identities and agency, which are central to the ways in which stigma is internalised or resisted. Stigmatised people often have highly marginalized social identities and limited agency, because of poverty and symbolic forms of chronic marginalization. Key to the process of resisting stigma is that people start to view themselves as competent social actors, capable of withstanding some of the impacts of marginalisation, if not actually able to change the underlying causes.

In order to illustrate our argument, three interventions involving female sex workers will be explored. Women engaged in sex work (visible and invisible) often have higher prevalence levels of HIV/AIDS than other population groups (UNAIDS, 2002; Cote *et al.*, 2004; Dunkle *et al.*, 2004; Chen *et al.*, 2007). A focus on female sex workers is particularly illustrative of our argument, because this group of women sit at the intersection of multiple forms of symbolic marginalisation or stigmatisation – HIV/AIDS, gender, occupation – and material marginalisation – poverty, limited access to health care and so on. All these shape the contexts in which sex workers construct their social identities and their ability to assert agency in ways that protect their health.

We define stigma as any negative thoughts, feelings or actions against people infected with or affected by HIV/AIDS (Campbell *et al.*, 2007) HIV/AIDS stigma is increasingly described as a major driver of the HIV/AIDS pandemic through limiting peoples' access to prevention, formal and informal care and more recently anti-retroviral treatment (Deacon *et al.*, 2005; Ogden and Nyblade, 2005; Rankin *et al.*, 2005). Stigma inhibits many women from learning their HIV status, for fear of abandonment or violence by their partners (Gaillard *et al.*, 2002; Medley *et al.*, 2004). Men – who associate their ability to conceive children as a central and prized dimension of their masculinity – may also deny or hide their status, for fear that this will hinder the likelihood of them conceiving children, leaving them to die without having fulfilled their masculine life destiny of 'leaving behind people who bear their names' (Steinberg, 2007).

It is important however, to move away from the common tendency to *describe* the effects of stigma, and to seek to *explain* its underlying drivers in order to inform stigma reduction interventions (Campbell and Deacon, 2006). In the following section a theoretical model of stigma will be outlined, leading on to a discussion of the possibility of effective interventions.

Stigma, Gender and Power

Sociologists and anthropologists highlight the role played by stigma in maintaining social inequalities (Link and Phelan, 2001; Parker and Aggleton, 2003) through the way in which it perpetuates existing patterns of social inclusion and exclusion in a given society. Various studies

have examined the links between the stigmatisation of HIV/AIDS and the stigmatisation of women, and more particularly the stigmatisation of female desire, with these interlocking stigma's serving to perpetuate a more general devaluation of women in many societies (Joffe and Begetta, 2003; Campbell *et al.*, 2005b). According to psychoanalytic psychologists, the stigmatisation of identifiable out-groups serves as a way in which people cope with the fear and uncertainty at the heart of the human condition. Individuals project their fear of the randomness of illness and death onto out-groups, as a way of distancing themselves from such threats (Joffe, 1999; Campbell and Deacon, 2006). The choice of out-groups is not random, but shaped by the already existing symbolic and material contexts of a society.

The material contexts of HIV/AIDS stigma revolve around issues of poverty, lack of access to adequate health services and the crippling burden of care faced by many people caring for someone living with HIV/AIDS (Castro and Farmer, 2005; Ogden and Nyblade, 2005; Campbell *et al.*, 2007). Closely tied to the material context of HIV/AIDS stigma is the symbolic context – relating the way in which HIV/AIDS is represented in many social settings. Pryor and Reeder (1993) suggest HIV-related stigma is supported by an associative network of symbolic links (sometimes logical and sometimes arbitrary) between AIDS-affected individuals and other negatively valued groups. In the US context in which their research is conducted, these include youth, the poor, ethnic minorities, sex workers, gay men, injecting drug users and so forth. Recent literature refers to the way in which different sources of stigma overlap and reinforce one another as the 'layering' of stigma (Deacon *et al.*, 2005). While the concept of layering makes us aware of the multiple interlocking representations that form HIV-related stigma, it remains too descriptive a concept. Rather, we draw upon the concept of inter-sectionality to deepen understandings of HIV-related stigma and its relationships to gender and how such stigma impacts on individuals.

The concept of inter-sectionality was initially evoked by feminists to challenge singular categories of oppression, especially the unitary concept of 'women'. More specifically it was argued that black women were oppressed quite differently to white women, because of their race, and to speak of a homogenous group called 'women' who all faced the same issues marginalised other categories and lines of oppression (Crenshaw, 1993; Phoenix and Pattynama, 2006). Inter-sectionality allows a focus on the multiple lines of power and exclusion that circulate in everyday life; class, race, sexuality, gender etc. and importantly how these intersect through the multiple representations they invoke to shape people's identities and experiences of everyday living. The concept of inter-sectionality "aims to make visible the multiple positioning that constitutes everyday life and the power relations that are central to it." (Phoenix and Pattynama, 2006:187)

Such is the inter-sectional nature of health-related social identities that HIV-related stigma is best thought of as the "nexus in a web of ostracised groups and threatening images" (Pryder and Reeder, 1993:269). People living with HIV/AIDS can be thought of as living with multiple forms of stigma, rather than one, that serve to marginalise them in different ways. Without recognising that there are likely to be multiple layers of stigma at work and how they interact and support on another, Reidpath and Chan (2005) argue it will be difficult to challenge HIV-related stigma.

People construct and reconstruct their social identities in material and symbolic contexts not of their choosing. Social identities are crucial in understanding people's agency (and lack of agency) especially in relation to health and health behaviours (Campbell and Jovchelovitch, 2000). Because of the inter-sectional nature of social identities, based on class, gender, race and so forth there are multiple, overlapping representations that inform social identities and representations of these issues "provide the building blocks of identity" (Howarth, 2001:231).

Focusing now on female sex workers in a time of HIV/AIDS it is possible to locate sex workers at the intersection of a number of stigmatised identities – as women, as poor and as sex workers. These intersecting negative identities reinforce the stereotyping of sex workers as 'vectors of HIV/AIDS'. Given the fact that such women are often poor, and socially excluded, they often lack the confidence and/or power to resist this layered stigmatisation (Farrimond and Joffe, 2006). It is these layers of stigma that form the backdrop and resources in which female sex workers construct and reconstruct their social identities, which in turn limit their agency to protect their health.

Closely linked to the stigmatisation of female sex workers is the idea of 'out of control' women, especially women living with HIV/AIDS who are often labelled as promiscuous or immoral. As Mary Douglas (1966) emphasised, when societies are threatened, they expand the range of social controls they exert over people. For male society, HIV/AIDS is a threat on two accounts. First, HIV/AIDS threatens to undermine male-dominated institutions of society and government (de Waal, 2003). Second, and more relevant to our interests, HIV/AIDS demonstrates the failure of male, patriarchal society to enforce patterns of women's behaviour – while these were always tenuous – the rapid spread of HIV/AIDS and its visible nature highlight this failure. In addition, a similar point has been made about sex workers, whose "existence challenges the standard family and reproduction-oriented sexual morality found in most societies" (UNAIDS, 2002:9), which is also a challenge to male authority to control women.

Stigmatising women with HIV/AIDS and female sex workers becomes a way of policing women for challenging traditional norms and is an attempt to overcome the anxieties associated with

declining power. The stigmatisation of HIV/AIDS needs to be understood within a framework which centralises the role of gender inequality and recognises the stigmatisation of people living with HIV/AIDS and sex workers as part of wider attempts by men to reassert their authority over women who transgress male norms. And this partially helps explain the high levels of violence against women that is associated with HIV/AIDS stigma and sex work (Farley and Barkan, 1998; Gaillard *et al.*, 2002; Medley *et al.*, 2004), which can be understood as attempts by men to reassert their authority over women's bodies in direct and violent ways.

Indeed HIV/AIDS has been used as a way for men to reassert their authority and control over women's bodies in a wide variety of ways. Other ways in which this has become apparent include the re-emergence of 'traditional' practices, seeking to control the sexuality of young women and girls. One such practice is virginity testing for females that has seen a resurgence in South Africa recently. Leclerc-Madlala (2001) identifies this as another way in which men seek to exert greater control over women and their sexuality.

Inter-sectionality provides a framework for understanding how layers of stigma can be transcribed from the social to the individual realm through the production of intersecting social identities. In addition, it highlights the centrality of power relations in structuring unequal social identities.

<u>Stigma Interventions</u>

A key challenge facing anti-stigma interventions is that of increasing the agency of those who are subject to marginalisation (Cornish, 2006), as part of the process through which they can start to view themselves as competent social actors, capable of resisting the impacts of marginalisation. Many interventions to challenge stigma have been based on social cognition approaches which have focused on providing people with information about HIV/AIDS through various educational programmes. However, numerous studies and reviews have identified that education does not necessarily change the way in which people behave (Brown *et al.*, 2003; Hayes and Vaughan, 2002). An alternative approach to stigma reduction has been is that of legal reform – criminalising discrimination and other forms of stigma (Parker and Aggleton, 2003). This macro-social approach is laudable, creating the legal context in which challenges to stigma can be conducted. However, neither approach involves increasing the agency of the stigmatised, even though they support the emergence of a context most likely to enable resistance by those who are stigmatised.

Participatory anti-stigma interventions, seeking to mobilise and empower the stigmatised, have become an important method of attempting to increase people's agency. Cornish highlights the complex challenge inherent in this goal. When people have "been subject to profound and

sustained symbolic and material exclusion, how is it possible for such a group to challenge that stigmatisation, and to develop alternative, positive understandings of their status, which could provide the basis for their collective action?" (Cornish, 2006:462-3).

Freire (1970; 1973) offers an approach that seeks to reconstruct highly marginalized people's agency. In situations of material and symbolic exclusion, people lack agency – they are 'Objects'. For change to happen, those who lack agency need to work collectively to challenge and transform the material and symbolic contexts of their marginalisation. Through the process of discussion and critical thinking people come to understand the barriers that shape their marginalisation and start to act to challenge them, in the process of becoming 'Subjects' with agency in their worlds.

A Freirian approach supports stigmatised groups to critically interrogate and challenge their stigmatised social identities and the representations that inform these. This creates a space in which they might reconstruct their social identities in more positive and active ways, increasing their agency. The process of developing understandings of the roots of stigmatising identities is the first step towards increasing people's agency to resist their impacts. In ideal circumstances this may be the starting point of collective action to challenge the root causes of stigma.

Throughout this process it is important that the material and symbolic contexts of stigmatisation are not thought of as separate, rather they need to be tackled as "complementary aspects of a single process of politicised change" (Cornish, 2006:470). Often participatory approaches drawing on Freire have focused too much on challenging the symbolic context and not enough on challenging the material context (Cornish and Campbell, 2007).

As will become clear, the types of 'material changes' that we refer to in this paper are modest in nature. Clearly there is an urgent need for large scale global change to reduce poverty and gender inequalities (Campbell, 2003), and we have no doubt that such change would dramatically improve the range of options facing many women driven into sex work by difficult circumstances. However, these are long-term challenges, and given the urgency of the AIDS epidemic, there is also a need for less ambitious medium and short-term strategies for immediate responses. Furthermore, 'power is never conceded without a demand' (Bulhan, cited in Seedat, 2001). Elites seldom voluntarily give up power. Sweeping changes in power relations (e.g. a more equitable distribution of wealth and power between the rich and poor, and between men and women) are unlikely to come without vociferous demands from less powerful groups. For this reason, many social development projects are motivated by the goal of increasing the capacity of excluded

groupings to develop critical understandings of their disempowering social circumstances, as a small first step in the longer road to effective resistance.

Wieck (1984) argues that social change projects should aim for 'small wins', setting themselves goals which are modest and achievable, rather than aiming for unrealistic goals which are less likely to succeed. Within a similar vein, Scheyvens (1998) argues for the value of 'subtle strategies of empowerment', actions that create real change in individual's lives, without necessarily challenging the broader social order.

In our understanding 'material change' includes any concrete action in which a marginalized woman is able to assert her agency in relation to problems commonly faced by similar others. This approach seeks to make concrete changes in women's lives without confronting broader relationships of power and inequalities, through the understanding that successful subtle strategies of empowerment build confidence and agency of marginalised social groups (Cornish, 2006). We argue that participatory anti-stigma interventions need to focus on increasing people's agency through creating contexts that support the construction of more positive social identities through small-scale achievable changes in peoples' lives. Such changes provide the starting point for people to rethink their social identities and challenging the stigmatising representations that undermine their potential health and well-being (Freire 1970, 1973).

Three Case Studies of Sex Worker Interventions
In this section we explore the potential for participatory anti-stigma interventions to improve the life circumstances of disempowered women, through building more positive social identities and increasing women's agency. We do this through a discussion of three case studies with female sex workers. In all three cases, the female sex workers were highly stigmatised by multiple, overlapping symbolic representations – with their positioning as women, sex workers and the poorest of the poor overlapping to entrench their disempowerment.

The three case studies are all similar in the fact that the interventions were never understood as gender empowerment interventions – rather they tackled gender inequality through intersecting identities – namely of sex work. In Campbell *et al.* (2006) we argued for gender empowerment through alternative identities. Reporting on a community-led AIDS intervention in rural South Africa, we observed that while the researchers viewed gender inequality as the central issue driving HIV-related stigma, women specifically chose not to instigate a gender empowerment intervention. The way they chose to 'work around' gender inequalities was to empower themselves through overlapping alternative identities which closely intersected with gender. These included their identities as home nursing volunteers, as members of households affected

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by HIV/AIDS, as members of an isolated rural community, and as AIDS activists in the intervention (Campbell *et al.*, 2006).

It was through these alternative but intersecting identities that a form of gender empowerment could be achieved – through women increasing their confidence and agency, taking visible leadership roles in the community, serving as role models to other women, especially younger women, and so on (Campbell *et al.*, 2006). The three case studies set out below take a similar position in that gender empowerment was done through alternative, but overlapping identities.

The Sonagachi Project

The first case study is the Sonagachi sex-worker project based in Kolkata, India. Cornish has subjected this project to much social psychological analysis (Cornish, 2004; Cornish, 2006; Cornish and Ghosh, 2007) and we draw on Cornish's work in this section. The project is widely accoladed as one of the most effective participatory HIV-prevention projects (UNAIDS, 2002). As well as mobilising sex workers, it has increased condom use and decreased the rate of STIs in the project area (Jana *et al.*, 1998).

Sex work in Kolkata is a highly stigmatised profession. A variety of different representations intersect around these women, marginalising them both materially and symbolically, and undermining the likelihood that they will protect their health. Sex work as an occupation is stigmatised, with many of the sex workers becoming cut-off from their families. This stigmatisation is internalised through the distinction between red-light districts, where sex workers live and work, and the family districts, where 'respectable' women work and live. The movement into becoming a sex worker is described as 'becoming bad' (Cornish, 2006). The material context of their occupation further marginalises them, as the sex workers are often subject to arbitrary police harassment and their work conditions are tightly controlled through a hierarchical system of brothel managers and agents.

HIV/AIDS is also highly stigmatised, with much of the focus placed on high-risk groups, including sex workers, who tend to have higher rates of HIV prevalence than the broader population. In their study on household responses to HIV disclosure in Mumbai, India, Baharat and Aggleton (1999) report that many people living with HIV/AIDS upon disclosure faced discrimination. However, they also note that there were substantially different responses to men and women living with HIV/AIDS, with men being treated much more positively than women. Baharat and Aggleton (1999) argue that men's superior social status, compared to that of women's explains the different responses.

Given the broader context of the stigmatisation of women in India, the different responses are to be expected. In his seminal article on gender bias in India Amartya Sen (1992) noted that there were around 37 million 'missing women' in India. Sen ascribes higher levels of female mortality to different standards of care men and women are subject to, which are underpinned by social understandings of the position of women in society. Understandings of sex work and HIV-related stigma can only be truly understood through exploring gender inequality in Indian society as an underpinning and driving factor in the stigmatisation of sex workers in a time of AIDS.

Challenging the stigma of sex work has been central to the success of the Sonagachi project – and in doing so, the project challenged gender inequality in Indian society by working with intersecting identities. The project has been particularly involved in problematising the representations of sex work – in effect challenging the symbolic context of stigma. One way this has been done is to reframe sex work through a rights-based discourse, arguing that women involved in sex work have rights like all other people in India, but these rights are generally denied to them. Cornish (2006) argues that the rights-based discourse instituted in the project recasts the discrimination faced by sex workers from inevitability to illegitimacy and provides a basis for challenging such discrimination. Closely linked to this is the move to position sex work as informal work like any other form of informal work where a person's labour is sold. In India, and especially Kolkata, there is a strong trade union movement around informal workers and it is through this framework of worker's rights that sex workers have started to demand equivalence to other informal sector workers and to represent themselves as informal workers, opening up a range of possible struggles framed as improving their working conditions (Evans and Lambert, 2008). Using the language of rights and unionisation, the sex workers in the Sonagachi project have managed to reframe the representations of them from negative, stigmatised ones, to more positive and empowered understandings (Cornish, 2006).

These two strategies of claiming rights and asserting equality with other (more 'respectable' professions) operate within the symbolic realm. They both attempt to change how people understand sex work and in so doing hope to challenge some of the stigma that is associated with the work. Yet, given the high levels of poverty and gender inequality in these women's lives, such rights are unachievable if material change does not happen as well (Cornish, 2006). In this regard the final and perhaps most crucial aspect of the Sonagachi project has been its role in improving the concrete working conditions of sex workers. The project has been particularly active, through its project structures, in dealing with everyday disputes, struggles and concerns that the sex workers experience (Cornish, 2006; Evans and Lambert, 2008). Concrete activities have included the project setting up a credit union allowing sex workers to save some money and take out emergency loans, without the restrictive conditions imposed by moneylenders, which

further bound sex workers into their marginal position. Another important material strategy has been supporting sex workers to speak at press conferences and workshops. In these situations the sex workers are typically afforded recognition and respect, in contrast to their everyday experiences of discrimination (Cornish, 2006).

Such activities can be seen as examples of peers asserting their agency and so building confidence amongst the sex workers, which can be understood as subtle strategies of empowerment, with women experiencing concrete changes in their everyday existence, even if they did not tackle the underlying material drivers of sex work in poverty and gender inequality. Rather these strategies create a sense of control and empowerment, through challenging stigma and creating models of ways in which they can act to improve their circumstances. In so doing they give women a sense of control in their working lives. This has served to enhance their sense of agency and confidence in relation to their health, given that people who have had positive experiences of being in control of other aspects of their lives are more likely to feel a sense of agency and confidence in relation to their health (Wallerstein, 1992).

Challenging the stigma of sex work in the Sonagachi project has been closely tied to improved HIV/AIDS prevention, treatment and care in the area. Whilst the project has remained narrowly focused as a sex workers' project, it has succeeded in working through the group identity of 'sex work' to empower women – through enabling Sonagachi sex workers to reconstruct more positive social identities and increase their agency to protect the health of themselves and others.

Cambodian Beer Promoters
Our second case study comes from Cambodia, and focuses on women involved in promoting international beer brands in local bars. Many of these women are also involved in sex work – often referred to as 'indirect' or 'invisible' sex work – with beer promotion being seen as their primary work. This project has been facilitated and analysed by Lubek (Lubek *et al.*, 2002; Lubek, 2005), whose work we draw upon.

HIV/AIDS prevalence amongst beer promoters is higher than amongst 'direct' or 'visible' sex workers in Cambodia. A number of factors contribute to this. Mainstream HIV/AIDS prevention interventions in Cambodia tended to focus on visible sex workers, whose primary work is sex work, ignoring this group of invisible sex workers (McCourt, 2002; Mills *et al.*, 2005). Use of condoms amongst beer promoters is low, with one study reporting that only 10 percent of beer promoters always used condoms, compared to 42 percent of visible sex workers (McCourt, 2002). This low use of condoms is largely driven by use of alcohol, the threat of violence from clients and the lack of concrete negotiating strategies (Lubek *et al.*, 2002; Klinker, 2005).

The female beer promoters are at the nexus of a range of stigmatised representations, which undermined their ability to protect their health and negotiate condom use. Beer promoters were often contrasted to 'respectable' women in a number of ways. Many 'respectable' women, married, or otherwise under the control of men, considered beer promoters to be a threat to marital stability, fearing that the women would steal their husbands. Beer promoters internalised this representation of themselves, commenting that they could never be respectable and have a family (McCourt, 2002).

Respectability was also linked into understandings of women and sexuality. Tarr and Aggleton (1999) report in their study on perceptions of young adults in Cambodia that women are expected to remain virgins until married. Men, in contrast, have no such expectations placed upon them. For beer promoters struggling to make a living, sex work may be the only way to make ends meet, and as such choosing not to engage in sex work may not be a viable strategy.

In addition the dominant representations of HIV/AIDS also served to stigmatise the invisible sex workers further. As in many other countries, sex work and HIV/AIDS are severely stigmatised. Busza (2001:442) speaks of a gradient of guilt being applied to people living with HIV/AIDS in Southeast Asia, where "sex workers…who contract HIV are perceived as most *guilty*", with this perception driven by the stigmatisation of sex workers in general (Marten, 2005; Mills *et al.*, 2005).

Situated at the intersection of these different representations, closely linking gender, HIV/AIDS, sex work and respectability, beer promoters had highly marginalised social identities. This made it very difficult to act in ways that could protect their health.

The intervention sought to increase HIV/AIDS treatment, prevention and care for the beer promoters through challenging the stigma of beer promotion. An important aspect of this was to try and increase condom use amongst the women, through promoting 100 percent condom use. Through a series of action-research processes, concrete strategies for negotiating condom use with clients and partners emerged (Lubek *et al.*, 2002). In one workshop, participants were asked to try these strategies in their next sexual encounter and report back at the next meeting. Many of the women did so and reported that the suggested strategies had been quite successful in increasing condom use. Such actions gave concrete examples of peers successfully exerting their agency in relation to a commonly experience problem by the group.

The workshops also facilitated the emergence of a collective sense of identity amongst beer promoters. Partly because of the heterogeneous backgrounds these women came from, the competition that the work inspired, and the stigma of the work, these women lacked a sense of collective identity (Lubek *et al.*, 2002; McCourt, 2002). The emergence of a collective identity is an important aspect of challenging the stigma of sex work (Busza and Shunter, 2001). Indeed it is the basis for critical thinking and discussion about the root causes of stigmatisation and an important strategy for increasing women's confidence.

The second aspect of the intervention has been to work nationally and internationally to reform the structural drivers of HIV/AIDS infection amongst beer promoters – through targeting beer manufacturers who indirectly employ these women. Demands have included increased wages and access to anti-retroviral treatment (Lubek, 2005). While achievements here have been patchy – with one manufacturer undertaking further training on HIV/AIDS for beer promoters, but unwilling to provide access to HIV/AIDS treatment (Lubek, 2005), it highlights ways in which activists might seek to tackle the macro-social factors that drive HIV/AIDS and stigma – poverty and lack of access to effective health services – rather than simply putting the onus on beer promoters to change their behaviour without making parallel attempts to build more 'health enabling' social environments. Here activists have sought to exploit the fact that beer manufacturers are firmly entrenched in the market in Cambodia – and as such are keen to maintain a positive corporate image, rather than being seen as exploiting vulnerable women.

The intervention supporting beer promoters has increased condom use amongst the women and challenged some of the stigma of being a beer promoter in a time of AIDS (McCourt, 2002). Again this project can be thought of having achieved a limited form of gender empowerment – allowing women to take control of their interactions with clients, increasing their sense of confidence in themselves and improving access to health services. It has not however effectively tackled any of the broader structural drivers of HIV/AIDS and stigma, or challenged the gender inequalities that make women particularly vulnerable. Working with beer promoters to improve their working conditions has been an important strategy in challenging gender inequality in a limited form.

Summertown Project
Our final case study is drawn from South Africa. The two case studies we have discussed above have boasted some successes along the lines of Wieck's 'small wins', or Scheyven's 'subtle empowerment strategies'. In contrast, the mobilisation of sex workers to challenge stigma in the Summertown Project was not particularly successful (Campbell, 2003).

The Summertown Project was a large-scale and well-funded project attempting to improve HIV/AIDS management in a South African mining community. The sex worker project was based in an informal settlement on the fringes of the large mining complex. Many women living within the settlement engaged in commercial sex work, primarily with the miners in nearby hostels. The informal settlement in which they lived and worked had high levels of poverty and mobility, creating a perpetual sense of instability (Campbell, 2003).

Representations of sex workers in the community were particularly negative. Few women publicly admitted to being involved in sex work and many went to great lengths to hide their occupation. Campbell (1998) relates a range of strategies that the sex workers undertook to position themselves as respectable women and how such strategies reduced women's confidence and agency to insist on condom use in their paid encounters.

Given the high levels of poverty in the community, the lack of an effective national treatment strategy in South Africa (at the time of the project) and conflicting messages about HIV/AIDS from the national government, HIV/AIDS as an illness was highly stigmatised. Indeed amongst the sex workers, the bitterest insult one sex worker could inflict on another was accusing them of being HIV-positive (Campbell, 2003).

The project was based on peer education amongst the sex workers and was relatively successful in attracting sex workers to attend these meetings. At these peer education meetings, topics included health promotion, condom use and critical thinking, as well as strategies to foster a sense of unity amongst the women involved.

However, overall the peer-education project did not achieve a significant increase in condom use in the project area, nor did it effectively challenge the stigma of sex work in the community. These results are partly ascribed to the technical intervention –the project was hampered by a lack of materials for the peer-educators to work with while peer educators received limited external support for their work (Campbell, 2003).

In the light of the reasons ascribed for the relative successes of the Cambodian and Indian case studies above, a key shortcoming of the Summertown Project was that, for various reasons, it failed to provide empowering experiences for the women involved. There were few concrete incidents where peers were seen to assert their agency on problems faced by many of the sex workers. Attempts were made to provide such empowering experiences. The project encouraged some sex workers to start selling food, but these efforts failed due to the high-levels of poverty in

the area, which made self-generated economic development almost impossible to achieve (Campbell, 2003).

In addition, the wider Summertown Project management committee, viewed HIV/AIDS as a medial and behavioural problem to be treated through STI treatment and information-based education and were not sympathetic to wider empowerment efforts. Thus for example, when project funders tentatively suggested that the project should place more emphasis into the economic development of sex workers (through buying them sewing machines and so on), this was rejected strongly by a senior medical officer on the project committee, who argued that the project was a health project – and that efforts at social development of sex workers lay outside its remit. The grassroots project facilitator did try and involve herself in resolving minor disputes and social problems in the sex worker settlement, but support and recognition for this type of work was not forthcoming from the directors of the project (Cornish and Campbell, 2007).

At the heart of the failure of the Summertown Project lay the fact that while the project had ambitious targets for the involvement of female sex workers the project activities failed to move beyond narrow HIV-prevention education and medical intervention because of powerful interests in the project management committee. In contrast to the other two case studies, sex workers involved in the Summertown Project had very few empowering experiences through which their confidence and agency could be built, which would then ideally have provided a basis for challenging stigmatising representations of sex work and HIV/AIDS, and enhanced women's sense of control over their sexual health and well-being.

Conclusion

That women are particularly vulnerable to HIV-related stigma is well recognised in much recent work. In this chapter and in our earlier work on HIV/AIDS stigma in South Africa (Campbell *et al.*, 2005b) we argued that a key driver of the stigmatisation of HIV/AIDS was its implicit association with the failure of adult men to control the sexuality of women and young people. Anti-stigma interventions, we argued, should therefore be focused on raising women's consciousness of gender oppression and tackling their unequal social status – as part and parcel of building the capacity of women to cope with HIV-related stigma. Working with men may also be an important aspect of challenging stigma, but in the contexts of the case studies we have presented, was not an approach that was viable.

Challenging gender inequalities however is not only difficult, but may not be the main priority of women who are subject to HIV-related stigma. Above we have referred to a rural South African AIDS intervention where women had no interest in tackling gender inequality directly, believing

that their energies were better spent in addressing what they regarded as more pressing issues such as poverty and health.

Following these concerns and the recognition that HIV-related stigma is not simply one stigma, but multiple overlapping forms of stigma, this chapter has applied the concept of inter-sectionality to highlight ways in which interventions aiming to empower women have worked through intersecting sex work identities that are also a source of stigmatisation and social exclusion that reinforce HIV-related stigma. Through working to strengthen the occupational identity of sex work, a form of gender empowerment has been achieved in these projects.

Importantly, this chapter has highlighted the fact that successful anti-stigma interventions need not only to challenge stigma but also create contexts which enable the confidence and agency of those who are stigmatised. As the case studies demonstrate it is through the provision of concrete experiences of agency amongst peers that confidence and agency was built. Such examples included working with women to improve their health-related agency (such as the provision of condoms and negotiating strategies in Cambodia), creating contexts in which peers succeeded in taking control of small but significant aspects of their lives (Sonagachi Project), and taking small steps to tackle the wider economic context of sex work (Cambodian Project). Such steps can be small, but importantly require people being able to actively take control and positively influence their lives.

Such concrete activities allow the women involved in sex work to experience real change in their lives. Even if such change is relatively small and doesn't directly challenge the overall structures of marginalisation within which people live and work, it provides them with a basis to start rethinking their social identities and so increase their agency. Where such positive experiences are not forthcoming, as in the Summertown Project, interventions are unlikely to be successful in challenging the stigma of HIV/AIDS and sex work and more broadly in achieving some form of gender empowerment.

Gender inequalities need to sit at the heart of any analysis of HIV-related stigma if interventions are to be successful. However, as this chapter has made clear, challenging gender inequalities directly may not always be appropriate. Alternative, overlapping or intersecting identities can provide an important approach through which gender empowerment may be achieved tangentially. Building the agency of those who are subject to marginalisation allows them to start to resist the effects of stigmatisation and propose alternative social identities. And given the right conditions this can provide a basis from which people can come together and start to challenge the underlying drivers of their stigmatisation.

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