

## LESSONS LEARNED



### Household Livelihood Security through an HIV and AIDS Lens: Uncovering and Influencing the Two-Way Link

EXPERIENCES FROM ANGOLA AND MOZAMBIQUE

## Summary

Efforts to make livelihoods in Sub Saharan Africa more secure are unlikely to be successful unless HIV and AIDS are addressed. Likewise, efforts to reduce the spread or impact of HIV and AIDS are unlikely to be effective unless people's livelihood strategies are taken into account.

CARE recently undertook two livelihoods assessments: in Angola, to guide the design of new programs, and in Mozambique as a mid-term evaluation of an existing project. In both cases, we used an HIV and AIDS lens to uncover information on how HIV and AIDS might influence people's livelihoods options, and how livelihoods options might affect their vulnerability to HIV and AIDS. (Please note that using the lens does not mean we undertook public health research.)

In this document, we briefly present CARE's conceptual framework for household livelihood security, then provide a theoretical overview of the two-way link between HIV and AIDS and livelihoods. Next, we rapidly sketch the contexts in which we undertook the research in Angola and Mozambique. We then review some of the most important steps that CARE in both countries took to overlay an HIV and AIDS lens onto our examination of household livelihoods:

- carefully training the research teams,
- ensuring research design involves clarifying guiding questions first, then selecting tools
- carefully selecting participants

### In this document we use the terms...

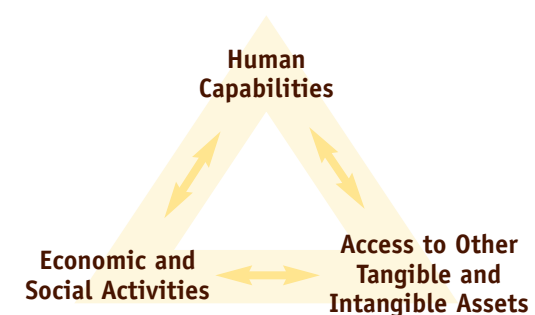
**Applying an HIV and AIDS lens** to mean the practice of integrating HIV-related inquiry into CARE livelihood assessments or evaluation of livelihood programs.

**Mainstreaming HIV and AIDS** to mean designing or modifying projects to ensure they build on core competencies in ways that reduce the risk of HIV infection and impacts of HIV and AIDS.

Finally, we highlight examples of what information the overlay uncovered and how CARE is using the findings to develop new or modify existing programs to influence the two-way link between HIV and AIDS and livelihoods in our work in Angola and Mozambique.

## Household Livelihood Security

For more than a decade, CARE has used a people-centered conceptual framework we call the Household Livelihood Security<sup>1</sup> approach to design, implement, monitor and assess our programs along the continuum from emergency relief to social and economic development. In its simplest definition, *HLS is the adequate and sustainable access to income and resources to meet basic household needs and fulfill rights. These include such things as food, potable water, access to health facilities and educational opportunities, housing, the ability and time to participate in community decisions and activities, and social integration.* HLS grew out of a food security perspective, but is based on the observation that food is only one basic need among several, and households may sacrifice adequate food consumption to meet other important needs. CARE



also understands that people must realize their rights; satisfying economic needs alone is not sufficient. The causes of poverty are complex, and the HLS approach provides us a framework to analyze and understand the web of poverty and people's mechanisms for dealing with it.

HLS embodies three fundamental aspects: human capabilities, tangible and intangible assets, and economic and social activities (graphic). The interaction among them, within



A young participant in CARE Mozambique's VIDA project.

the context of external factors (such as political structures, economic trends, social and cultural factors, and climate) influence what livelihood strategies a household will pursue. An understanding of this interaction is fundamental if CARE's programs are to effectively strengthen households' livelihood security: it allows us to consider the multiple factors that influence household behavior, and to select interventions that will best contribute to overcoming poverty.

While the household is the initial unit of analysis, the HLS approach also encourages users to go beyond the household to better understand differences at various levels:

- within a household (based upon gender, age, social status, decision-making power and control over resources)
- among households (power dynamics, more and less secure neighbors, working relationships within

It is now well recognised that household food insecurity in rural and urban Southern Africa cannot be properly understood if HIV and AIDS is not factored into the analysis. Livelihoods-based analysis of linkages between food security and HIV and AIDS show that the impact of HIV and AIDS is systemic, affecting all aspects of rural livelihoods; and that effective analysis of the causes and outcomes of HIV and AIDS requires a contextual understanding of livelihoods unique to a given area and/or social groups.

*Mainstreaming HIV and AIDS into Livelihoods and Food Security in Malawi: An Analysis of CARE Programmes*  
Scott Drimie and Dan Mullins,  
February 2005

## ANGOLA AND MOZAMBIQUE

a community, formal and informal social networks)

- external to households (cultural and economic factors, political influences, climate, institutions and policies)

CARE typically applies the household livelihood approach by first undertaking a livelihoods assessment in a given area. The basics of how to conduct livelihood research are amply covered elsewhere<sup>1</sup>. In this document, we examine how and why we should overlay an HIV and AIDS lens onto household livelihood assessments in an effort fully to grasp and address the strong, two-way link between HIV and AIDS and livelihoods.

### The Two-Way Link between HIV and AIDS and Livelihoods

Taking a household livelihood approach can help us understand two-way relationships, including that between HIV and AIDS and livelihoods. A livelihood assessment overlaid with an HIV and AIDS lens can help CARE and communi-

ties understand how HIV and AIDS are major livelihoods issues and not merely health problems: people's ways of making a living can make them more vulnerable or less vulnerable to HIV and AIDS; meanwhile, HIV and AIDS influence livelihoods by undermining assets or people's ability to use assets effectively.

### The Research Contexts in Angola and Mozambique

From 1989 through the end of Angola's war in 2002, CARE provided emergency relief to conflict-affected people in central Bié Province, once the breadbasket of the nation. As Angolans shifted from crisis response to economic and social reconstruction and development, CARE committed to better understanding current and potential household livelihoods in Bié. In 2004, we worked with several communities to undertake a household livelihood assessment to guide development of new programs. We designed the assessment with a particular effort to apply HIV and AIDS considerations to all aspects of the research.

#### Livelihoods Affect HIV

Secure livelihoods can help reduce negative impacts of HIV and AIDS; insecure livelihoods can increase vulnerability.

**Risk** of HIV transmission rises when poverty/insecurity compels individuals to, for example, engage in transactional sex or live far from home to secure a job.

**Speed** at which an individual progresses from HIV infection to onset of AIDS increases in the face of poor nutrition, overwork, lack of money for health care.

**Access and Adherence** to treatment (antiretroviral therapy and treatment of opportunistic infections) are dependent, among other factors, on ability to pay, ability to travel to clinic, and good nutrition.

**Resilience** to the negative social and economic impacts is greater if people living with HIV, their families and friends, have more secure livelihoods.

#### HIV and AIDS Affect Livelihoods

**Human Assets:** put simply, people get sick and die, thereby wiping out knowledge, wisdom, labor, love and support. Care-givers must shift time and energy to caring for the ill, away from productive activities.

**Financial Assets:** incomes drop while expenses for health care and funerals rise.

**Productive Assets:** assets may be sold for money; others may be retained, but underused – a child caring for ill parents might still have fields and tools, but insufficient time or skills to use them.

**Natural Assets:** people may have access to communal resources (rivers, forests, lakes), but illness and death can undermine their ability to use them.

**Social Assets:** relationships within and between families, neighbors and local services can be the most important asset in times of illness and death, but may become overstrained.

**Political Assets:** those infected and affected may withdraw or be excluded from community activities and decision-making; their needs and ideas are less likely to be heard.

Not surprisingly, reliable data on HIV and AIDS in Angola are scarce. At the end of 2003, UNAIDS estimated an adult prevalence of 3.9 percent nationwide with higher prevalence in cities than in rural areas. Two years later, the highest rates were reported in some border provinces – up to 9 percent of pregnant women at sentinel sites were HIV-positive. As the nation recovers from nearly three decades of war, and as soldiers and displaced families return home and transportation corridors reopen to trade, HIV is likely becoming more prevalent throughout the country.

It is within this context that CARE strove to ensure that our 2004 household livelihood assessment in Bié examined livelihoods in light of their possible links to HIV, and HIV and AIDS in their possible links to the ways that people and households gain their livelihoods. CARE intended to use the information from the assessment to inform our future programming in Bié. The research process was itself one way of helping more people understand the links between livelihoods and HIV and AIDS.

CARE has worked in Nampula Province in northern Mozambique since 1986. As in Angola, our early work centered on moving relief supplies during the long war. Peace has prevailed in Mozambique since 1992, and our transition to recovery and development programming occurred years before the two-way link between HIV and livelihoods was well understood.

HIV prevalence is increasing rapidly in Nampula, with a worrisome jump from 5.7 to 8.8 percent in just two years<sup>2</sup>. While still lower than the national average prevalence of 13.6 percent, the implications are serious in light of the grossly inadequate health system, the limited reach of the government's AIDS program, and the reliance of the rural majority on labor-intensive agriculture as a livelihood strategy.

CARE's Viable Initiatives for the Development of Agriculture (VIDA) project began in 1997 and is now in its second phase. Reaching 40,000 households in Nampula Province, VIDA's aim is to increase the adoption of certain agricultural technologies and practices, improve the function of agricultural input and output markets, build the capacity of the

Ministry of Agriculture and Rural Development, and increase household food consumption.

Given the HIV profile within the Nampula livelihoods context, was CARE's strategy of devoting most of our VIDA project resources to economically active adults the correct one? At the project's half-way point, we opted to overlay an HIV lens onto the mid-term evaluation to gain additional insight into how HIV and livelihoods linkages are evolving in Nampula and to ensure that, going forward, VIDA appropriately mainstreams HIV and AIDS considerations into its activities and management.

### How We Overlaid an HIV and AIDS Lens on Livelihood Research

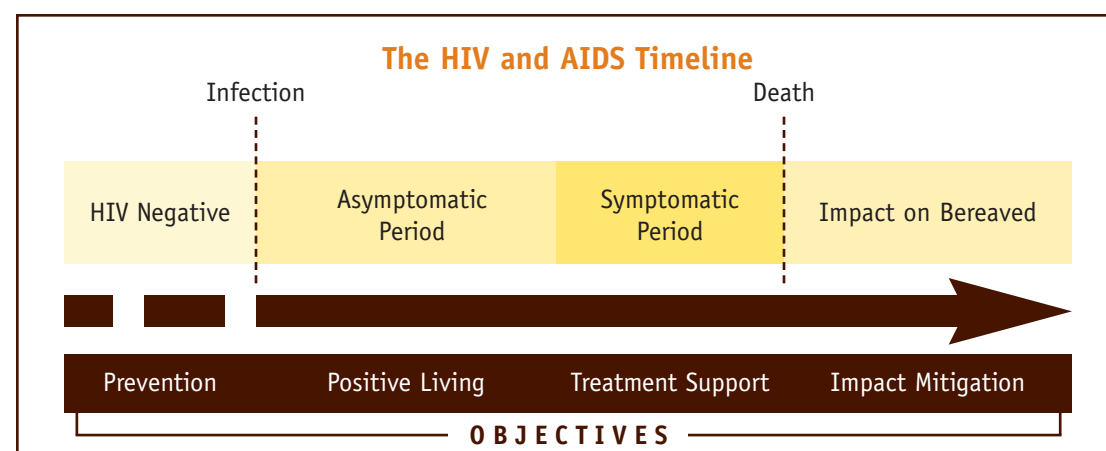
Whether undertaking a livelihood assessment to inform future programs, as we did as in Bié, Angola, or evaluating existing programs, as we did in Nampula, Mozambique, it is possible to use an HIV and AIDS lens while researching livelihoods. Practically speaking, how did we do this in Angola and Mozambique?

#### 1: Develop the skills base of the research team

In Angola and in Mozambique, CARE assembled livelihoods research teams whose members brought complementary skills and knowledge – a mix of people familiar with, for example, the local economy (trade, artisanry, agriculture, livestock-rearing), the culture, traditions and social/power systems, education and health (public, sexual and reproductive, HIV). All team members, however, participated in a CARE training to ensure a common understanding of and skill in:

- Livelihood assessment: an introduction to CARE's livelihood framework
- HIV and AIDS: basic information on HIV transmission and prevention, progression from infection to onset of AIDS, overview of treatment issues, social and economic impacts of AIDS
- Participatory research: how to select, develop and use participatory methods and tools

To help researchers understand the links between HIV and AIDS and livelihoods, we intro-



duced a simple timeline of the main phases of HIV and AIDS. This helped break down the very broad problems of the disease into smaller, more manageable pieces, and encouraged us to consider relevant interventions and objectives for each phase.

CARE used the above timeline to make sure all team members understood basic information on HIV and AIDS:

- most people are HIV **negative**.
- at some point in their lives, some people are **infected with HIV**.
- after infection, a person living with HIV can be completely healthy (**asymptomatic**) for many years – often 10 or more.
- after some years, when HIV weakens the body's immune system, the person begins to have opportunistic infections and may progress to have AIDS. This is known as the symptomatic period.
- without **treatment** for opportunistic infections and with anti-retrovirals most people with HIV eventually develop AIDS, and after a period of severe illness, they die.
- family member and friends are affected by a range of **social and economic impacts**.

With this information, people were ready to understand some important objectives (see lowest section of the timeline graphic) that CARE tries to achieve when dealing with HIV and AIDS:

- **Prevention:** reduce risk of new HIV infections.
- **Positive living:** enable people with HIV to live longer, healthier lives.

- **Treatment support:** enable people to access treatment, and to take it properly.
- **Impact mitigation:** prevent or reduce negative social and economic effects on family members.

It is important to note that these objectives overlap; they are not actually sequential. For example, members of a single family may be at different stages of the timeline at the same time. Even for the same person, multiple objectives can be important at the same time. Positive living includes safe sex to prevent passing HIV to others, and to avoid re-infection. Access and adherence to treatment depend on a base of positive living, including good nutrition, psychosocial support, prompt access to quality health care, and safe sex practices. Treatment reduces the amount of HIV in the body, and when proper treatment is combined with safe sex practices, risk of new infections is greatly reduced. Social and economic impacts, such as stigma or loss of income, can happen at many points along the timeline.

After discussing these issues, the research teams went back through the timeline to review the negative and positive links between HIV and AIDS and livelihoods at each stage and in terms of each objective:

- **For people who do not have HIV:** How might their livelihoods increase their risk of infection? How can more secure livelihoods reduce this risk? How might greater economic opportunities actually increase risk of new infections (such as



Youth in Bié, Angola, depicting their hopes and dreams.

by enabling someone to have multiple sexual partners)?

- **For people who have HIV:** How can insecure livelihoods result in faster progression from HIV infection to onset of AIDS? How can more secure livelihoods help slow this progression?
- **For people who need treatment for opportunistic infections or antiretrovirals:** How can insecure livelihoods make it difficult to get access to treatment, or to properly adhere to treatment in the long term? How can more secure livelihoods improve access and adherence to treatment?
- **For those who are affected by HIV and AIDS in their family or community:** How do insecure livelihoods make them more vulnerable to the social or economic impacts of the illness or death of others? How can more secure livelihoods prevent or reduce these impacts?

## 2: Clarify the questions first, select informants and tools second

With the rich menu of research tools developed in recent decades, particularly those used in participatory rural appraisal, an assessment team risks choosing tools for their ease or interest, and only afterward considering the tools' ability to elicit the targeted information. Likewise, protocol considerations often dictate, at least in part, the informants who are chosen to participate in an assessment.

In Angola, CARE's process for planning the research and training the research team was purposefully designed to avoid such tendencies. As the researchers progressed through their training topics (livelihoods, HIV and AIDS, the basics of participatory appraisal), we regularly checked back to the livelihood framework to make sure that our research design and the information to

be collected would capture the all-important linkages between livelihood components. A deliberate duplication of information was built into the methodology to allow triangulation of data and to avoid gaps if a particular tool failed in any location or with any group.

At each stage of the research team's training in Angola, we stopped to apply an HIV and AIDS lens:

- We paused during our consideration of the livelihood framework to analyze possible linkages: how illness and death undermine livelihoods, and how livelihoods can influence risk of HIV and resilience to AIDS.
- This led us to identify additional information that we needed to collect, including: patterns of travel to towns and labor migration (see box); gender power structures and negotiations about sex (within and outside marriage) and divorce; circumcision and initiation ceremonies and teachings about expected sexual behavior upon attaining adulthood; knowledge, attitudes and practices in relation to sex and HIV and AIDS; labor constraints and the consequences of chronic illness and prime age death on household livelihoods; and existing community and extended family support to vulnerable households and orphans.
- We then had to decide what combination of tools, methods and informants would be most likely to produce information in the categories we sought. We decided to make special efforts to:

1. *Arrange single-sex focus group discussions and sessions for young women and young men separate from those for adult/elderly women and men.*

2. *Carefully introduce sensitive topics such as sex, initiation and gender power into our discussions.*

3. *Include additional key informants who would not likely have participated in a livelihoods-only assessment, such as curandeiros (traditional healers) and health workers.*

In Mozambique, meanwhile, CARE used the HIV and AIDS lens to examine how we could

modify VIDA to effectively mainstream HIV and AIDS into its future work. We began with three general research questions (How do various people in this community make a living? How do livelihoods influence risk of HIV infection or resilience to poor health? How does poor health affect people's livelihoods?), then dug more deeply to identify the types of information we wanted. For example:

- Are program staff ready to mainstream? Does VIDA place staff or others at risk with its travel and living policies? Are staff thoroughly educated in the basics of HIV and AIDS? Are they objective and nonjudgmental, are they able to counsel others? What are the program's responsibilities towards community volunteers and other stakeholders?
- What is the HIV and AIDS impact on livelihoods in Nampula? Are the impacts on different types of households being monitored? Is VIDA taking appropriate steps to adjust to the changing reality?
- Is the project design mainstreamed? Has the two-way relationship between HIV and AIDS and livelihoods been adequately incorporated into the project objectives, targeting, interventions, methodologies, and partnerships?

In Angola, we learned that the risks associated with travel to large market towns vary from village to village. Men and women from Cachineni traveled to Kuito and Huambo to sell their goods, requiring overnight stays and probable risks. Men from Chitepa Embala, by contrast, rushed back from Kuito on the same day they marketed their charcoal, perhaps to keep tabs on their wives but also, in the words of one informant, they were 'too covered in charcoal dust and didn't earn enough money to attract town women.' Yet women from the same village did spend the night in Kuito – they stayed with relatives – and this was considered 'safe.'



*A savings group in Mozambique holds its weekly meeting.*

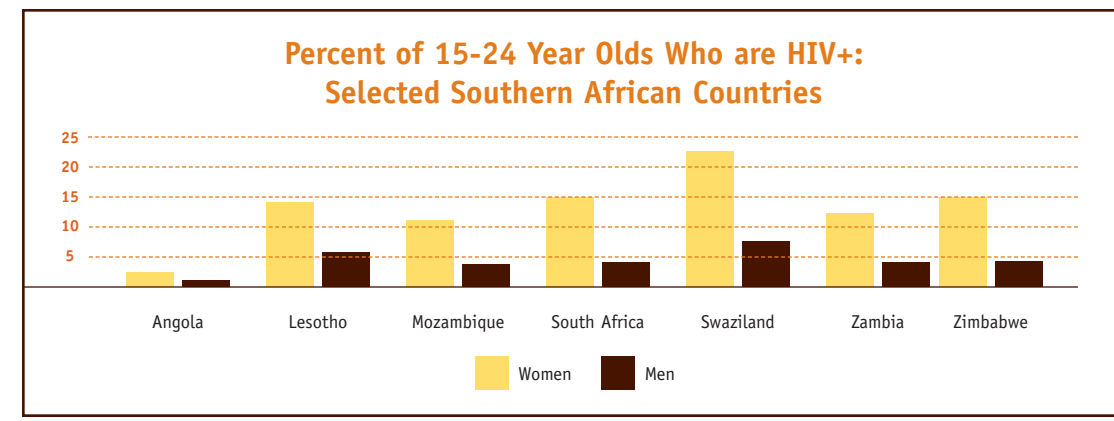
- Does VIDA have any current effect on HIV and AIDS? What are the emerging effects on prevention, mitigation and care/treatment? Are there unintended effects, good or bad? Can additional, positive effects be achieved?
- Do we have sufficient evidence? Do VIDA's monitoring systems capture the information required to mainstream HIV and AIDS into the program? What must we change to collect this information? (For example, what staff do we need? The agricultural student enumerator who regularly collects livelihoods data may be able to ask what crops a person grows but not how many sexual partners he had.) Is information disaggregated by age or households affected by chronic illness?
- Have we created a learning and dissemination ethos and system? Does VIDA encourage and practice learning and knowledge-sharing? Will the assessment report be examined with an HIV and AIDS lens – are the linkages, lessons and recommendations explicit and understood?

In both Angola and Mozambique, we used a hierarchy of settings and discussions to obtain infor-

mation. For each setting, we determined which questions we wanted to ask, then selected tools that would help stimulate discussion. We used:

- large community meetings to introduce the research team and research topics, and to engage in general discussion (for example, we asked community members to draw maps to identify important physical, economic and social assets in the community).
- focus group discussions of eight to 12 people, to discuss issues they had in common. For example, a focus group can comprise people who are providing home-based care to the ill; people who are or who have been chronically ill; or people of the same gender and age group. Focus group discussions allow more active participation and discussion at greater depth. We used a number of tools to help stimulate discussion about people's livelihoods, about how livelihoods can influence health, and how health status can influence livelihoods.
- in-depth or key informant interviews to elicit information from people (often identified during

| Sample: Community Information Gathering Plan        |  | M = Male F = Female  |
|---|--|--|
| Tool/Technique                                      | Information Revealed   | Informants   |
| Existing surveys                                    | <ul style="list-style-type: none"> <li>Nutrition</li> <li>Waterpoints</li> <li>Natural resources (macro)</li> <li>Macro-economic</li> </ul>  | Documents  |
| Timeline  | <ul style="list-style-type: none"> <li>Household knowledge (e.g. cash crops)</li> <li>Natural resources – micro and change</li> <li>Production mix and change</li> <li>Consumption mix and change</li> <li>Climate and change</li> <li>Governance and change</li> <li>Shocks &amp; stresses (prompt for health issues)</li> <li>Future?</li> </ul>   | Mixed or separate, M and F   |
| Participatory Map                                   | <ul style="list-style-type: none"> <li>Natural resources – micro</li> <li>Infrastructure</li> <li>Tribal/lineage/displaced persons issues</li> <li>Mobility/migration in and out</li> </ul>  | Mixed or separate  |
| Seasonal calendar                                   | <ul style="list-style-type: none"> <li>Mix of productive activities, remittances</li> <li>Livestock</li> <li>Gathering</li> <li>Labor constraints</li> <li>Labor strategies and opportunities</li> <li>Marketing/Exchange</li> <li>Consumption</li> <li>Expenses</li> <li>Water</li> <li>Mobility in/out of community</li> </ul>   | Mixed or separate  |
| Activity ranking                                    | <ul style="list-style-type: none"> <li>Ranking</li> <li>Constraints</li> <li>Opportunities</li> </ul>  | M / F / Young M / Young F  |
| Venn diagram  | <ul style="list-style-type: none"> <li>Community structures</li> <li>Decision making</li> <li>Learning/skills transfer</li> </ul>  | Mixed or separate  |
| Household/individual interviews                     | <ul style="list-style-type: none"> <li>Household wealth/vulnerability typology/labor availability/sickness</li> <li>Household capabilities &amp; Credit</li> <li>Groups + participation</li> <li>Assets (livestock, tools, bicycle, land)</li> <li>Inputs</li> <li>Intra-household decision, assets, resources</li> <li>Action on chronic sickness/death/divorce?</li> <li>Impacts and responses over time</li> <li>Prod activity mix + wages/food for work + remittances etc.</li> <li>Responses to shocks/coping</li> <li>Processing + value added</li> <li>Marketing/sales</li> <li>Consumption</li> <li>Water</li> <li>Shelter</li> </ul>        | M / F / Young M / Young F / Care-givers  |
| Focus Group 1: human & social capital               | <ul style="list-style-type: none"> <li>Community skills audit</li> <li>Transfer knowledge between generations and households</li> <li>Access to specialized skills</li> <li>Gender/age division of tasks</li> <li>Impacts of / resilience of households to prolonged chronic illness; to death of adults (Δ household timeline)</li> <li>Community organization: structures, decision making, tasks</li> <li>Attitudes to participation by leaders, M / F / Young M / Young F</li> <li>Rights and obligations</li> <li>Differentiation - household wealth/ vulnerability typology</li> <li>Managing vulnerability</li> <li>Lending/Credit</li> </ul> | M / F / Young M / Young F  |
| Focus Group 2: production, consumption & households | <ul style="list-style-type: none"> <li>Production, gathering, income mix – constraints &amp; opportunities</li> <li>Differences – rich/poor, female-headed household, chronic sick, youth v older etc.</li> <li>Responses to shocks, risk reduction + coping</li> <li>Risks of certain activities – landmines, violence, HIV transactional / commercial sex etc</li> <li>Migration/mobility (mapping): why, who, when, etc.</li> <li>Processing + value added</li> <li>Exchange</li> <li>Marketing</li> <li>Market distance + conditions</li> <li>Intra-household decision making, assets, resources</li> <li>Action on death</li> </ul>             | Mixed or M / F / Young M / Young F   |
| Focus Group 3: resources and opportunities          | <ul style="list-style-type: none"> <li>Water</li> <li>Shelter</li> <li>Natural Resources</li> <li>Infrastructure &amp; Services</li> <li>Opportunities</li> </ul>  | Mixed or M / F / Young M / Young F   |
| Key informants                                      | <ul style="list-style-type: none"> <li>Specialist skills</li> <li>Agricultural potential</li> <li>Other potentials</li> <li>Services (health: traditional and formal)</li> <li>Infrastructure</li> <li>Natural resources</li> <li>Markets</li> <li>Macro-economics</li> <li>Governance/ decentralization</li> <li>Future trends</li> </ul>   | Specialists: health worker, trader, chief, curandeiro, religious leader, ag dept., administrator |
| Prioritization                                      | <ul style="list-style-type: none"> <li>Work with focus groups to prioritize</li> <li>Constraints</li> <li>Opportunities</li> </ul>   | M / F / Young M / Young F  |



large community meetings and focus group discussions) who have important information or particularly interesting stories. These in-depth interviews can be simple discussions, but can also involve use of participatory research tools.

To the left is a sample research plan, showing what types of information are desired, and what tools and informants will provide that information.

**3: Create single-sex focus groups, segregate groups by age and status, and seek out vulnerable people**

In Southern Africa, the highest risk of HIV transmission involves unprotected sex, especially with concurrent partners. People’s livelihoods, their age and their gender influence why, when and how they have sex, how often, and with whom. HIV infection rates among children under the age of 15 are generally low. But rates for girls between the ages of 15 and 19 increase dramatically, and are much higher than rates for boys in the same age range, as shown in the graphic above<sup>iii</sup>. People are influenced by cultural assumptions based on age: “youth should be in school” or “boys are expected to have a few girlfriends” or “a girl needs to have a baby to show she is ready to be a woman.”

CARE and others often use single-sex focus groups guided by same-sex researchers, but if we want to obtain information and insights such as those above, we need to go beyond this simple division. Even in a single-sex group, a teenage girl may not speak openly in the presence of her mother or grandmother’s peers. In Mozambique, some teenage boys noted that the CARE research was the first time that youth had ever been asked to participate in community meetings. One commented, “We can’t talk about things like this in front of our uncles!”

The table below shows one way of dividing people into focus groups. In some places, groups may be arranged by a combination of sex, age and marital status. For example, a 20-year old married woman might fit better with 30-year old women, while a 24-year old unmarried woman may fit with youth. In other places, it can be more important to divide those who have children from those who do not. People in the community can help determine the best categorizations for focus group discussions. Other social conditions that may take precedence when choosing focus groups are people’s status as care-givers, care receivers (chronically ill), or vulnerability due to HIV and AIDS in the household.

| Age and Status   | Sex    |      |
|--|--------|------|
|  | Female | Male |
| Under 15 years (youth)                                 | Female | Male |
| 15 - 19 years (older youth, unmarried)                 | Female | Male |
| 20 - 40 years (married adults or adults with children) | Female | Male |
| Over 40 (elders)                                       | Female | Male |

Finally, across all categories of people – age, sex, status – those with the weakest livelihoods and those with the greatest health problems are often the least likely to participate in community meetings, including assessments and evaluations. In both Angola and Mozambique, the teams made extra efforts to find people who did not attend community meetings, and to include them in focus groups, individual interviews, and home visits.

### Lessons Learned from Applying an HIV and AIDS Lens to Livelihoods

When CARE overlaid the HIV and AIDS lens onto livelihoods research in Angola and Mozambique, some of the many useful results pointed to simple, practical ideas for mainstreaming HIV and AIDS into current and future livelihood security activities. (It is worth repeating that our aim was not to design public health responses but to improve our ability to contextualize HIV and AIDS as factors in livelihoods and to respond appropriately.)

In this section, we offer some of the more interesting examples of how we applied what we learned from the research to new projects in Angola, and modified the VIDA program in Mozambique.

#### Increasing people's perception that HIV and AIDS are relevant to their lives.

In rural Angola and rural Mozambique, extreme poverty and its related threats to people's survival, coupled with a relatively low HIV prevalence rate and the long delay between HIV infection and onset of AIDS, mean that people rarely include HIV and AIDS among their most pressing problems. In the VIDA project area in Mozambique, for example, people are far more likely to want to prevent malaria and crop diseases than to invest time and energy in learning about HIV and AIDS. In Angola, CARE realized that our work in Bié, where most people hardly know what HIV and AIDS are, must take a different approach, and found that linking HIV and AIDS to people's daily livelihood strategies turned out to be quite easy. When researchers and project staff discussed livelihoods in the

communities, people spoke about production and income activities; that is, food security. But limiting the linkages between HIV and AIDS only to food and income creates very narrow understanding and action. We therefore introduced the other components of CARE's HLS model – nutrition, health, water, education, shelter, community participation and personal safety – into our community discussions on the risks and impacts of HIV and AIDS. This approach readily helped people make associations between their daily realities and poor health in general, including HIV and AIDS. We were also able to help people see that their war experiences, including illness, death, impact to livelihoods and inability to plan for the future, bore similarities to HIV and AIDS. While people commonly remarked, "we have the tendency to run and not have solidarity...we are not used to thinking because of the war," they expressed motivation to explore different strategies for facing HIV and AIDS.

#### Helping people make better use of existing productive assets in the household.

Poor health or reduced household labor makes it hard for people to use the resources they already own. CARE's VIDA project in Mozambique has historically focused on improving crop production and marketing of agricultural products. During the evaluation, we sought out families affected by chronic illness and elderly/infirm people living without support of younger adults, and learned that in many communities, fields were up to five kilometers from people's homes. The ill, caregivers, and elderly rarely had the time or energy to reach and work their fields. Instead, they had to rely on what they could grow in the immediate vicinity of their houses. This pointed to an obvious need to modify the VIDA project, for example, to include support for nutrition gardens, fruit trees, small livestock-raising and even fish ponds near people's home. We have amended the VIDA project to include these activities, and have sent staff to Lesotho to learn from CARE's programs that support nutrition gardens in homes and schools.

#### Strengthening inter-household and community relationships.

Social networks like the extended family and membership in church groups are often the most important assets held by the resource-poor. Those with weak social assets may suffer consequences when they are in need. We found that people often intentionally invest in social networks when they are healthy, as a type of insurance that they will benefit from when they are ill or have other problems. CARE can work with such formal and informal networks to better help people protect themselves against HIV, and better support ill people and the family members who struggle to care for them. In

Mozambique, for example, some members of churches and mosques provide basic home-based care for ill community members, and often do household chores or work in their gardens and fields. In rural Angola, where people are trying to rebuild neighborhood and community relationships in the aftermath of the war, church groups have a promising capacity to strengthen community resilience and responses to HIV and AIDS. They have traditional support systems, such as communal funds directed to people in need, are involved in moral education and can mobilize people. It is important, however, to consider not only existing types of networks such as religious organizations, but to also form new networks to meet new realities. CARE launched a liveli-

### Structuring an HIV and AIDS and Livelihood Assessment Report as a Learning Tool

The assessment's final report can be structured to make it more useful as a planning and learning document.

Use the report as a training tool for staff, partners and community members. People can read and discuss it section by section, to better understand potential links between livelihoods, susceptibility to HIV infection and impacts of chronic illness and death. We too seldom use reports in this way.

Use the HIV and AIDS lens to focus attention on HIV susceptibility and vulnerability. Provide examples of susceptibility/vulnerability and links to livelihoods throughout the report. This can be done in at least three ways:

- ® Executive summary: Mention key HIV and AIDS vulnerabilities and mainstreaming options.
- ® Main text: add examples of links between livelihoods and HIV and AIDS to illustrate findings wherever they apply. Specific analysis is more useful than general points.
- ® Analytical section on HIV and AIDS and Livelihoods: include a section or appendix that pulls together the key points and analysis, and highlights ideas on how to address them.

A single report can't identify all potential links between HIV and AIDS and livelihoods, but can provide a series of examples and analysis that will stimulate critical thought and action. Some of the examples can flag risk situations; others can suggest activities for programming; and still others might identify gaps in information that become future research questions.

Use a gender, social status and age lens throughout. All three strongly influence livelihoods, risk of HIV infection and vulnerability to illness and death. When possible, specify. It is more helpful to say that 'adult, landless men do piece work' than 'some people' do it. In another example, widows can retain land and possessions in some societies; in others, their deceased husband's family appropriates all assets. The difference is enormous and clearly relevant to livelihoods in areas with increasing rates of HIV and AIDS.

*...from an email to CARE Angola from Dan Mullins, CARE HIV and AIDS Technical Advisor to the Southern and West Africa Region, 2004*



*Young woman in Bié, Angola, draws her dreams for the future.*

hoods project in 2005 to increase the agricultural production of returning soldiers by (among other activities) restocking animals, improving commercialization, and reinforcing local economies. Early in the project's life, we examined our activities and objectives through an HIV and AIDS lens, and quickly recognized that CARE must also pay attention to ex-combatants' wives and children if project activities are to succeed. Indeed, we found that wives of demobilized soldiers can be particularly vulnerable because they are often far from their own families, making them dependent on their husbands and their husband's families, and creating conditions where exploitation can take place. We began to create savings and loan associations with wives, an activity that will reduce their economic dependency and provide solidarity and personal security. The women's growing economic independence will increase their livelihood opportunities (a number of groups are buying de-mined land that they will cultivate), reduce their risk of HIV infection, and increase resilience to the social and economic impacts of illness and death.

#### **Improving extension services and partnerships.**

External support systems reach into communities, but their reach is quite limited. A single

extension agent may work with a formal group of 20 or 25 people, but have no links to existing, informal community groups, or any contact at all with the remaining households in the village. Extension agents often tend to work with those who come to them – usually those who are relatively better off – and are less likely to reach out to vulnerable people who rarely attend community meetings but who need more or different types of support. Extension services can more deliberately link to existing community structures, and develop partnerships that enable improved outreach to more vulnerable people. For example, an agricultural extension agent could partner with the local clinic to work with church groups, burial societies, and informal savings groups to address health care, home-care for the ill, and outreach to marginalized or vulnerable people to improve access to nutritious food and income. In Mozambique, based on the findings of the mid-term evaluation described above, the VIDA project has broadened extension workers' scope and helped them link with other organizations. In Angola, a new CARE project is building community's resilience and responses to HIV and AIDS. We are using a 'learn-by-doing' approach in six pilot villages, selected according to criteria that have an impact on resilience and response to HIV and AIDS, including the existence and influence of churches, the amount of alcohol use, the existence of polygamy, accessibility, educational levels, access to markets and existing livelihood strategies. CARE trained church groups, women, youth leaders and local administrators on topics including gender and sustainable community development, forming a firm basis for a participatory and developmental relationship between CARE and the communities (note that this is important for CARE as it transitions from a role of relief provider to one of development partner). One community group translated the training into mobilizing the whole village to rebuild a broken bridge, which now links the community to others in the area. This improvement in mobility may itself increase the risk of HIV transmission, and illustrates the need to couple such activities with others, such as education on HIV and AIDS.

#### **Labor availability and coping strategies.**

Rainfed field crops are the main source of livelihood in rural Bié, Angola, where poor soil fertility and lack of fertilizer mean yields are low and new land must be continuously cleared. Fields are often far from villages, and cultivation and clearing are done by hand. Crop production is thus highly dependent on fit labor. Indeed, the few current livelihood alternatives (daily wage labor, charcoal burning and carrying crops to market) are also dependent on fit labor. Because HIV and AIDS are not yet very visible in rural Angola, incorporating HIV and AIDS issues into our livelihoods programs may mean focusing on the most vulnerable people in the communities, and addressing the risks of HIV and impacts of ill health in creative ways. Development programs often tend to work with the more powerful and easy accessible people, assuming that dependents and others in the community will benefit. Our challenge now is to create mechanisms for including people who have less strength to do agricultural or household labor and who are extremely poor within existing livelihoods problems is an important step to mainstream HIV and AIDS. There are vast opportunities to explore agricultural techniques that are important for HIV and AIDS and livelihoods. Nutrition can be improved through new and/or multiple crop production (peanuts, for example, which have high nutritional value and are easy to cultivate in Bié). Low-labor activities such as small animal production, growing fruit trees and home gardens will create opportunities for weaker people to cultivate, and rebuild traditional support, where community members work on each others land in a rotation.

#### **Footnotes**

<sup>1</sup> CARE has published extensively on the topic of HLS. Interested readers can see <http://www.kcenter.com/phls/hls.htm> (in particular, the linked document CARE Household Livelihoods Security Assessments: A Toolkit for Practitioners, TANGO International, Tucson, Arizona, July 2002 from which this section was adapted) and <http://www.livelihoods.org/> for additional information.

<sup>2</sup> Whiteside, Martin, 2004, 'Mainstreaming HIV/AIDS into Livelihood Programming and Assessment: Some ideas and learning points arising from work in Angola and Mozambique in 2004,' December.

<sup>3</sup> Data are from UNAIDS, Report on the Global AIDS Epidemic 2006.

#### **Document Content**

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#### **Conclusion**

Overlaying an HIV and AIDS lens onto our livelihoods research in Angola and Mozambique was a prerequisite to mainstreaming HIV and AIDS into our current and future programming. CARE has long experience in conducting livelihoods assessments, but this new approach to the research meant careful training and preparation.

Notably, in both countries we immersed the research teams in relevant topics (CARE's livelihood framework, the basics of HIV and AIDS and its social and economic impacts, and participatory research methods and tools), clarified our research questions, and carefully chose informants and research techniques to elicit the information we needed. The HIV and AIDS timeline that appears above was a central training and reference tool before, during and after the research, and continues to be important as we monitor and improve our work.

Overlaying the HIV and AIDS lens onto livelihoods has prompted concrete changes in our programs in Angola and Mozambique. We have tested ways of making HIV and AIDS relevant to people who have other pressing priorities for survival. We are using old and new social and community networks to support vulnerable households. We are re-thinking how we can support coping strategies and strengthen local partnerships to build individuals' and communities' resilience and response to HIV and AIDS. CARE, our participants and partners will continue to learn about – and take steps to influence – the two-way link between HIV and AIDS and livelihoods as we move forward.

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