

Earning Their Way to Healthier Lives

Mulheres Primero (Women First): Health and Legal Training Combined with Income Opportunities Helps Rural Mozambican Women Mitigate HIV Risk¹



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Women First participants.

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In Zambezia Province's remote villages—often hours from urban areas down bumpy dirt roads—women toil in their homes and gardens just as they might have done hundreds of years ago. Strict male and female roles keep women digging on the land by day, cleaning and cooking by night, and supervising their children in between chores. They have little free time, little access to the outside world—even the radio is a rare treat—and basic household products are many miles away in the nearest trading center. They also have little help. Men are responsible for earning income for the family, but in an area with few employment opportunities, many cope through excessive drinking and risky sex. As women try to protect themselves from illness and manage their households, they do not have the money, time, or information to make even small changes to improve their lives.

The Mulheres Primero (Women First) program, implemented by International Relief and Development (IRD), aims to give rural women options for a better life. It provides them with a combination of small business skills training, access to household products to sell, and health and HIV peer education sessions. Together these activities give women the resources—skills, information, peer support, and assets—to make informed health decisions. Recently, the program added a legal rights component to address issues such as sexual and gender-based violence and property and inheritance rights.

¹ An AIDSTAR-One compendium and additional case studies of programs in sub-Saharan Africa that integrate multiple PEPFAR gender strategies into their work can be found at www.aidstar-one.com/focus_areas/gender/resources/compendium_africa?tab=findings.

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PEPFAR GENDER STRATEGIES ADDRESSED BY WOMEN FIRST

- Reducing violence and coercion
- Increasing women's and girls' legal protection
- Increasing women's and girls' access to income and productive resources, including education.

This case study features the Women First program and how it helps rural Mozambican women protect themselves against HIV and other health risks by addressing the multiple needs that can leave them vulnerable to infection. AIDSTAR-One conducted in-depth interviews with key experts at the Ministry of Health, the Canadian International Development Agency, the Ministry of Education and Culture, the UN Development Fund for Women, and the U.S. Agency for International Development (USAID) Mission. They also conducted group and individual interviews with program staff at the country and local levels, held focus group discussions with five women's groups participating in the Women First program, and held one discussion with husbands of women in the program.

Gender and HIV in Mozambique

Mozambique is one of the few countries in sub-Saharan Africa where HIV prevalence has increased in recent years, up from 8.2 percent in 1998, to 14 percent in 2002, to 16 percent in 2007 (Mozambique UN General Assembly Special Session 2008; National AIDS Control Council 2006).² Women are disproportionately vulnerable to infection—58 percent of adults living with HIV are female. The discrepancy is even greater among youth, with 22 percent of women aged 20 to 24 living with HIV in 2005, compared to 7 percent of men of the same age (Mozambique UN General Assembly Special Session 2008). Further, care is seen as a women's responsibility, and women and girls are primarily responsible for the care of the nearly 420,000 children orphaned by HIV (UN Children's Fund n.d.).

According to the UN Population Fund, a complex matrix of factors increases the vulnerability of women, particularly young women, to infection in Mozambique. These include low levels of literacy and school enrollment, limited economic opportunities, early marriage and sexual initiation, low condom use, limited access to information on safe sex and to sexual and reproductive services, and widespread practices such as sexual and domestic violence and multiple and concurrent partnerships (UN Population Fund 2008).

In interviews for this study, Mozambican Ministry of Health and donor agency officials similarly described the interconnectedness of poverty, health outcomes, and gender norms in contributing to the HIV epidemic.

² According to the Joint UN Programme on HIV/AIDS (UNAIDS) and the World Health Organization, the current rate is 12.5 percent, up from 10.3 percent in 2001 (UNAIDS 2008).

Informants noted that intergenerational sex, sex for grades, widow cleansing,³ and residing in polygynous households are common practices that leave both young girls and women vulnerable. Overall, entrenched gender norms that position men as key decision makers, with women having limited say in their own and their children's lives, provide the framework within which the epidemic occurs.

Mozambique's government is addressing gender inequality through policies and legislation. For example, the 2004 Family Law is designed to protect women's property rights. However, about 63 percent of women were found to be uninformed about the Family Law three years after it was passed, and many were driven off their property either in retribution for their husband's death from an AIDS-related illness or for being infected with HIV themselves (U.S. Department of State 2008). In September 2009, the Domestic Violence Bill was signed, with implementation scheduled to begin in March 2010.

Ministry of Health officials interviewed as part of this study confirmed that the impact of gender inequality on HIV outcomes is a relatively new concept in Mozambique, as HIV is still largely seen as a medical issue. Yet officials have begun to recognize that gender-related barriers such as poverty are also barriers to HIV prevention efforts. Similarly, nongovernmental organizations working in HIV prevention are beginning to add activities that address gender-related barriers to their programs in order to improve their impact.

These insights are slowly influencing policy. In January 2009, the Ministry of Health released its new Strategy for the Inclusion of Gender Equality in the Health Sector. The strategy includes collecting disaggregated health data for the first time. However, it is still unclear which agency will be responsible

³ In Mozambique, this practice usually involves requiring widows to have sex with the husband's brother immediately after the husband's death.

for operationalizing the strategy and how it will be monitored and evaluated.

Other government agencies have begun to address gender inequality and its role in HIV. The Ministry of Women and Social Affairs, for example, has developed a National Action Plan on Women, Girls, and HIV. The Gender Consultative Group, tied to the Ministry of Women and Social Action, is working with the National AIDS Council to incorporate gender equality into the government's next Poverty Reduction Strategy.

Despite these government efforts, much more must be done to address gender-related barriers to HIV prevention, treatment, and care efforts. Women and girls still have less knowledge about safe sex and less access to sexual and reproductive health services than men. And although access to income could enhance women's prevention options by making them less dependent on men, a report by 22 key development institutions identified women's lack of economic participation as the key constraint to gender equality and the area in which the least progress has been made in the last 10 years in Mozambique (Tvedten, Paulo, and Montserrat 2008). Fewer than 5 percent of women in the labor force are employed in the formal sector, and 7 and 2 percent participate in unskilled and skilled nonagricultural labor, respectively (World Bank 2007).

The Women First Approach

From the outset, Women First saw women's economic status as interlinked with their health and ability to prevent and cope with HIV, and it recognized the need for integrated services to achieve positive outcomes. For example, women are often decision makers around food, health, and family planning without the resources, information, and negotiating power with their husbands to ensure food security, adequate and timely access to health

care, and overall healthy family relationships. This quote from a program participant illustrates women's multiple needs that are linked and need to be addressed together: "During the peer education sessions we learn about ways we can improve our health and the health of our children; we also touch upon social issues and gender inequalities in our communities. But when I don't have food for dinner at home, I cannot spend time with the peer group."

Thus IRD integrates income-generating strategies into health programming and vice versa to improve food security and nutrition, health and access to health care, and healthy relationships between partners—which ultimately improves women's ability to negotiate for their own and their family's health. Women focus group discussants said that many of the products they sold as part of the Women First program—soap and condoms, for example—reinforced the link between health and income as they delivered messages about good health to better market their products to community members.

Development and Implementation

Women First was first implemented in 2005 in rural villages along transportation corridors in Inhambane Province and since then has expanded to Zambezia Province. The program addresses the role that poverty and lack of access to health information play in the spread of HIV by building women's business skills and income-generating capacity to enhance their negotiating power. One of the program's guiding principles is that sustainable income generation and financial independence are key to enabling women to improve household food security, access health care, and protect their health. Program activities to reduce transmission of HIV include improving women's access to condoms, providing HIV education, providing HIV testing and counseling, and strengthening women's self-

efficacy to negotiate for safer sex. The program also expects that more income and health-related information will contribute to improved HIV care and support within households.

IRD initially partnered with the Women's Society of United Methodist Church of Mozambique in Inhambane Province to implement a peer health education program. Women participants reported that they could not attend weekly health sessions as many were overburdened and lacked the resources to travel. In 2005, IRD modified the program to combine health education with an income generation component, using funding from both the Canadian International Development Agency and Unilever. This redesigned program became Women First. In 2006, Women First expanded to Nicoadala and Namacurra districts in Zambezia Province, with the support of USAID. Since 2006, the program has had over 870 participants.

Following an Avon-type model,⁴ the program supplies participants with household products—such as soap, detergent, oil, sugar, pasta, matches, and candles—to sell door-to-door in their own and nearby villages. The program works with existing groups of about 12 women. (The initial cohort of existing groups comprised those that were previously organized by World Vision on behalf of a health and nutrition program [Ntasis, dos Santos Matusse, and Esteves Mendes 2008]). In each group, women's businesses advance through three tiers of selling quotas. Three women start in the lowest tier and, as they pass to higher tiers, other women replace them and move up until all women in the group have joined the program. To begin, a woman receives a basket of products that is worth 500 MT (Mozambique Metical) to sell on credit, and she attends a monitoring session each week to report on her sales. These sessions are

⁴ Avon is a global cosmetics company headquartered in the United States that generates the majority of its sales through the use of a one-to-one sales model. Representatives typically sell Avon cosmetics, traveling door-to-door to showcase products of interest to potential customers.

meant to ensure women receive ongoing support as sellers, problems are monitored and addressed rapidly, and commitment to the program remains high. After she pays off the principal, she can use any additional profit to purchase more products and advance to the next selling level. After completing the third sales level, women graduate from the group and can sell independently, though they must continue attending weekly monitoring sessions. The women work as a team to set prices, and a selected group member (called the storekeeper) monitors the entire group to ensure accountability and success. In addition to the weekly meetings, women get support in the form of entrepreneurial training that includes sessions on the in-kind credit model, market dynamics, calculating profit margins, and bookkeeping. The program also offers prizes such as radios to further motivate and empower sellers.

When women arrive for their weekly monitoring sessions, they must attend a 45-minute participatory health session based on a manual developed by IRD. The 52-session health manual takes a “body and soul” approach, with simple instructions and content that is updated regularly based on lessons learned or questions from women themselves. Health sessions cover a wide array of topics ranging from basic health and hygiene to HIV to social issues such as stigma and violence. Women often facilitate health sessions, using a peer education model to ensure discussions are relevant and appropriate, and thus have a greater impact. Nonmembers and men are welcome to attend the health sessions.

In 2009, IRD added components to the program to respond to needs that program participants identified. To respond to women’s lack of access to credit, normally available only to formal associations, the program partnered with Banco de Oportunidade, which in 2009 extended credit to 40 women in the program. Women First also added a legal component in which a legal advocate travels between communities to provide information and training on human and legal rights, including



Women First participants.

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topics such as property rights, sexual and gender-based violence, accessing health care, children’s rights, and discrimination. Nonmembers and men are encouraged to attend these sessions to add to the discussion of these issues. The program’s legal component uses theater performances to communicate the information and reinforce messages covered in the legal training.

For the income-generating component, Women First selected a door-to-door sales model because household products otherwise are only available to program villages at inflated prices from local traders or at relatively distant shops and markets. Products are competitively priced—about 20 percent cheaper than local market prices—because the program connects participants directly with distributors based in provincial capitals and large towns, avoiding the added cost of a middleman who will travel to rural areas to sell these products at high prices. Thus the program benefits suppliers by allowing them to capture rural markets that are otherwise dominated by local traders. The door-to-door model also provides the convenience of bringing daily household products (such as cleaning products and food staples) directly to the home, saving women the transportation cost and time of traveling to the market.

PROGRAM INNOVATIONS

- Linking income generation to health training
- Using a door-to-door sales model
- Private sector partnership in the provision of credit to individual women
- Weekly monitoring to root out any challenges immediately
- Flexibility in program design to respond to additional issues (such as rights, violence, and credit)
- Obtaining local leadership support to facilitate changes in norms
- Prizes for top sellers (bicycles increase mobility, radios expose women to new information).

What Worked Well

Currently, 200 women in 16 groups in two districts participate in Women First, with a monthly sales volume that increased from less than U.S.\$2,000 in January 2007 to U.S.\$18,000 by July 2008. About 4,700 MT is spent annually on each woman to cover the costs of the monitoring visits, the incentives, and the storekeeper bonus.⁵ According to program staff, the Women First program has been successful because over time many of the women have experienced increased financial autonomy, greater equality within the household, improved status in the family and community, and improved health practices. In program communities, there is less acceptance of violence and greater support for women as income earners. These changes in entrenched traditional norms occur because women’s rise in generating income through the program is gradual, giving husbands and community members time to adjust to the consequent cultural shifts.

Prior to the program, women participants said they were entirely dependent on their husbands financially. As income earners, they now have a say in spending decisions and household priorities such as schooling for children. When asked numerous times about who controls the money earned by sellers, the women interviewed repeatedly and emphatically said, “Me!” Women have more control over when and how much money they give to their male partners, and women will seek assistance and mediation from a community member, such as a local leader, if conflicts over money arise with their partners. Women are also responsible with their finances. According to a provincial bank manager, Women First participants who receive credit from the Banco de Oportunidade are impeccable about making their payments. Women reported that this is because they have a new attitude about money now that they are no longer living hand to mouth, choosing to invest in their businesses rather than spending all of their profits. Women said they now want to think about tomorrow and what happens even after tomorrow.

Women in focus groups reported that their status in the home and community has improved dramatically, which has improved marital relationships. As one woman said about her home life prior to the program, “At home, only the rooster sang”—a sentiment that was echoed by others in the group. Now women say husbands are listening to them more and that there is greater equality in the home. Women sellers add proudly that their children have greater respect for them, treat both parents more equally, and show more affection for their mothers than

⁵The amount that is spent annually per woman participant does not include management and administrative salary costs.

they had in the past. Women also feel empowered in their level of mobility. Prior to the program, women said they were expected to stay close to home. Now they can travel freely, as men know they are leaving the home to sell products. Women who have graduated from the program to become independent sellers receive bicycles from the program, enabling them to sell their products in communities farther away. With mobility has come exposure to life outside of their communities, providing women with new ideas and information they share and apply to their own lives.

The women interviewed said that husbands support their participation in the program rather than seeing it as undermining women's traditional roles in the household. This is in part because the program explains from the beginning that women are selling for themselves and their group and this income goes back to them—not IRD or the distributors. While the responsibility of earning income could increase women's overall workload, women participants said they are working the same or slightly fewer hours per week and are able to hire help in the fields so that they can continue to sell. Also, many men have been actively supporting the women's businesses, helping women with sales and participating in trainings, or helping indirectly with household chores and other household responsibilities. Thus the very roles for which women are valued are changing. Although women enthusiastically described how their husbands are now washing dishes or caring for the children, men participating in a group discussion downplayed their role in the home, an indication that though men are willing to help, cultural norms around gender roles in the home are still quite entrenched.

Women also described changes in sexual practices. Women in the program reported that when they are not economically dependent on others, they are less likely to engage in transactional sex. Prior to the program, men "protected" women from sexually transmitted infections by waiting two days after having sex with another woman before resuming

unprotected sexual relations with their wives. After participating in the program, women reported that they are more likely to discuss condoms with their husbands as an alternative and effective form of HIV protection. Some women said they are able to negotiate safe sex with partners, while others said they encourage their partners to use condoms only with other sexual partners.

The program has initiated real change in women's capacities and confidence to speak with others in the community about health, and many have informally taken on the role of community health workers. They even discuss topics not directly related to the products they sell, such as ending discrimination against people living with HIV. With the information gained from health training, they talk to their teenage children about HIV, abstinence, and condoms.

Women in the program described overall improvements in their health as a result of training in new health practices, such as picking up trash around the home, washing dishes right away, using clean water, and washing hands before preparing and eating meals. Top sellers who have won radios from the program described how they have been exposed to how other people in the world live, including how women in other countries run businesses, fight mistreatment, and experience more supportive relationships. The legal rights training has raised women's awareness of and demand for the right to property and fair inheritance, as well as the value of registering marriages to ensure inheritance rights.

Though program participants recognized that women are still vulnerable to domestic violence, they also said that times have changed. While a woman would not have reported violence in the past, now she will complain to members on both sides of the family or to the *regulo* (community leader). Women also said that earning income reduces (but does not eliminate) the risk of violence because husbands are less aggressive when women are helping financially. Top sellers who won radios through the program have

EVALUATION

An external evaluation was conducted during the program's first 18 months examining its economic viability, paying attention to the program's first objective of improving women's economic status through small business entrepreneurship (Deloitte 2008). It determined that between January 2006 and January 2007, monthly sales from the women's groups steadily increased each month, from less than U.S.\$5,000 in January 2006 to U.S.\$15,000 one year later, and recommended that the Women First program continue operations in Zambezia Province.

heard radio messages that they have a right to say no to sex. As one woman said, "In classes we learned that when a woman doesn't want to (have sex), he can't make her." As a result of these messages, women now say that men must accept when women say no. Men have also heard these messages through the health and legal training as well as the theater performances, and women said they are now less apt to be violent.

Program participants said that they aspire for their children to receive as much education as possible. One woman from a remote community was even able to send her child to attend a teaching college. Women listed a range of future careers for them but excluded running a small business because they felt their children can do better than themselves. "The best husband is a pen," one woman said in explaining her preference for her daughter to continue school rather than marry too early. Participants also reported that nearly every woman who does well in the program takes in more orphaned children and is able to provide them with better care. Participating women also said that since joining Women First, they have received more requests for money and support from family and community members, and that they take pride in being able to assist others.

These testimonials paint a powerful picture of women with greater self-reliance, agency, and self-assurance. Some women said that they had always had the sense that a "citizen" was someone outside of their rural setting and a concept from which they were excluded. With a better understanding about their rights, established business relationships in their own and neighboring communities, and a voice in their homes, they now say they feel like citizens.

Lessons Learned

In implementing and adapting Women First, program staff have identified many lessons learned. Recognizing that poverty is inextricably interlinked with gender inequality, the program combined health education with income generation, which drew women to the program and helped them address a number of other issues linked to their financial vulnerability. The program found that providing women with the opportunity to earn income can change nearly every aspect of their lives.

However, how women earn income and whether men and community members commit to their participation affects the success of outcomes and whether women experience any negative consequences such as violence or loss of assets. Women First's gradual approach to change is a key to its success with respect to community acceptance, not only

of the income-generating component, but more generally of changes in entrenched traditional norms, practices, and behaviors. Women earn a small profit initially, and profits accrue gradually over time. As a result, household power dynamics shift incrementally, giving both men and women time and space to adjust to changes and therefore more easily adjust to new ideas and changes in traditional practices. It also allows time for couples and communities to accept new roles for women and men.

Program staff also learned that an income generation model that provides in-kind credit in the form of marketable goods is more successful than a traditional microfinance model. This is because participants in the Women First program have to work from the outset to earn money, which prevents them from losing their assets as a result of being unable to pay back credit. This model also allows individuals to gain business skills before they risk significant assets.

Traditional income generation programs cannot ensure women have power over how the income they earn is spent. Women First helps women retain control over income and their business assets in several ways. First, weekly monitoring sessions protect women by allowing them to tell men and other family members that they cannot lend money or misuse assets because the money belongs to the group, and that any losses would have to be reported at the next session. Second, the program allows men to support women in their businesses rather than prohibit their involvement, ensuring men's commitment to the program. Finally, the program builds in support for women through a group lending system, with group members monitoring and helping each other retain control of their businesses.

In fact, staff and participants said that the peer support in the group lending system help women address a range of obstacles, such as violence, property grabbing, and health problems, and that the

principles of working together to protect assets and realize higher sales play a key role in reinforcing their successes.

Another lesson learned is to keep the parameters of the program flexible. Even after adding the income-generating component to what initially was a health program, program staff recognized that women face numerous other issues related to power, poverty, poor health, and HIV. For example, when a husband dies, women often lose their homes, income, and assets. Even if they could negotiate for safe sex with husbands, they do not know the HIV status of his other partners. They cannot protect themselves from HIV once he dies because of practices such as widow cleansing. In polygynous marriages, women are not protected by marital rights to guard their businesses or property, or their children's property. The program has remained flexible to address these and other issues by adapting health sessions and adding program components. The commitment to addressing women's needs holistically enables the program to ensure better health outcomes and contributes to the success of women's businesses.

Challenges

One of Women First's biggest challenges is the program's dependence on intensive program staff involvement. Staff continually seek feedback on program successes and failures so they can adapt the program as needed. They also provide health and business training to the groups. This reliance on program staff strains program resources and prevents the program from being easily replicated or growing more rapidly, and it cannot be maintained indefinitely. The program is looking to relieve some of the staff burden by connecting women sellers directly to distributors rather than relying on staff as the facilitators. They hope to train some participants as trainers so that the program can expand with less staff involvement. This continues to pose a challenge, however, as training manuals require some classroom



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Women First Participants.

education and literacy, and the regular presence of program staff ensures accountability and provides motivation to women sellers.

The program requires further monitoring and evaluation, as prior evaluations have not fully measured changes with respect to gender-related drivers of HIV risk behavior or captured social and health effects of the program. Also the program, while successful in its current sites, has yet to be tested with replication or adaptation in other settings.

More broadly, a key challenge stems from the national response to addressing gender inequality as a driver of HIV. Though gender focal points have been assigned within each ministry (at the national and provincial levels), they have differing degrees of influence, knowledge, and commitment with respect to gender. As a result, gender-related issues are treated inconsistently, and gender equality is not always captured in national policies or government programs. At the same time that gender has been mainstreamed across all sectors, it is addressed without specific or direct funding, resulting in an accountability gap where government officials have little incentive to address gender issues or acquire gender expertise. This problem is even more severe at the local level, which

is further removed from gender-related knowledge and access to gender-specific funding. Finally, coordination of gender-related HIV programming is almost non-existent except among a few large programs, as documentation and dissemination of information on nongovernmental organization and government efforts on HIV are limited. The Ministry of Health has begun mapping HIV-related efforts, including those that address gender-related drivers, but a high-level body both at national and district levels will be required to facilitate coordination across services once mapping is completed.

Until national efforts better address gender equality, programs such as Women First will work largely in isolation, without the ability to coordinate with or receive support from the national, subnational, or local government, or from other agencies and organizations. Lacking government staff and resources to support coordination, these programs are missing a valuable opportunity to move national priorities and strategies forward, provide coordinated services, or share lessons.

Future Programming

The next step for Women First is to link women's groups directly to private distributors. In time, the program would like to transfer the role of negotiating with distributors to group members and monitor this process for two years. Negotiations to establish this direct linkage recently fell through, as the program has experienced difficulties in locating private distributors who are accepting and committed to the program's goals and objectives, as opposed to motivated by the opportunity to increase their market share.

The program is exploring other forms of in-kind credit that could be provided to women so that a similar model could be implemented in other areas with different needs. For example, milling machines as in-kind credit could allow women to start milling businesses, and

they could pay back the cost of the machines as they advance through the program. Models such as this could also stimulate complementary businesses such as food processing. ■

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RESOURCES

Integrating Multiple PEPFAR Gender Strategies to Improve HIV Interventions: Recommendations from Five Case Studies of Programs in Africa: www.aidstar-one.com/gender_africa_case_studies_recommendations

Integrating Multiple Gender Strategies to Improve HIV and AIDS Interventions: A Compendium of Programs in Africa. Women First (Mulheres Primeiro; p. 88): www.aidstar-one.com/sites/default/files/Gender_compendium_Final.pdf

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