Integrated Approaches to enabling the most vulnerable to participate in markets

Alex Daniels and Andy Jeans

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Abstract:

Even when markets become more accessible to poor people in general, wealth differentials occur and the most vulnerable are the ones excluded. The reasons for their exclusion are complex and inextricably linked with many aspects of their lives; an integrated approach takes these multiple dimensions of poverty into account, whilst addressing their deep levels of poverty through employment and enterprise. This article focuses on reaching those who are excluded from markets due to pervasive social discrimination and other challenges specific to their disability and health context. Two case studies, with people with disabilities and those affected by HIV/AIDS, describe entry points and key services required to facilitate and sustain their participation as employees and enterprise owners. They demonstrate how successful models use participation in economic activities to achieve sustainable impact through stimulating attitude change, and create a more level playing field for their access to markets and wider development processes.

Introduction:

Market development approaches, or making markets work for the poor (M4P) is a generic approach to developing market systems that benefit poor people. It allows facilitating agencies to address identified systemic constraints and bring about large-scale and sustainable change, and has resulted in many positive large scale results (Elliot et al 2008). It aims to make market systems work more effectively, but also more inclusively. However, such approaches tend to operate in isolation, have a narrow focus and be very specialised to achieve the high quality and scale in specific service areas or markets (SEEP 2008). The opportunity to include severe discrimination in the process of analysis in M4P approaches is often not taken up. As a result inadequate attention has been given to reaching some of the most marginalised - and poorest - groups, and few market development programmes consider including them amongst their beneficiaries. There is a risk that the systemic marginalisation and consequent severe poverty that is the experience of the most vulnerable is perpetuated, rather than reduced.

Yet traditional approaches to people with disabilities and those affected by HIV/AIDS focus on medical, welfare or charitable interventions; promoting the general perception that working with these groups is costly, specialist and unsustainable. The view that such groups of people can only participate in markets as consumers or recipients of welfare is not only disempowering to those who can participate as employees and employers but has significant consequences for tackling poverty. The case studies in this paper indicate a requirement for integrated interventions at a different level, preceding market development approaches, in order to overcome the depth and multi-dimensional nature of challenges faced by severely discriminated groups in their integration. The interventions address these challenges and at the same time enable market led economic empowerment so that these discriminated groups have the potential to participate in M4P or wider development approaches.

Like many of those particularly vulnerable and marginalised in society, both these groups of people are in vicious cycles of poverty which can be passed down through generations with consequent long term impact. Disabled people face a range of complex societal issues in many developing countries, which include: discrimination (negative social and familial assumptions), internalised oppression (stunted ambition and negative self-image), isolation (social and physical marginalisation), and asset poverty (lack of social or other forms of collateral) (Albu 2004). Their absence in productive employment helps to lock them in a vicious cycle of poverty. By becoming economically active they not only release their families

from the 'burden of care' but they also begin contributing to the local economy. Likewise, low-income people affected by HIV and AIDS are often caught in a downward spiral of sickness and poverty. Poverty fuels the epidemic: through factors such as limited access to health care and education, minimal economic options, and lack of sexual rights for women; and the epidemic exacerbates poverty, as income and assets are depleted with the cost of health care, caring for the sick, orphans and funeral expenses (Pronyk et al 2007; Parker et al 2000; Sumartojo 2000). There are many critical factors influencing discrimination within these groups, not least gender and the form of impairment, but in-depth analysis of this is beyond the scope of this paper.

HIV and AIDS are reversing years of forward progress in social and economic development whilst nearly 22.5 million people are living with HIV and AIDS in sub-Saharan Africa (UNAIDS/WHO, 2007), and there are (debated) estimates of 20% of the world's poorest being people with some form of disability (Braithwaite, Mont 2008; Elwan,1999). With both disability and HIV/AIDS being inextricably linked with poverty; projects which focus on the economic empowerment of such groups should be a high priority.

This paper centres on models which demonstrate how participation in economic activities and integrated support can transform the negative beliefs which underpin the exclusion of discriminated groups, creating a better foundation and a more level playing field for their participation in wider development processes. Despite the limitations of scale in these 2 case studies, which were also not established as research projects, it is hoped that the experience and analysis provide some helpful pointers on the factors affecting the levels of participation of some particularly vulnerable groups and the techniques which enhance their inclusion in markets and the wider society, and contribute to wider systemic change.

Background to Case Studies

The two case studies were both developed and implemented in partnership with APT Enterprise Development (UK) from 2004-2008. The examples given cover different forms of marginalisation and exclusion: with disability, many people have been discriminated against from birth, excluded from participating from education and many other life experiences. With those affected by HIV an AIDS, many are affected much later in life; their rapidly altering health has consequences for the support needed to sustain their participation as employers and employees.

LIFE Project in Kenya

Kenya has approximately 1 million people (5.1%) of the population living with HIV/AIDS (UNAIDS/WHO 2006), with one of the worst affected areas in Western Kenya being the Butula Division, an isolated rural area, with HIV prevalence at 33.5% in 2001 and 21.8% in 2007 (Ministry of Health, Kenya). The LIFE project in Butula Division, Kenya, aimed to improve the livelihoods of PLWHA and their dependents through micro enterprise development; and to raise awareness and reduce the stigmatisation that PLWHA encounter. It was an attempt to break the vicious cycle of HIV/AIDS; by assisting PLWHA to pursue self supporting and positive lives, making a productive contribution to the socio-economic wellbeing of their local community and helping to reduce the stigmatisation.

The project was implemented by Rural Education and Economic Enhancement Programme (REEP) in collaboration with SITE Enterprise Promotion (Kenya) which provided technical and capacity building inputs on enterprise promotion; supported by the Big Lottery Fund. REEP aims to ameliorate the suffering of PLWHAs through actions that help them access better care and support; including medication, post testing care and support, peer education, publicity campaigns, and advocacy for changes in, for example, wife and land inheritance - practises which perpetuate the spread of HIV/AIDs. Its outreach programmes emphasise the message that people can live positively with AIDS. REEP works with approximately 1000 volunteers (not paid as REEP staff members) - community change agents including community health workers, peer educators, and paralegals - who have been strengthened with knowledge and experience in their field of expertise. The livelihood development work was implemented at 2 levels – at supplementary levels and earning incomes through enterprise, working largely through volunteer enterprise development animators (EDAs).

These were selected beneficiaries (PLWHAS) who were trained by a small team of enterprise development staff.

Disabled People (DP) Project in Uganda
Approximately 2.4 million disabled people live below the poverty line in Uganda (Lwanga-Ntale, 2003), and make up 50% of those who are chronically poor. The project was based in 6 Districts of Northern Uganda (Lira, Apac, Arua, Gulu, Soroti and Nebbi), an area suffering from the consequences of a devastating 20 year conflict. It aimed to build the capacity of disabled people in Northern Uganda to access livelihoods, enabling DP to participate in enterprise as employers and employees, gain access to appropriate enterprise services and change attitudes both towards and of DP.

The project primarily used an enterprise-based training model (EBT - including apprenticeships, work experience placements and exchanges) to promote the acquisition of marketable skills. EBT was selected because it enables DP to participate in work (and life) experience from which they had previously been excluded (such as contacts/negotiation with suppliers and consumers, working with colleagues), whilst accessing relevant enterprise skills. It also enables community members, employers, customers and others, to see DP engaged in productive activity, rather than "hidden" in a specialist institution that highlights their impairment,.

Key lessons learned from an initial project were built into this project, most notably to increase the visibility of disabled people as economically active through the promotion of disabled role models. This phase of the project therefore added an awareness and communications element to the activities with the aim of directly challenging and changing attitudes. It also supported the District Disability Unions (DDUs) and advocacy campaigns. The project (DFID-funded) was implemented by National Union of Disabled Persons of Uganda (NUDIPU), the national umbrella organisation of Disabled People's Organisations (DPOs) in Uganda

Table 1: A brief summary of the population reached is included below:

LIFE Project in Kenya	**DP Project* in Uganda**
2415 people (71% women) with increased income levels either by expanding or by starting a livelihood; having received direct intervention in enterprise; 75% in agriculture based ventures. Profits were made by 80%; but ranged widely, with about one third over KES 1000/week*.	400 (36% women) obtained marketable skills leading to operating their own enterprises (312) obtaining positions as employees (56); with most increasing incomes to at least Ush 6-12,000/- per day; (1 secured a 1.2 m contract)*; 32 dropped out**
16305 (59% women) with improved care and support from services provided (eg counselling, testing, legal advice, support) to groups) including 5843 in 44 support groups - many of which indirectly benefited from enterprise interventions. Some changes to service provision.	Number of organisations, NGO and private sector, made changes to service provision and practise become more inclusive. Number of beneficiaries reached as a consequence not quantified.
An estimated 17,735 sensitised on HIV/AIDS; 30000 children participated in awareness raising campaigns. Clear impact on attitude and behavioural change – particularly in PLWHA confidence – and reduction in community stigma	13770 directly participated in awareness raising activities; 20000 reached by awareness raising campaigns Qualitative evidence of behavioural change outside direct beneficiaries– including an increase in enterprise activity by DP

* These profits enabled people to be self reliant and independent, removing the need for welfare/food aid.
****** Much of the 'dropped out' data refers to the fact the project team had been unable to trace the beneficiary due to displaced people returning to home villages).

Entry Points
Many of the reasons for the exclusion of these groups relate to non-enterprise factors; and apply to many of the markets that they would like to enter. To enable their entry into markets

as enterprise owners and employees requires a holistic analysis of the barriers hindering them. In addressing objectives beyond that of entry into the market, both these projects enabled greater attention to be paid to the fact that markets are embedded in social systems and social constraints – and non enterprise factors can have an overwhelming influence on participation in markets. Analysis (including that from earlier stages of the projects) indicated that these groups are not participating because there is widespread discrimination amongst customers, service providers, family members and other community members in the market environment, as well as the negative self image of PWD and those affected by HIV/AIDS themselves. PLWHAs are additionally excluded through challenges related to their health.

The models considered have entry points for these marginalised groups through:
- Enterprise Based Training; which is placed within and sustained by the private sector
- Community based animators with understanding of enterprise, health and other social issues; sustained within local communities

Both are assisted by the fostering of support networks, particularly needed because the traditional family networks are not working for them.

Findings: Techniques to Stimulate Participation in Enterprise

The projects were involved in facilitating a number of services that are often included in MED promotion – such as enabling access to skills, finance, agricultural extension, markets, linking with intermediaries and group work. In summary, business development interventions were:

Technical Inputs/Skill Development
- Included a range of sources of technical learning from institutions, and businesses (including apprenticeships in the DP Project) and skilled community volunteers (LIFE Project).

Business Counselling Services & Market Linkages:
- Assistance with identification of profitable market niches appropriate to the individual and means of accessing them, problem solving and follow up. These were developed according to beneficiaries' requirements (for example, working together to access market information through mobile phones)

Business Management Training:
- Included standard courses required to access credit, tailored individual or group assistance with business planning

Credit
- Support groups enabled the establishment of savings systems. Linkages with microfinance organisations to access start-up and working capital were increasingly accessed as the projects progressed.

However, the following describes key services and areas that are particular to enabling excluded groups to participate in micro enterprise. There is insufficient data to prove which services are most critical – but there is a clear indication that a package is required. A brief illustration of known elements is provided:

- ***Initial advocacy/sensitisation***

The first key step to overcoming ingrained discrimination was to build confidence, and awareness of rights and obligations and of the potential of people themselves to generate incomes through employment and enterprise. Families, as well as target beneficiaries, were included in this step due to their high level of influence.

In the LIFE project psychological counselling was offered to those who were initially uncertain of their capacity to take on a new venture. Many people, following an HIV positive diagnosis, lose their self-respect and self-confidence. REEP's volunteer Community Health Workers (CHWs) gave reassurance and advice on managing their HIV treatment with a work routine, even during periods of ill health. The twin strategies of providing individual counselling by health workers and enterprise workers (who met together regularly) and group support

systems, helped to nurture the self-confidence of PLWHA as their businesses grew, and living and working with HIV/AIDS became a practical proposition rather than a daunting prospect.

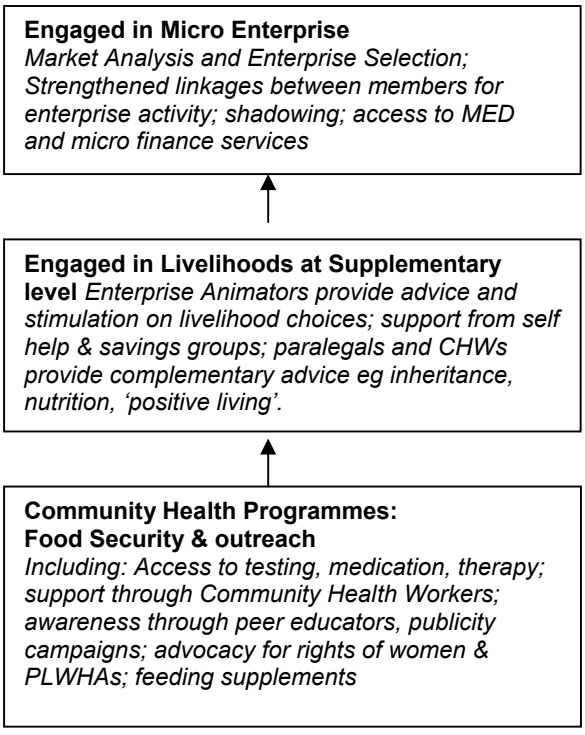
In the DP Project initial sensitisation, including of the families of DP, was undertaken through the connection with the District Disability Unions (DDUs), who raised awareness of rights as part of their remit. The project also integrated this sensitisation into business skills training helping disabled people to overcome their own and their families' reservations to becoming independent, and provided counselling and advice as businesses progressed.

- ***Market led enterprise selection and access to skills***

Knowledge of market and understanding of enterprise needed to be integrated with knowledge of health status (eg different stages of HIV/AIDS), forms of impairment, and understanding the depth of discrimination and other challenges faced at home – and from institutions. This integrated approach was relevant to enterprise selection and access to skills, with benefits apparent on the impact on different facets of beneficiaries' lives and different project objectives.

In the LIFE project, the volunteers, called Enterprise Development Animators (EDAs), together with star entrepreneurs and farmers, trained other PLWHA within the vicinity of their homes in agricultural related enterprises, and in commerce, taking up the responsibility of mobilising other PLWHA in their community, visiting and helping to organise them, and using their fields/home gardens as demonstration plots. The role of these animators and specialised extension workers are different, but in an environment where the majority of extension services are not reaching the community, animators were invaluable in filling the gap.

Figure 1: LIFE Model



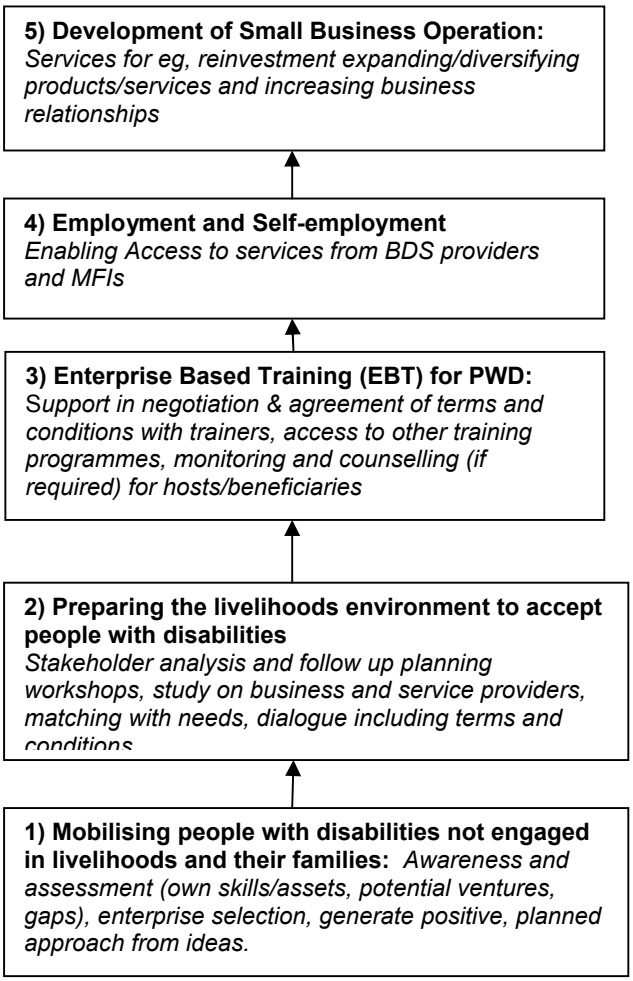
The first function of the EDAs was to ensure that PLWHA learned to engage in livelihoods at a supplementary level (middle box in Figure 1); how to cultivate kitchen or pot gardens, where land space was restricted, in order to meet their dietary requirements. The majority of participants engaged in farming, although other activities included agric-/horticultural and fish trading, garment and other retail, pre-school, hotel keeping, tailoring and basket weaving, rope making, and carpentry. Each individual was trained in one, or more, complementary enterprise activity in order to safeguard against the risk of failure in one area of production (for example, a poor horticultural harvest would be supplemented from honey production). This shift in livelihood practises from traditional labour and resource intensive ventures to appropriate small scale income generation options helped PLWHA to engage in livelihoods, and made an essential contribution to their survival with dignity in the community.

At the next stage, market niches were identified depending on both market analysis and the needs of the clients. For example, because PLWHA do not possess the stamina required to produce some of the traditionally grown crops in the area, such as maize and sorghum, the EDAs, by being trained in market analysis, helped their clients to select produce, such as tomatoes and water melon, that generally involved lighter workloads, shorter maturation

periods and fetched higher prices at local markets. Because the EDAs were themselves PLWHA, this enabled them to understand both the physical and mental constraints that faced their livelihood trainees. Trainees could chose to form a group enterprise, or to start their own business. Another APT project which had involved an analysis of the honey sector in the country facilitated the selection of bee-keeping as an enterprise sector. Skills of the staff of the organisation (SITE Enterprise Promotion) involved were shared with the LIFE project; knowledge and skills of working with PLWHAS were taken back to their enterprise project.

In the DP Project, disabled people identified the skills they were keen to learn, and local opportunities were researched, depending on what was viable in the market and according to the needs of the beneficiary. Clearly different forms of impairment had an impact on this and although there was a bias towards physically disabled people among the direct beneficiaries of this project, a wide range of economic activities were engaged in by the disabled beneficiaries. The project made a deliberate attempt to try and break away from the more traditional skills associated with disabled people – deaf as carpenters/welders, blind as cane chair makers for example. There were at least 22 different business activities ranging from tailoring, electronic repairs, baking, motor vehicle repair to bee-keeping, ploughing, fishmongers, a variety of petty trading and small arts and crafts work. This gave disabled people a greater voice in what they chose to do, in response to the market.

Figure 2: Promoting EBT (Enterprise Based Training):



The Uganda project also followed a step wise approach (Munasinghe, 2008). The enterprise based training model, summarised in Figure 2, was implemented alongside a complementary model for advocacy and sensitisation (working with DP, community self help groups, Disabled People's Organisations at Regional and District levels, and at National Levels), and was designed to facilitate better inclusion of persons with disabilities in the community.

The project struggled, especially in the early stages, with managing expectations of trainees, resulting in part from previous welfare or charitable approaches of intervening organisations, and in part from attitudes present in society. Stimulating this change is a time consuming area of the project, but successful role models, demonstrating their increased pride and self esteem, proved to be an effective catalyst.

- ***Follow up and support ;***

Although for some stigmatised groups the key area is on overcoming barriers to their initial entry in enterprise activity, some form of support, such as mutual, problem solving groups, for people who are breaking new ground was valued as they developed their enterprises. Additional interventions were also needed to address the challenges of widely varying health more common amongst PLWHAS.

Support group concept: Support groups helped PLWHA to meet openly, compared to earlier days spent in isolation. These, or other groups, were stimulated by a business need, to undertake group-based livelihood activities which included resource mobilisation, table banking, "merry-go-rounds", access to market information and bulk sales. It also facilitated access to labour from group members during particular stages of crop production cycles. The formation of support groups changed the social status of PLWHA who were previously living in isolation from the community and family. By the end of the project these support groups were becoming recognised as a regular community structure for both awareness creation among the community and focusing on livelihoods enhancement.

In the DP Project, the District Disability Unions, linked with DPOs (many of which are impairment specific), also provided support to their members, linking them to services and to each other for enterprise and other types of problem solving.

Shadowing: A form of enterprise legacy planning, and insurance against periods of ill health, known as 'shadow workers', was designed to ensure the sustainability of the business and to provide the security that was lost when the wider family network was no longer available. Enterprise beneficiaries were advised to seek assistance, ideally from an elder child of working age, to help to run the business during periods of ill health or treatment. These shadow workers learned the basic skills involved in the business - knowledge about local market conditions, sources of credit, and local input suppliers helped to retain the lines of communication and the network of associational bonds that are crucial to the survival of a business. However if friends or distant relatives had to be substituted as shadow workers with whom there was inadequate trust, support from this source was limited.

- ***Stimulating attitude change of beneficiaries and their communities***

Attitude and behavioural change amongst discriminated groups and their communities is important not only to deliver on sustainable impact of project objectives, but to catalyse and stimulate change to attain levels of outreach in impact. The main stimulant to attitude change was the establishment of successful role models, supported by sustained awareness raising activities which included their promotion and publicity.

In the LIFE project, attitude change related to 'positive living', as well as discrimination against women and as PLWHAs. The volunteer animators acted as role models, together with other key success stories. These were also supported by awareness campaigns, including peer to peer strategies using parent, youth and child educators, presentations (choir group, talks, drama) at schools, churches, and social functions (such as markets, funerals, sports tournaments), as well as radio programmes and IEC materials at events organised by other stakeholders.

The LIFE project had a clear impact on attitude and behavioural change and the reduction of stigma and discrimination. The confidence built among PLWHA was the most notable change in their behaviour brought about by the project, as evident from increased numbers of PLWHA revealing their status in public; positive living and playing an active role in family livelihood development (for example, 98-99% of women felt they were consulted on family decisions and participated in family events despite their HIV positive status); dealing with markets and service sector; and standing for their rights in terms of being remarried or reporting land grabbing. Interviews and focus groups meetings indicated that community acceptance of PWLHA can largely be attributed to their success in livelihood and enterprise ventures,

supported by awareness raising within the community (Munasinghe 2008). Enterprise activities also directly indicated behavioural changes of customers; for example, one of the most popular restaurants in Butula was owned and managed by a PLWHA.

In Uganda, DP has very few role models successfully operating in business, to observe. Most have never witnessed a successful disabled business person, and find it hard to conceive of themselves as self-reliant. In addition to establishing over 360 DP as positive role models, activities included raising awareness, challenging negative assumptions and promoting examples of successful role models through road shows, radio programmes and TV, as well as positive participation of DP in community clean up operations and bicycle rides.

Evidence collected from individual interviews and focus group discussions, and an (external) evaluation of the campaigns, reinforced project data that this has had a significant impact on attitudes. Commonly beneficiaries referred to their previous total dependence and not being recognised as people, to changes in both their own independence and the attitudes around them as others started to see they could support themselves. There were positive changes in public attitudes towards DP. Significantly, observations during the evaluation indicated that the project had gone well beyond its immediate beneficiaries, with evidence of behavioural change in enterprise participation:

- Before the project started DP in Lira routinely went out onto the streets to beg on a Friday. This was widely acknowledged by the community as 'acceptable'. Since the DP project began this practice has completely stopped and the community is more used to seeing disabled people as market vendors than beggars.
- A number of examples of DP (non beneficiaries) establishing micro enterprises (eg kiosks) alongside or close to successful role models of the project.
- DDUs noting individual members opening bank accounts and a "culture of savings" being generated

- ***Advocacy for improved (enterprise) services***

Advocacy by beneficiaries, and by their representative organisations, for improved – and non discriminatory – enterprise service provision is a key area for sustainable change. The establishment of role models and the evidence they provided was a critical stimulating factor, supported by building the capacity of representative organisations to follow up and lobby for demanded services.

The physical demonstration of DP and PLWHAS willing and able to learn a wide variety of skills and to run successful businesses was apparent in its effect on local institutions and small businesses. Service providers became aware of how their own negative attitude was, in many instances, the biggest barrier to inclusive participation. Reasons for exclusion included assumptions on their ability to pay; sometimes they were simply disregarded. This fear was mutual – for example DP themselves expressed a reluctance to become involved with micro-credit because of the way they thought they would be treated. DP's limited assets and a lack of credit history were also cited as barriers.

This contributed to a number of changes in service provision, amongst vocational training centres, employers, market linkages and others; some credit based examples are given below:

- PLWHA were able to access credit and purchase shares from Butula Financial Services Association (supported by Kenya Rural Enterprise Programme), with a range of loan products specifically designed to cater for clients with HIV/AIDS that combines flexible repayment terms with life assurance provision. Without this, PLWHAS had been effectively excluded from KREP despite its clientele being poor in terms of incomes and assets and with little business experience.

- Association of Micro Finance Institutions of Uganda (AMFIU) promoted the inclusion of DP in the MFI sector. They reported a 96% increase in numbers of

disabled people accessing MFI services with MFIs making decisions based on business plans rather than applicants' impairments.

- Evidence of banks making their premises accessible to DP.

- ***Working in partnership with relevant specialist organisations***

Partnerships between specialist organisations are needed to draw on strengths and knowledge from different sectors. This is needed at different levels – including the overall design and management of the interventions as well as responding to individual needs of beneficiaries.

Both lead partner organisations had specialist knowledge of the client group and their situation (NUDIPU and REEP) requested assistance to address their clients' expressed need to generate income through enterprise.

Working in partnership with both enterprise and non enterprise service providers – including in health care, livelihoods and advocacy work – was part of implementing the LIFE project and accessing relevant support to address different facets of beneficiaries' lives. For example, advocacy work on cultural practices such as land and widow inheritance has consequences for both HIV and AIDS, enterprise management and assets. It was also apparent in the DP project; including with respect to the capacity building of communities, DDUs and DPOs to continue advocacy work so that DP are more effectively included in mainstream programmes in the future.

However, in such resource-poor environments, at the grassroots level, there is also a need for the beneficiaries' local contact to have basic understanding of multiple aspects - someone with the knowledge and understanding of market factors – but who also knows about nutrition needs or about the different facets of being discriminated against from birth. Referrals can then be used to access further specialised expertise.

- ***Resourcing the interventions and their sustainability:***

Clearly there are costs associated with developing a body of volunteers and a sufficient number of role models to stimulate change. There is some justification for subsidising such programmes that open opportunities for excluded groups to participate - the target beneficiaries are certainly less likely to be able to pay because of the discrimination and associated destitution which they face, and the lack of access to assets or the family support normally enjoyed. As they participate they develop the capacity to purchase services.

The projects thus used different strategies for resourcing the interventions:

- Attempting to ensure that costs were met by the client as far as possible by assisting with negotiating their contribution.
- Embedding costs into the process of establishing the stimulants of change; for example facilitating access to skills or upgrading the facilities of enterprise trainers; including bicycles or other benefits to volunteers which help to promote their area of expertise.
- On going running costs were minimised to be appropriate to resource poor communities and met in different ways from a variety of local sources. For example EDAs providing training in honey production take a cut from the honey harvest; community health workers became integrated into other health programmes recognised by the Ministry of Health and thus independent from REEP; the choir group that raised awareness was self sustaining through operating as a social enterprise and charging fees for performances. It is also worth noting that non financial gains – particularly that of social status - was also a significant contributor to sustaining advice and support.

In the LIFE project, sustainability is achieved by establishing a knowledge base within the community, in the capacity of livelihood animators, community health workers, peer

educators, paralegals etc. The use of volunteers was viewed as a good investment in social capital and the establishment of a community resource base, with the ultimate objective of enabling the community members to take on responsibility for running most of the project partners' activities in the future. It relies upon engendering an ethos of positive living, and because the EDAs and CHWs are committed volunteers that in general receive communal approval for their work, the potential for assistance to continue into the future, once LIFE has ended, is greater. Indeed, many REEP EDAs were expected to maintain relationships with their clients when the programme closed.

In Uganda the project established economically successful role models to stimulate attitude change and tackle discrimination, amongst communities in which they live and operate, and service providers. This established a customer/client relationship between disabled people and local service providers, with employer/trainers more receptive to employing disabled people in the future; parents more encouraged to invest in the future of disabled children; and improvement in the livelihoods of disabled people through their capacity to continue in self /employment which will include impact on their dependants.

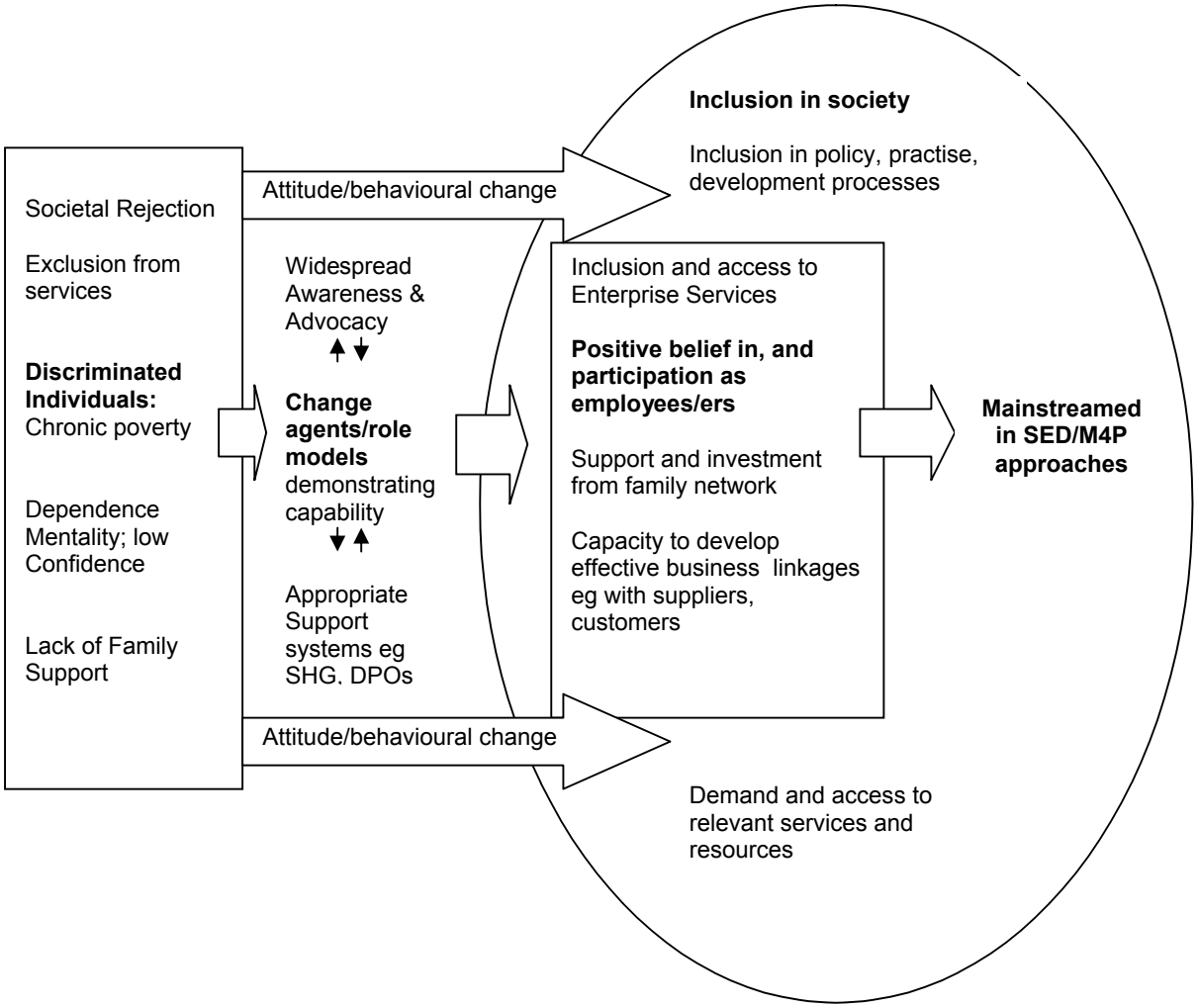
In both cases further long term monitoring will be required to monitor the extent of the outreach and widespread behavioural change obtainable from a relatively small scale project; and improvements in advocacy capacity will help to apply leverage on a greater scale for more widespread institutional change for national, and potentially international, benefits.

Discussion

What is different about this approach is the deliberate effort to work across sectors – using inclusion in enterprise as a catalyst for change in other aspects that are fundamental to the well being of the target group, and taking into account the multi dimensional nature of discrimination. Such an approach and some of the techniques described will be appropriate to other very vulnerable and excluded groups.

The projects described included a range of enterprises and although they are market led, they are not sector defined. By empowering people with the right to choose and stimulating them to tackle discriminatory barriers, this approach was different from analysing a particular sector and making it accessible to one particular group – such as DP. There are sectors which have become accessible to DP (such as blacksmithing in Sierra Leone or certain craft industries in a number of African countries) through tradition or intervention, yet access and acceptance in particular sectors has not led to more mainstreamed inclusion. Catalysing a change of attitude and behaviour across a range of sectors increases the potential of significant scale and outreach, with wider systemic change that mainstreaming can bring. The process is outlined in Figure 3.

Figure 3: Approach to Stimulate Discriminated Groups participating as Employers/Employees



The complex and multi dimensional nature of the context facing discriminated groups – including their exclusion from society and services, their low self esteem and chronic poverty, require a significant change in attitude and behaviour. This is stimulated by change agents/role models demonstrating their capability, supported by appropriate support systems, advocacy and widespread awareness raising. With the successful demonstration of a sufficient cadre active as employers and employees attitude and behavioural change is stimulated both amongst discriminated groups themselves and those providing support – whether in business services, family investment or as customers. Once this is in place there can be better inclusion in other approaches – whether M4P or other wider development processes (eg health, education).

Tackling discrimination and stimulating attitude change and establishing a more equitable – and inclusive - foundation for sector based programmes, and as a preliminary step is compatible with a number of frameworks. Considerations of these factors should be included in market assessment processes in M4P used to identify causes of underperformance of all aspects of a market systems, or in other entry analysis that aims to assess what is required to

bring about equitable, pro-poor market structure (such as in Oxfam's entry analysis in Carney 2002); and these interventions part of an initial response to establish a more level playing field and as part of generating a more 'enabling environment' in a market map as described in Practical Actions Markets and Livelihoods Programme (2007). Initiating activities to precede sector led MED programmes is also compatible with SEEP's suggested approach, which proposes a more holistic and co-ordinated approach to poverty eradication, particularly for people affected by HIV and AIDS, with a staircase of economic strengthening and MED services appropriate for people experiencing different levels of poverty, delivered by institutions or specialists knowledgeable in the use of tools at that level (SEEP 2008).

Elsewhere, cross sector approaches are being demonstrated with microfinance as the key entry point for linking economic interventions to concrete health outcomes, for example health related training at loan centre meetings (Pronyk et al 2007) or in specific micro-finance instruments.

The case studies described help to address the mismatch that arises when different development players (such as CBO capacity building, health, and others, and those promoting SED and providers of business development services) are responding to discriminated and very vulnerable groups - between client needs and service availability. There has often been general reluctance for mainstream projects to get involved in what they see as being specialist advocacy work for minority groups. The disability sector has been especially prone to this because of assumptions made about how much of a role is needed for adaptive support. On the other side discriminated groups have often shied away from getting involved in mainstream MED programmes preferring instead to rely on their own organisations to find ways to provide for them. These are models that enterprise organisations can link with and build on, working in partnership with local organisations (DPOs, HIV etc) to access and address the needs of very vulnerable groups.

Conclusions

The huge strides in economies of scale and GDP per capita gained through market development approaches can still leave severely marginalised people excluded – or even further marginalised, with inequalities being replicated rather than challenged.

M4P could be more inclusive by drawing on some of the positive elements of these models, by, for example:

- ensuring that service providers are genuinely inclusive and do not multiply and endorse the discrimination present, and/or
- including Disability and HIV/AIDs in the analysis in the same way as gender is included.
- providing or linking to additional services that relate to health or other development needs alongside business development interventions

However, without additional interventions to stimulate attitude and behavioural change, this will not be sufficient for a credible challenge to systemic marginalisation and consequent chronic poverty. These case studies have shown it is possible to support discriminated groups to become successful entrepreneurs and employees and in doing so this has helped transform the negative beliefs which underpin their exclusion from society. In future it will be easier for DP and PLWHAS in the project areas to be accepted as trainees, employees and business owners, as well as participate in wider socio-economic processes.

For MED practitioners who wish to maintain the quality and focus of a particular approach and who are interested to increase the participation (or reduce the level of exclusion) of the most vulnerable in markets, effective partnerships are needed to deliver the package of interventions required to overcome ingrained discrimination and exclusion, and reach the most vulnerable.

References:

AIDS Epidemic Update Paper 07 UNAIDS/WHO 2007

Albu, Mike (2004) 'Evaluation of an action-research project by the National Union of Disabled Persons of Uganda (NUDIPU) and APT Enterprise Development'

Braithwaite, Jeanine & Mont, Daniel (2008) 'Disability and Poverty: A Survey of World Bank Poverty Assessments and Implications' HDNSP, World Bank.

Brindson, Vivien; Kawooya, Andrew; Marion Mbabazi, Munasinghe, Chintha and Maximimill Nabwire (2008) 'Empowerment and Income for HIV-AIDS affected people: Butula Division, Busia District, Western Kenya' Evaluation Report.

Carney, Diana (2002) 'Sustainable Livelihoods Approaches: Progress and Possibilities for Change' DFID.

Dharmapriya, Kithsiri; de Mel, J Henry; Moll, Kevan; Munasinghe, Chintha (2008) 'Enabling Participation: Business Development as a Tool to promote Disabled People's Rights, Sri Lanka' Mid-term Review March 2008

Elwan, A (1999) Poverty and Disability, background paper for the World Development Report

Elliot, David, Gibson, Alan and Hitchins, Rob (2008) 'Making markets work for the poor: rationale and practice', Enterprise Development and Microfinance Vol 19 No 2

Hallmark Events & Promotions (2006) Attitude Change Communications Campaign

Lwanga-Ntale, Charles (2003) 'Chronic Poverty and Disability in Uganda' Development Research Training

Munasinghe, Chintha (2008) 'Building the capacity of people with disability in Northern Uganda to access their livelihoods: A handbook for disability advocates and practitioners'.

Munasinghe, Chintha (2007) 'Breaking the Vicious Cycle: A Model for Social Inclusion and Economic Empowerment of Communities Affected by HIV/AIDS'

Parker, R. G., Easton, D. & Klein, C. H. (2000) Structural barriers and facilitators in HIV prevention: a review of international research. *Aids,* 14**,** S22-S32.

Pronyk, P. M., Hargreaves, J. R. & Morduch, J. (2007) Microfinance programs and better health - Prospects for sub-Saharan Africa. *Jama-Journal of the American Medical Association,* 298**,** 1925-1927.

Sub-Saharan Africa AIDS Epidemic Update Regional Summary UNAIDS/WHO 2008

Sumartojo, E. (2000) Structural factors in HIV prevention: concepts, examples, and implications for research. *Aids,* 14**,** S3-S10.

SEEP Network Guidelines for Microenterprise Development in HIV and AIDS-Impacted Communities: Supporting Economic Security and Health, Book 2 for Microenterprise Development Practitioners (2008)

Authors:

Alex Daniels (Programme Development Manager) and Andy Jeans (Chief Executive) are employed with APT Enterprise Development, a UK based NGO which promotes economic empowerment and social change by helping the most vulnerable and disadvantaged achieve sustainable livelihoods and by addressing the barriers that limit their participation.