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# Social Entrepreneurship Interventions in the HIV/AIDS Sector: A Social Entrepreneurship — Social Work Perspective

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## Abstract

Despite the growing interest in social entrepreneurship research in the social work literature, very little research examines how social entrepreneurs tackle social work challenges in the HIV/AIDS sector. Consequently, we lack research on how social entrepreneurship might contribute to the social work's domain of healthcare. In this article, we employ grounded theory research to study how a group of social entrepreneurs (n=58) selected as Fellows by Ashoka, one of the world's most influential social entrepreneurship support organizations, solve HIV/AIDS problems. This article identifies four major interventions that social entrepreneurs employed in tackling HIV/AIDS problems: *relational*, *service*, *economic*, and *policy*. We analyzed these four primary interventions and classified them into a typology based on: 1) *locus of change* (institutional-oriented or macro social work versus agent-oriented or micro social work), 2) *resources used* (material/utilitarian versus symbolic/normative), and 3) *client-social enterprise relations* (client as recipient versus client as co-creator). This article contributes to social work research by demonstrating the possibility of integrating multilevel (e.g., micro and macro) and multidimensional (e.g., service, economic, and policy) interventions in addressing the HIV/AIDS problems. It also suggests avenues for future research to lessen the gap between social work and social entrepreneurship research so as to advance social work research.



## Keywords

Social entrepreneurship, health, HIV/AIDS, social work

## Introduction

HIV/AIDS is both a social welfare and healthcare problem that is integral to social work (SW) research and practice (Hampton et al., 2017; Kidman and Haymann, 2016; Strug et al., 2002). As of 2015, over 36 million people were living with HIV/AIDS (PLWHAs) globally, but less than half had access to medical treatment (UNAIDS, 2016). As many scholars and experts have claimed, the state and civil society have not done enough to solve HIV/AIDS and its related problems (e.g., patients' inability to pay for medicine and treatment, children left orphans by HIV deaths, or the stigmatization of people with HIV/AIDS) (Halmshaw and Hawkins, 2004; Blas, et al., 2008), while the business sector has little interest in this problem (Williams, 2012). These studies highlight the sectoral inefficiencies— state, civil society, and business — in addressing HIV/AIDS and its related problems.

In recent years, social entrepreneurship (SE) has gained much attention in SW practice and theory. Despite a lack of consensus on the definition of SE, SE is generally understood as a process of pursuing business and innovation opportunities to enact social change (Mair and Marti, 2006; Zahra *et al*., 2009). In SW research, SE is viewed as the *business of SW* (Gray *et al*., 2003). SW scholars conceptualized SE as 'the hybrid of social work macro practice principles and business innovation activities' (Germak and Singh, 2010, p. 79). SEs have emerged as a 'well-being providers' around the world (Roy et al., 2014), offering alternative and effective ways to solve health care and SW problems through community-based actions in a sustainable approach (Millar, 2012; Linton, 2013). SW and SE share a conceptual overlap rooted in *social value creation, morality, social justice,* and *client interest* (Berzin, 2012; Chandra, 2017; Gray et al., 2003; Grimes *et al*., 2013). SW embraces SE's social welfare logic (Doherty *et al*., 2014) although SW has not conventionally focused on the commercial and innovation logics.

Recent years, however, have seen a growing interest in the promise of social innovation and entrepreneurship to advance SW research (Germak and Singh, 2010; Ho and Chan, 2010; Bahar, 2017) amid criticism of the macro-micro *divide* in SW, which has marginalized macro practices (Rothman and Mizrahi, 2014; Bahar, 2017). Other reasons for the surging interest in SE in SW field include the growing complexity of today's social problems and the declining funding for social services across the globe (Germak and Singh, 2010). The business and innovation practices in SE — partly to address the funding gaps and partly to offer more effective solutions to social problems – – could affect how service providers interact with clients and how a client is defined.

Despite the growing interest on SE as an innovative, entrepreneurial and sustainable approach to SW practice (Germak and Singh, 2010; Nandan *et al*., 2015), there is little empirical research on how SEs address SW's domain of healthcare challenges pertaining to HIV/AIDS. The few papers on SE in the SW literature have been primarily conceptual (e.g., Ferguson, 2012; Roy et al., 2014; Tucker *et al*., 2012) and provide little intellectual exchanges between SE and SW. HIV/AIDS and related problems are complex, and difficult to solve (i.e., 'wicked problem'; Rittel and Webber, 1973, p. 155) hence there is merit in finding answers from new perspectives such as SE. To-date, we do not know what *interventions* — the activities, processes, procedures and

actions — that social entrepreneurs employ to solve HIV/AIDS problems. An understanding of how social entrepreneurs make such interventions will make important contributions to the theory and practice at the intersection of SW and SE. In this study, we ask the following question: *How do social entrepreneurs solve HIV/AIDS problems?*

**Solving HIV/AIDS problems: From social work to social entrepreneurship**

HIV was discovered to be a retrovirus in 1983 (Montagnier, 2002) and was viewed as a deadly 'cancer' that killed more than 80% of patients within two years of diagnosis (Stulberg and Buckingham, 1987). While HIV/AIDS treatment changed radically since 1986 with the introduction of the first anti-retroviral drug AZT (azidothymidine) (Montagnier, 2002), which dramatically reduced HIV/AIDS mortality (Blower *et al*., 2000), from the early 1980s to 1996, the primary role of social workers (SWs) was to assist AIDS patients in finding meaning in life while facing the dying process (Strug *et al*., 2002). Today, SWs' *primary* intervention aims to reduce high-risk behaviors and enroll people with HIV/AIDSs in primary medical care and new treatment protocols (Edmonds *et al*., 2015), and their *secondary* role is in HIV/AIDS prevention (Strug et al., 2002) as well as to support medication adherence (Gaston *et al*., 2015) and palliative care (Small, 2001).

Although HIV/AIDS is now considered a treatable long-term chronic illness, as current medications do not offer a medical cure (National Institute of Allergy and Infectious Disease, 2017), scholars have found that stigma and discrimination against those with the virus, and patients' related fears around disclosure, are the key barriers to effective care, treatment and prevention (Foreman and Rathaille, 2015; Stangl et al., 2013). Scholars have also found evidence that social inequality due to poverty, lack of public education about HIV/AIDS and its spread, homophobia, and housing and gender inequities underlie health inequalities, including death (Pockett and Beddoe, 2017). Other scholars demonstrate that social support, and emotional and informational support as well as formal and informal supports (e.g., family support, HIV peers), is important for people with HIV/AIDSs (Waters et al., 2017). Other scholars, using a macro perspective, argue that collaborations among all parties solving HIV/AIDS problems are critical (Abell and Rutledge, 2010).

In recent years, employment has been seen as a social determinant of health for people with HIV/AIDSs globally because employment can regulate sleep and healthy behaviors, and increase neurocognitive functioning and medication adherence (Hergenrather *et al*., 2016; Vance *et al*., 2015). *Employment* is a common intervention used in SE, particularly among work-integration SEs (WISEs), as a means of empowering disadvantaged clients economically, psychologically, and socio-politically (Datta and Gailey, 2012; Ferguson, 2007). Several studies show that SE-SW projects that integrated vocational and clinical services for homeless youths were more effective in improving the well-being of clients than traditional social services programs (Ferguson, 2012; Ferguson and Xie, 2008). Other studies also provide evidence that SE-SW projects have effectively enhanced independence, health status, social networks and employability of vulnerable population through employment (Ho and Chan, 2010; Krupa et al., 2003; Tedmanson and Geurin, 2011). However, SE offers more than just employment. For

example, SEs have made health workers more accessible to clients by providing mobile services (Seelos *et al*., 2006), an area at the periphery of SW. SE could also optimize the delivery of comprehensive health interventions; help make such services less reliant on external funding, and more responsive to the needs of communities (Tucker et al., 2014). The *innovation* (Bahar, 2017; Zahra *et al*., 2009) and *financial sustainability* (Doherty *et al*., 2014; Gray et al., 2003) aspects distinguish SE intervention model from the traditional SW model. Essentially, SE emphasizes on creative, innovative and enterprising ways of solving problems through borrowing, tweaking, modifying and hybridizing new and existing ideas and solutions, among others, to pursue more effective and or efficient solutions to social problems, including borrowing techniques traditionally used in SW (e.g., counseling, diagnosis, prevention, and treatment etc.).

The literature shows that social workers who work with HIV/AIDS issues have largely focused on the *micro* interventions such as providing medical care (Edmonds *et al*., 2015), prevention (Strug et al., 2002) and support (Gaston *et al*., 2015) to clients and their families, and linking them with relevant service providers, like health, social support and education (Ntshwarang and Malinga-Musamba, 2012). In contrast, SE (or SW embracing the SE model) can be thought of as an integration of *micro and macro level* interventions, as it not only focuses on caring and treating the clients but also employing multi-sectoral strategies to create favorable conditions and institutions to deliver innovative and sustainable solutions to people living with HIV/AIDS (Tucker et al., 2014). For example, Mauricio Ramos, a social entrepreneur from Mexico introduced a home-based care and medication model, partners with health worker volunteers, creates training programs and engages in healthcare policy advocacy – which bridged the micro and macro level work. In this example, SE combines different roles of social workers, educators, health providers and involves efforts to create systematic changes in the social system and power relations (Nicholls and Murdock, 2012), the roots of most social and health problems.

Because SE combines (product and process) innovation, business practices, and various aspects of empowerment programs (e.g., training, managing, communicating, interacting with others) in a real-life context, SE can be seen as a logical extension of SW practice and research, and a source of new insights for SW research and practice. SE and SW have theoretical overlap, in that like the SE, the field of SW acknowledges the value of partnership with service users (Lymbery, 2006) and emphasizes the issues of empowerment of service users (Turner and Maschi, 2015). However, to date, we know little about what SEs do and how SEs are solving the HIV/AIDS issues and how their work might inform SW research. In this study, we define *SE interventions* as a range of *activities, processes, procedures and actions* adopted by social entrepreneurs to solve social problems. Theorizing SE interventions will contribute to both SW and SE literature by providing a better understanding of interventions employed by SEs in supporting vulnerable population such as PLWHAs and provide practical insights to practitioners and policymakers. This requires an in-depth examination of what SEs actually do.

Today, we are witnessing a growing number of global SE platforms that find and support outstanding with pattern setting ideas for social change, from Ashoka and Echoing Green (based in the US), Schwab (based in Switzerland) to AVPN (based in

Singapore). This presents new opportunities and a natural laboratory to study how SE operates to effect change for individuals, groups and the larger socio-political system and to study what interventions that SEs employ to enact change.

## Methodology

We employed the grounded theory approach (Glaser and Strauss, 1967) and used Gioia's method of open (first-order), axial (second-order) and selective (aggregate dimension) coding (Strauss and Corbin, 1990; Gioia *et al*., 2013) to code the profiles of Ashoka social entrepreneurs (or 'Fellows') to answer our research question (i.e., the interventions employed by social entrepreneurs to solve HIV/AIDS problems). More details about the Gioia's method are provided in the online Appendix I. We adopted the grounded theory approach because there is little prior work in this domain (i.e., cross-fertilizing SE and SW research) and we know very little how SE might extend SW practices in the HIV/AIDS sector.

We operationalize SE interventions as the 'strategies' adopted by the Fellows to tackle social problems. The profiles of Ashoka Fellows in the HIV/AIDS sector contain a section on 'strategies' to solve HIV/AIDS problems, which formed the core of the data analyzed in this article. These profiles were written and maintained by Ashoka based on multiple rounds of interviews with social entrepreneurs by multiple interviewers and presented in a uniform format in Ashoka's website (https://www.ashoka.org/en/our-network). A sample fellow profile can be found in online Appendix II.

## Sampling

Ashoka was chosen as a sampling site because it is one of the world's largest and most successful SE support organizations and plays a major role in shaping our understanding of how SE operates to effect change for individuals, groups and the larger socio-political (macro) system. Ashoka had more than 3,000 Fellows as of November 2016 and categorized its Fellows into six fields of work — civic engagement, economic development, environment, healthcare, human rights and learning/education. Our focal interest was the Fellows in the HIV/AIDS category, situated within the field of healthcare. As the first step to sampling, we found that out of over 3,000 Fellows, there were 388 of them working in the healthcare field. Secondly, we looked into these 388 Fellows and identified that there were 58 Fellows working on HIV/AIDS-related issues, which is 14.9% of the population in the healthcare category or 1.8% of the overall population. Due to a small size of the population (n=58), we decided to extract and study the entire population in this study to increase the credibility of the findings (Lincoln and Guba, 1985).

After extracting the written profiles of these 58 Fellows from the Ashoka web page (https://www.ashoka.org/en/our-network), we performed qualitative data analysis using the grounded theory approach. The Fellows' profiles contain information on the problems that they seek to solve, their new ideas, and the solutions or strategies (i.e., interventions) that they employ solve the problems. As shown in Table 1, the majority of the Fellows were elected between 2000 and 2009, nearly 60% were male, and they came from 19 countries which were mostly (89.5%) 'developing' and 'less developed'

economies. Thus, this article examines the entire population of Ashoka SEs working in the HIV/AIDS field.

*Insert Table 1 about here*

## Data analysis

Prior to this analysis, the two researchers conducted pilot face-to-face interviews with the founder of Ashoka (Bill Drayton) and the Deputy to the President of Ashoka (Amy Neugebauer), in 2013 and 2014 respectively, to gain familiarity with Ashoka's SEs' work (the interviews are not included in this analysis but are available upon request). These interviews prove to be useful during the main data analysis stage as they provide contextual information (e.g., about why and how the SEs were selected by Ashoka, the consistency of their narratives and Ashoka's profiles).

Next, the two researchers read five randomly selected Ashoka Fellows' profiles in the HIV/AIDS category and coded them as part of their coding training. This was intended to build a deeper familiarity with the interventions employed by the SEs; and these training samples were later included in the main data analysis. Next, in the actual analysis, using RQDA, an extension of R programming for qualitative data analysis (Chandra and Shang, 2017a; Huang, 2014), the two researchers independently coded the profiles of the Fellows in the HIV/AIDS category using 'open coding' to produce first-order concepts (Strauss and Corbin, 1990) and gradually abstracted them to the second order themes and, then, aggregated them into theoretical dimensions (Gioia et al., 2013). The open coding generated 238 initial codes for the 'intervention strategies' employed by the Fellows, some of which were overlapping and had to be trimmed down (for example "campaign to build sensitivity on HIV issues" and "public campaign using various media outlets" were combined into "media campaign" as first-level coding; "employing peer educators to dispel myths about HIV" in various groups such as women, transsexuals, men were combined into "peer-to-peer model" as the first-level coding). After three rounds of coding and meetings to refine the codes (i.e., intervention types or nuances), the two researchers completed the data analysis after reaching theoretical saturation. In the end, we identified 46 unique SE interventions (e.g., toy therapy, community pharmacy model, self-employment, and rights advocacy). Finally, the two researchers cycled back and forth between the emergent findings and cognate literature to make sense of the findings and position them in the literature. We also presented the study in two international conferences to gain feedbacks, which helped refine the findings and contributions.

## Findings

### Social entrepreneurship interventions for HIV/AIDS problems

Our study reveals that social entrepreneurs employed four major intervention strategies – – the activities, processes, procedures and actions — for HIV/AIDS problems: *relational, service, economic, and policy*. Figure 1 shows the analytical coding process that led to the findings.

*Insert Figure 1 about here*

The term *relational interventions* are the SEs' strategies to improve the social relations and understanding between people with HIV/AIDSs and the public and healthcare workers by enhancing the dissemination of knowledge and information about HIV/AIDS to all stakeholders. This stems from the SEs realization that the first challenge in tackling HIV/AIDS is the stigmatization and discrimination problem that people with HIV/AIDS face. Relational interventions have three aspects: i) building public awareness, ii) educating healthcare providers, and iii) fostering cross-sector collaboration. These interventions are primarily micro (Rothman and Mizhrahi, 2014) in nature as they focus on helping individuals the SEs connect with each other.

*Building public awareness* is a common SE intervention used to de-mystify the HIV/AIDS problems and improve public perceptions and attitudes towards people with HIV/AIDS. It includes a range of tactics such as media and outreach campaigns, sports events (e.g., football training and competitions involving professional soccer players), and curriculum changes to include information on HIV infection (see Figure 1). When society is better informed about HIV/AIDS, its fear of HIV/AIDS sufferers generally decreases, and empathy increases, which lessens the fear of those with HIV/AIDS about seeking medical treatment (Treves-Kagan et al., 2016). We found myths about HIV/AIDS in the data (e.g., 'intercourse with virgins can cure HIV/AIDS', 'oral sex with a transsexual man will remove STIs'). The SEs in our study aimed to debunk these myths and demystify HIV/AIDS by educating communities about reproductive health and safe sexual behavior and misconceptions about people with HIV/AIDS. These SEs' interventions appear to align with the 'health awareness – health outcomes' hypothesis (De Walque, 2007). This is well illustrated in the following quote from Ashoka's website about Catherine Watson, the founder of StraightTalk newspaper and media in Uganda:

> [She] believes that only when the public openly talks about adolescence, sexuality and STDs [that] meaningful interventions will achieve lasting results. [She] started the *Straight Talk* [community] newspaper to provide adolescents in Uganda with frank information about sexuality and HIV/AIDS.…Around the radio shows, adolescents have formed listeners' clubs to discuss the issues and monitor each other's behavior.

Our study also found that the SEs in the 19 countries *educated healthcare providers* (e.g., doctors, nurses, and medical students) to enhance their awareness, sensitivity and empathy towards people with HIV/AIDS. The following quote from Ashoka's website about Glory Alexander, founder of ASHA Foundation and a fellow of Ashoka India, illustrates this:

> ASHA also provides sensitivity training to hospital staff and trains antenatal clinic nurses to act as counselors for HIV+ mothers... She secures a place for the Prevention of Mother to Child Transmission program by drawing out doctors' biases about HIV-positive persons and calmly refuting [their misconceptions] … with moving stories and hard evidence.

Importantly, we found that the SEs forged *cross-sector collaborations* and leveraged them as *resources* for their SEs. These include collaborations with corporations and labor unions, civil society (e.g., families, traditional healers, religious groups), NGOs, and the government to promote the well-being and rights of people with HIV/AIDS. They did this by disseminating knowledge about HIV/AIDS and by utilizing cross-sector partners' expertise, resources, and networks to support their SEs' mission. The following quote from Ashoka's web page illustrates these practices in presenting Benjamin C. Mbakwem's program, Ashoka Nigeria:

> By reaching [out to] local entrepreneurs…[He] gains business people's trust and offers them technical assistance and trainings for their apprentices…. He solicits their time to conduct education programs and workshops on sexually transmitted disease prevention and treatment, leadership, and counseling techniques.

*Service interventions* are the SEs' strategies to improve healthcare services in, and physical structures of, hospitals, healthcare clinics and communities to improve the well-being of people with HIV/AIDS. These interventions focus on developing *innovative healthcare services, models,* and *buildings*. Some of these interventions are material (utilitarian) in nature including new treatment approaches (e.g., herbal therapy, paying family members to be caregivers, and initiating mobile clinics, web-based support, community pharmacies, homeownership insurance to ensure that HIV patients continue to own their own homes to support the medical treatment processes). Other interventions were symbolic (normative) (e.g., using cultural, artistic, religious icons and activities) to enable change (Bourdieu, 1985; Foreman and Whetten, 2002), and some were hybrid material and symbolic (e.g., using play with toys for children as therapeutic methods and cultural symbol in media campaigns). For instance, the SEs created mobile service outlets to provide direct medical care and education to those isolated from information and services, or mobilized peers (with similar socio-economic and health conditions) to counsel other people with HIV/AIDSs; as quoted from Ashoka's website on Christine Du Preeze (Ashoka South Africa) and Linzi Smith (Ashoka South Africa):

> [Developing] a practical solution for reaching out to the farm workers on site with effective, reliable and regular healthcare solutions on HIV/AIDS... [Du Preeze's organization] also has an outreach program through mobile clinics to ensure that workers even from distant farms… are accessing the services conveniently.
>
> During these sessions, Linzi identifies potential peer leaders. One-on-one interviews are then held, with Linzi making selections based on criteria such as their willingness to speak about sex taboo topics in traditional Zulu culture. Selected men are further mentored by Linzi over a number of months. They learn tactics to persuade other men to take responsibility for their sexual behavior, and they learn to provide counseling and support for those in the company who are infected.

Another type of service intervention is to innovate the existing healthcare processes by, for example, establishing standards and protocols for medical treatment. As Samsuridjal Djauzi, founder of Yayasan Pelita Ilmu and fellow of Ashoka Indonesia, notes:

> [Djauzi] …developed standard operating procedure [SOP] for HIV diagnoses and therapy, which years later became the national standards for all hospitals and health clinics in the country….The protocols… [increased the staff's] acceptance of AIDS patients in hospitals. Now, almost every hospital accepts patients with HIV/AIDS and is able to conduct surgeries when necessary.

*Economic intervention* is another Ashoka SE strategy that seeks to develop economic resources of people with HIV/AIDS and to sustain the SEs' operations and mission. The economic interventions comprise *capacity building* and *leveraging cross-sector partners' resources*. We found that the Ashoka SEs adopted two types of capacity building. In the first, Ashoka SEs provided *free medication and basic needs* such as shelter and food to people with HIV/AIDSs that enabled them to meet their basic needs. The second capacity building type aimed to provide *economic empowerment* to the people with HIV/AIDSs and their families via vocational training and jobs with health insurance to help support themselves, get medical care, and to build their self-esteem and self-reliance; support for starting or maintaining microenterprises, and micro-financing. The use of the empowerment approach (Kabeer, 1999; Kerrigan *et al*., 2015) in the SEs suggests a growing need to increase clients' capacity and empowerment to making their own decisions to improve the quality of life rather than just receiving 'care' from social service agencies (Kmita *et al*., 2002). These interventions employ material (utilitarian) resources (e.g., non-collateral loans, jobs with health insurance) to enable HIV/AIDS patients to improve their economic resources, which in turn help them gain better access to health care (Bordieu, 1985; Foreman and Whetten, 2002). These are illustrated in Ashoka's description of Kallol Ghosh of Ashoka India and Margrethe Junker of Ashoka Uganda:

> [Kallol] has established a residential center that aims to meet their [street children's] basic housing, education, and healthcare needs…. protect them from the outside world but also help them integrate with surrounding social networks.
>
> Her [Margrethe's] model includes counseling, [HIV] testing, medical treatment and social support through microfinancing and other income-generating activities…to financially support themselves and their families. As people receive early treatment for infections and anti-retroviral drugs when needed, [and] training and opportunities for self-help, they continuously get stronger and healthier. Moreover, they gain confidence and strength and take leadership roles in the community and defy social isolation.

Another type of rarely discussed economic intervention is *leveraging cross-sector partners' resources* to render the SEs' HIV/AIDS-related treatments more affordable. For example, to lower the costs of HIV/AIDS medication, Georgina Alvarado, an Ashoka from the United States has 'negotiated partnerships with pharmaceutical companies who are her natural allies in the quest to provide the latest medicines to HIV patients in prison, at state expense'.

Lastly, *policy interventions* are SE's institutional (i.e., macro level) strategies to promote policy changes to help people with HIV/AIDS. They have grown as a response to government 'inefficiency' in addressing HIV/AIDS problems, especially due to the politically sensitive nature of stigmatized infectious diseases like HIV in some countries (Wu, *et al*., 2010). In doing so, the Ashoka SEs employed *advocacy* (legal, legislative, civil rights, workplace, and healthcare), published information/fact sheets, and sought news media on AIDS/HIV issues as tools to promote institutional and attitude changes to protect and better serve people with HIV/AIDS. In these interventions, the SEs always collaborated extensively with various stakeholders such as with government agencies, legislators, lawyers, patients, stigmatized (e.g., AIDS) groups, community leaders, corporations, labor unions, and religious groups. These interventions are essentially macro SW (Rothman and Mizhrahi, 2014) in nature as they focus on altering the social, political and economic structure as a means to enable change at the individual level. These are illustrated in Ashoka's description of Ashok K. Rao from Ashoka India and Zackie Achmat from Ashoka South Africa:

> To provide the necessary legal support to people living with HIV/AIDS, [Rao] networks with the lawyers …in Mumbai and …Bangalore. [He] has campaigned to guarantee women's property rights and nondiscriminatory education, provided adequate public health services, and implemented measures that will reduce the socioeconomic dependency of women.
>
> He [Achmat] is therefore building the grassroots Treatment Action Campaign [TAC] as a vehicle for poor communities to lobby collectively for [free] state provision of antiretroviral medications…to lobby the government to offer life-extending medications to the public and especially to the poor… TAC…sought to consistently and credibly challenge and dispel state arguments that HIV does not lead to AIDS, and that there are unsustainably high costs to rolling out a national treatment plan.

**Theorizing a typology of SE intervention in the HIV/AIDS sector**

The findings of the open coding process as shown in above Figure 1 allowed the researchers to identify SE interventions, which provide a foundation for further theorization. After cycling back and forth between the specific interventions employed by each of the 58 SEs (e.g., work-integration, peer-to-peer counseling, mobile gaming) and the cognate literature in three rounds of iteration and to eliminate overlapping concepts, we identified 46 unique SE interventions and proposed a typology of SE interventions in the HIV/AIDS sector based on three aspects: the *locus* of change, the type of *resources* used to enact social change and the nature of *client-SE relations* (see Table 2).

*Insert Table 2 about here*

We propose that the SE interventions contain both *institution-oriented* (e.g., policy advocacy, media campaigns, persuading lawmakers to enact legislative changes) and

*agent-oriented* (e.g., creating low-cost care or alternative therapy models for clients) practices, parallel to *macro* and *micro* SW practices, respectively (Austin *et al*., 2005; Rothman and Mizhrahi, 2014). Some of these SE interventions involve *material* or *utilitarian resources* (i.e., focusing on better healthcare services, technology and economic issues that prevent access to services ) to enable changes (e.g., creating income-generating microenterprises or small businesses for clients such as weaving, internet cafes, farming, motorbike/auto repair, rabbit and chicken breeding microenterprises) as well as *symbolic* or *normative resources* (e.g., using toys, dance and films, games, sports as symbolic tools to campaign against the stigmatization and discrimination towards people with HIV/AIDS) (Bourdieu, 1985; Cress and Snow, 1996; Foreman and Whetten, 2002; Moss *et al*., 2011). As client-SE relations are central to both SE and social workers' social value creation (Chandra, 2017; Germak and Singh, 2010), we propose a distinction between SE interventions that focus on *clients as recipients* (e.g., religious-, farming-, alternative home- or community-based therapy where clients are treated as 'patients') and as *co-creators* (e.g., peer-to-peer counseling and treatment, work-integration, skills building where clients become an integral part of the of services (solutions)).

Some of the SE interventions that we examined can be classified as *hybrid* (material and symbolic resources; institution- and agent-oriented) and thus appear more than once in Table 2. For instance, the use of 'toy therapy' by Jackie Branfield (an Fellow from South Africa and founder of 'Operations Bobbi Bear') serves as a *cultural tool* (macro) to fight against discrimination, and also as a counseling tool (micro) to assist sexually abused children cope with their psychic wounds. Accordingly, 'toy therapy' appears under both the institution/macro and agent/micro SW categories. As Table 2 suggests, SE interventions are *integrative* as the SEs embrace both institution-oriented (macro) and agent-oriented (micro) aspects in SW as well as material (utilitarian) and symbolic (normative) resources and also client-oriented.

Overall, we found that none of the Fellows used a single intervention in solving HIV/AIDS issues; rather all used *multiple* interventions. For example, Tahir Khilji (Ashoka Pakistan) employed HIV-positive transvestites as peer-counselors (i.e., peer-to-peer model); mobile research teams to collect data on the road (i.e., mobile clinic and research model); mobilizing volunteer medical doctors and lawyers to chat with people with HIV/AIDS and used the research findings to educate policymakers on HIV/AIDS (i.e., healthcare policy campaign); advocate for legal protection (i.e., legal advocacy). This shows the *richness and multidimensionality* of the SE interventions to solve HIV/AIDS problems in response to the complex and multidimensional nature of the HIV/AIDS problems.

## Discussion

Building on the conceptualization of SE as a hybrid of SW and business innovation practices (Bahar, 2017; Berzin, 2012; Germak and Singh, 2010), and as a tool to improve society's well-being and health (Roy *et al*., 2014; Millar, 2012), this article examined the interventions that 58 Ashoka SEs employed to solve HIV/AIDS problems. By analyzing the 58 SE intervention profiles using open coding approach, this article first identified

and summarized that SEs have mainly used four types of intervention. Based on this finding, the researchers further theorize 46 unique SE interventions according to their characteristics in three aspects: the locus of change, the type of resources used and the nature of client-SE relations (to be discussed in the next paragraph). It also explored how this study might advance SW research and practice. Our study is the first that examines Ashoka's entire sector of SEs working in the HIV/AIDS area (n=58) and offers at least three contributions to the SW literature.

First, this article contributes to the SW literature by demonstrating that Ashoka's 58 SEs solving HIV/AIDS problems use four major types of interventions: 1) *relational* (i.e., building public awareness, educating healthcare providers, and fostering cross-sector collaboration), 2) *service* (i.e., developing innovative healthcare services, models, and facilities), 3) *economic* (i.e., capacity building and leveraging cross-sector partners' resources), and 4) *policy* (i.e., policy advocacy, activism, publishing data on the problems, influencing stakeholders to provide cheaper drugs for people with HIV/AIDS) (see Table 2). These interventions solve individual- and institutional-level problems related to HIV/AIDS. Consequently, we theorize that SE interventions can be classified into a typology comprising the locus of change (*institution-oriented or macro SW vs. agent-oriented or micro SW*), the type of *resources* used to enact social change (*material/utilitarian vs. symbolic/normative*), and the nature of *client-SE relations* (*client as recipient vs. client as co-creator of interventions*). This typology offers a good starting point to deepen our understanding of the nature of SE interventions in the HIV/AIDS sector. Overall, this article reveals that SEs rarely employ a single or unidimensional strategy; instead, they employ *integrated and multidimensional SE strategies* to tackle HIV/AIDS problems.

Second, the study is the first that shows that, given the complexity and multi-dimensionality of HIV/AIDS problems, SEs did not merely combine macro-SW practices and business innovations (see Germak and Singh, 2010) but also embraced micro SW work practices including helping people with HIV/AIDSs deal with economic difficulties and improving their health knowledge via capacity-building approaches and working closely with key stakeholders (e.g., health workers, medical students, hospitals, NGOs, community leaders, volunteers, government, legislators, law enforcers etc.). Therefore, we reconceptualize SE as *multilevel and multidimensional processes* that *hybridize social work practices using various resources and approaches to create social value for and through clients in a financially sustainable manner*. These findings may shed light on new avenues for future SW research and practice as they support the use of integrative and inclusive approaches to tackle HIV/AIDS issues, and highlight the plausibility of combining macro and micro SW in SW research (Bahar, 2017; Rothman and Mizrahi, 2014) and to embrace new theoretical foundations (e.g., institutional theory and business management) into the heart of SW research and practice.

The *client as co-creator* concept suggests that not all solutions to HIV/AIDS problems should be developed by SW providers (e.g., SEs or social service agents). In fact, clients (e.g., people with HIV/AIDSs) could provide fruitful strategies and practices if included in the solution development process. This is in contrast to most studies in HIV/AIDS that are rooted in the *client as recipient* model (Foreman and Hawthorne,

2007). The *client as co-creator* model suggests the usefulness of partnering with clients such as people with HIV/AIDS, as *lead users* (Von Hippel, 1986). Clients can offer their deep insights based on their experience (e.g., in HIV/AIDS prevention, treatment, dealing with discrimination) into the problems they face, particularly problems for which the system has not yet found solutions.

Additionally, viewing the client-as-co-creator or lead-user enables SW scholars to define and/or expand upon the role(s) of clients, particularly given the growing complexity of social problems, their cost to society and the need to find workable, innovative solutions that will benefit the clients and thus the broader society. This is one area where SE can bring new insights to SW research and practice.

The *symbolic (normative)* or 'soft' resources from institutional and identity theory (Bordieu, 1985; Cress and Snow, 1996; Foreman and Whetten, 2002) could also inform future SW research and practice about the importance of changing society's values, mindsets, and attitude about HIV/AIDS issues. For instance, Grameen Bank's success in addressing poverty has not been solely driven by its small loans (material/utilitarian resources) to clients but importantly the '16 Principles' (see http://www.grameen.com/16-decisions/) (symbolic/normative resources) that promote behavioral change for its clients (e.g., "We shall build and use pit-latrines." (Principle #9) as a self-care tactic to prevent health problems that could reduce the efficacy of the small loans and the success of the program). The symbolic resources identified in this study (e.g., using dance, songs, films, sports, religious symbols, toys, mobile gaming to enact behavioral change) could be tested for their efficacy by comparing them with the use of purely material resources or a combination of the material and symbolic resources and thus could open avenues for future research.

The *economic development approaches* that the SEs employed to enhance clients' well-being, health and social status, such as work-integration programs, supporting/financing small businesses, providing insurance to protect homeownership, advocacy to protect people with HIV/AIDSs from being fired, remain understudied and rarely practiced in SW field. This gap separates SW from SE. It is well known that most SEs employ economic development models (e.g., the work-integration (WISE) (Spear and Bidet, 2005)), where a job is not merely a means to generate income but a *therapy* itself (i.e., for instance, Noor Huda Ismail, Ashoka Indonesia, designs a job system that enables its ex-terrorist clients to cook and serve customers as a "humbling process", which help them return to normalcy, or what we label "job as therapy"). Current SW research and practice tend to focus on clinical and social welfare issues but overlook how and to what extent clients can be rehabilitated and reintegrated into a mainstream lifestyle through jobs. This provides opportunities for future SW research to examine and test various 'job as therapy' (i.e., job design) models, drawing upon social-psychological and management theories.

Our study also suggests some partnership opportunities between SE founders/managers and social workers. For instance, Ashoka Fellows could partner with social workers and clients to enhance the efficacy of SE interventions. Or SEs and social workers could train local residents or clients as social workers so as to work together (see

Table 2) or clients could train social workers and SEs to view the problems from their perspectives. Currently, we know very little about how social entrepreneurs and social workers can work together to improve the current interventions and to devise new ones. This would enable researchers to compare the effectiveness of SE interventions when performed solely by SEs versus by social workers versus those that involve a partnership between SEs and social workers.

Our study further implies the need to lessen the gap between SW and SE research so as to advance SW research amid the growing complexity of social problems and the increasing need to create workable solutions and sustainable impacts that each field alone cannot solve sufficiently. For instance, market-orientation (Kohli and Jaworski, 1990), bricolage (i.e., creative ways to deal with constraints; Baker and Nelson, 2005) and humanistic management (i.e., seeing management as an ethical process to benefit society; Pirson *et al*., 2014) concepts could offer new avenues to study innovations in micro SW approaches. Likewise, emancipation (Wittmann-Price, 2004) and social movement research (Benford and Snow, 2000) could infuse new perspectives about liberating the oppressed people (including people with HIV/AIDS) and mobilizing the crowd to enact systemic change that offers breakthroughs for macro aspects of SW research.

Lastly, this article sparks questions about the plausibility and benefits of SW practitioners adopting the role of SE practitioners. During our analysis phase, we observed that many of Ashoka's (and non-affiliated) SEs had SW backgrounds (e.g., Maria Garcia-Lorenzo and Aicha Channa, Ashoka Philippines and Egypt). From a social position lens (i.e., institutional theory), social workers have natural strengths in 'social' resources (e.g., empathy, counseling, collectivism) and they can use their work experience in SW management/administration to enhance the economic resources (e.g., leadership, entrepreneurialism; see Chandra and Shang, 2017b) and add service innovation to their skills set. Hence, social workers are well positioned to take up SE work and to recognize that SE is not that mysterious and in fact, is aligned with much of SW values, practices and goals.

Some critics fear that the use of business and innovation practices in SE-SW might change how social workers work with clients (e.g., clients becoming a co-producer of interventions) or that it contradicts the purpose and values of SW. The global trend of nonprofit organizations embracing the SE model provides social workers the opportunities to experiment with SE-SW practice and to use evidence to assess its value to SW field. Obviously, SE is not a panacea for all social problems and more research is needed to understand its boundary condition.

This study is not without limitations. The sample size of this study was limited to 58 Ashoka SEs. Although we analyzed the entire population of Fellows working on HIV/AIDS-related issues (n=58) in Ashoka, our findings may be an artifact of Ashoka's definition of SE and its selection criteria, which highly values innovativeness. Thus, future research could examine the strategies employed by social entrepreneurs working in HIV/AIDS-related problems in other settings (e.g., Echoing Green, L3C social enterprises) and non-affiliated SEs and in the 'developed' world since most of Ashoka's SEs studied here were working in 'developing' and 'less developed' nations. Future

research can include larger samples and also surveys to test the efficacy of the SE strategies identified here. Importantly, future research can further explore the economic, technology and new clinical/therapy approaches adopted by SEs working in the HIV/AIDS to understand their efficacy compared to existing approaches. Furthermore, in SW research and practices, SE remains a 'contested terrain' (Choi and Majumdar, 2014) with scholars debating the boundary of SE (Young and Lecy, 2014), whether it is morally justified and ethically legitimate model to serve disadvantaged communities (Chell et al., 2016) or possibly a fraud (Stecker, 2016) due to its business practices. Future studies could look into how business practices and social interventions of SEs are possibly impacting upon clients and provide a better linkage between SE interventions and potential implications to disadvantaged population.

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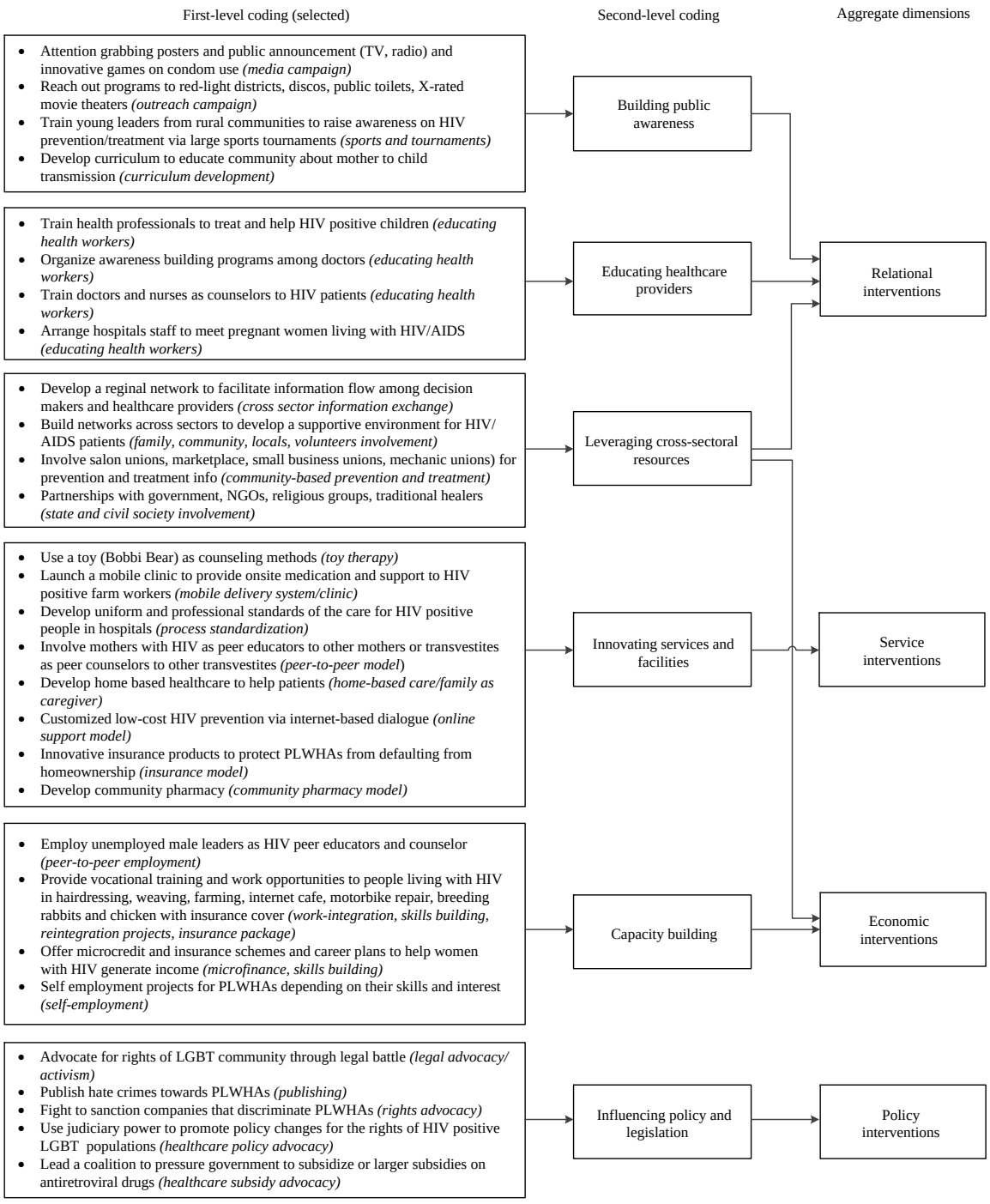
Table 1: A Distribution of Ashoka Fellows in the HIV/AIDS Sector

| Year of Fellow in the HIV/AIDS Sector Elected into Ashoka | # of Fellows |
|---|---|
| 1990-1999 | 16 |
| 2000-2009 | 35 |
| 2010-2016 | 7 |
| Total | 58 |
| | |
| Gender of Fellows in the HIV/AIDS Sector | # of Fellows |
| Male | 34 |
| Female | 24 |
| Total | 58 |
| | |
| Country of Origin of Fellows in the HIV/AIDS Sector | # of Fellows |
| Argentina | 3 |
| Bangladesh | 1 |
| Brazil | 3 |
| Burkina Faso | 2 |
| Chile | 1 |
| Colombia | 1 |
| Egypt | 2 |
| India | 7 |
| Indonesia | 6 |
| Mexico | 5 |
| Nigeria | 6 |
| Pakistan | 1 |
| Philippines | 1 |
| Poland | 2 |
| South Africa | 10 |
| Thailand | 2 |
| Uganda | 2 |
| United States | 1 |
| Uruguay | 2 |
| Total | 58 |

Table 2: A Typology of Social Entrepreneurship Interventions in the HIV/AIDS Sector

| | | Institution-oriented (macro social work) | | Agent-oriented (micro social work) | |
|---|---|---|---|---|---|
| | | **Material (utilitarian) resources** | **Symbolic (normative) resources** | **Material (utilitarian) resources** | **Symbolic (normative) resources** |
| **Client-Social Enterprise Relations** | **Client as co-creator** | Peer-to-peer counseling, mentoring, care | Peer-to-peer counseling, mentoring, care | Work-integration; Skills building; Sports/sports tournaments; Income generating projects; Empowerment; Small businesses with health insurance; Reintegration program; Peer-to-peer counseling, mentoring and care | Sports/sports tournaments; Empowerment; Music festivals |
| | **Client as recipient** | Lobbying government/policy makers; Healthcare policy advocacy; Educating health workers; Legal, rights advocacy/activism/assistance; Workplace advocacy; Fundraising for clients; Government funded homes; Cross sector information exchanges; Advocacy for free/subsidy for medicines; Community pharmacy model; Service standardization | Media campaign (creative, sensitive); Toy therapy as a symbol; Innovative games; Cultural and artistic activities; Religious and cultural leaders for legitimacy; Issue reframing; Health and legal awareness campaign | Low-cost care/medical care; Home-based care/nursing; Family support network/family as caregiver; Community-run sanctuary/health care centre; Government funded homes; Mobile delivery system/clinic/research team; Toy therapy as a method; Natural/alternative/traditional therapy; Monastery/farming therapy; Professional support networks; Volunteer model; Train locals as social workers; Voluntary HIV testing; Fee-based aftercare programs; Microfinance/microcredit; Insurance for homeownership; Low-cost mobile services; Online community support; Hotline service | Mobile delivery system/clinic/research team; Monastery/farming therapy; Family support network/family as caregiver; Music festivals; Mobile gaming; Toy therapy as a symbol; Religious and cultural leaders for legitimacy; Innovative games; Online community support |

Figure 1.Analytical Coding Process for SE Interventions in the HIV/AIDS Sector



## Appendix I: Gioia Method

In this study, we adopted the Gioia methodology (Gioia et al. 2013), a methodology for doing qualitative research that extends the grounded theory tradition developed by Strauss and Corbin (1997). The Gioia approach focuses on exploring and discovering new concepts, processes, or mechanisms. The final product of this approach is a process model or a "theory".

The Gioia's method starts with coding raw textual data to create *first-order concepts* (or 'open coding'). For examples, based on the Ashoka Fellows' profiles we coded openly these concepts: **'HIV-positive patients are sometimes rejected by hospitals' and 'Stigmatizing attitudes and acts of discrimination also come from nurses and doctors' as first-level codes**).

The next step is to merge the first-order concepts with similar content or ideas into *second-order themes* within a firmer theoretical realm (or 'axial coding'). For example, first-level codes 'HIV-positive patients are sometimes rejected by hospitals' and 'Stigmatizing attitudes and acts of discrimination also come from nurses and doctors' created earlier can be abstracted into '**Discrimination from health workers'** as a *second-level code*.

The last step is to aggregate the second-order themes into *aggregate dimensions* (or 'selective coding'). For example, second-level codes such as 'Discrimination from health workers', 'Exclusion in the labour market' and 'Rejection by schools' can be aggregated into '**Society stigmatization and discrimination**' as an aggregate dimension.

We portrayed the three-order of data analysis structure in Figure 1. This data structure provides an intuitive way for researchers to convey findings and eases readers or journal gatekeepers to easily follow the researchers' reasoning in transforming data to theory/model.

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## Appendix II: Ashoka Fellows

Ashoka is a global organization with a mission to find and support outstanding social entrepreneurs (or 'Fellows') with pattern setting ideas for social change (https://www.ashoka.org/). It provides funding, mentoring and networking support to elected fellows.

Ashoka has strict selection criteria and selects only the most outstanding SEs worldwide as Fellows based on five criteria: newness of the idea/solution, creativity/innovation, social impact, entrepreneurial quality, and ethics. Each Fellow has a profile that contains information about the *new idea* of the social entrepreneur, the *social problem* that the SE is trying to tackle, the *strategies* employed by the SE in solving the problems and *biographical background* of the social entrepreneur.

These profiles were written and maintained by Ashoka based on multiple rounds of interviews with social entrepreneurs by multiple interviewers and presented in a uniform format in Ashoka's website (https://www.ashoka.org/en/our-network).

A sample profile of the Fellow Fabián Medina Cabrera is provided below. Harley was elected as Fellow since 2002 and he has been worked in the HIV/AIDS sector in Colombia by providing an economic model that improves the quality of life of HIV/AIDS patients through work-integration and linking them to vital health benefits (https://www.ashoka.org/en/fellow/fabi%C3%A1n-medina-cabrera).

In this research, our focal attention was on the *strategies* employed by the Fellows as they represent the *interventions* employed by each Fellow.

# A Sample Strategy Profile of Ashoka Fellow Fabián Medina Cabrera

**THE STRATEGY**

Fabián's organization–Fundación San José Obrero–prepares people with HIV/AIDS for new sources of livelihood and advocates for their employment and viability as contributing members of society. By reconstructing their daily routine with a productive, gainful job at its center, Fabián helps HIV-positive individuals and those living with AIDS in Bogotá reintegrate into the mainstream with both social support structures including family, coworkers, and others living with HIV/AIDS, and with access to crucial medical assistance through a health benefits package.

The core element of Fabián's strategy is linking people with HIV/AIDS to small businesses, beginning with a weaving enterprise, through which he trains them in textiles, employs them, and in many cases links them to other businesses for longer-term jobs. Employees produce high-quality, woven products and various other handmade items, which Fabián sells at Colombian and international markets, including Swiss and Brazilian. Besides much needed income and a sense of contribution among a team of coworkers, Fabián's program offers access to healthcare realized through joint employee and employer contributions to state health benefits. As this initiative continues to grow, develops a market presence, and increases its revenues, Fabián plans to pay into additional social security benefits, including a pension that group members can leave to their immediate families upon death.

Understanding that his program by itself cannot train and employ all people with HIV/AIDS, Fabián is using the model employment atmosphere created through the weaving business to advocate for more acceptance within the mainstream workplace. Through seminars held at companies where the participants usually include board members, executives, and office administrators, Fabián conducts activities geared toward eliminating the stigma attached to people with HIV/AIDS. Having already held seminars in 20 companies and with new workshops being planned, Fabian has evidence that these efforts are achieving success in overcoming the discrimination that often confronts people with HIV/AIDS. In one workshop, after listening to his coworkers say that they would accept someone with HIV or AIDS, an employee stood up and said that he was both gay and living with AIDS. The man was not only able to come to terms with his identity within the workplace but also able to continue to work there. As a result of Fabián's workshops, several people who had been working in the weaving microenterprise have been contacted by their former employers and invited to return to their old jobs with full job security and health coverage.

Jobs provide more than just income and benefits. Because employment is often a key to social acceptance in Colombia, working helps people with HIV/AIDS reconnect with their families. Fabián fosters the reintegration of the family by incorporating family members into the microenterprises to work alongside their HIV-positive relatives. For cases of family estrangement, however, Fabián has set up small group homes in which the residents and their children construct an environment that emulates a family unit. These living arrangements–as well as Fabián's family reintegration initiatives–have had a profound effect on the participants' behavior, self-esteem, and personal outlook. Like the health insurance program, residents share the expense of the group houses with the foundation, which contributes 10 percent of operating costs.

Within five years, Fabián plans to establish new microenterprises and group homes in Baranquilla, Medellín, Cali, and several border towns–all areas of high vulnerability for an epidemic spread of HIV/AIDS. Although the Bogotá pilot strategy was to draw estranged people to the group homes first and then involve them in the microenterprise, Fabián intends to focus on the job-training and microenterprise components during expansion, using profits to open houses only when completely necessary. Having already gained interest for his project in three new cities through promotional events and appearances with program beneficiaries, Fabián has entered the early launch stage of a new graphic arts initiative in Cali.

A major component of Fabián's strategic plan for the coming years–fundraising events and outreach to high schools and universities–will garner new customers for the small business, attract investors, and increase public awareness of the issues surrounding HIV/AIDS. Fabián has also worked with the Global Health Fund for the Fight Against AIDS, the National University, and UNAIDS to advocate for larger health subsidies and sanctions against companies that do not abide by Colombia's laws protecting people living with HIV/AIDS. Fabián projects that his work will affect 10,000 people annually per program site.