



**HIV-Related Stigma and Discrimination in
Small Enterprises: Employers' and Employees'
Knowledge and Attitudes about
HIV workplace Policy in
Kabale, Uganda.**

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Dedication

To those experiencing HIV/AIDS-related stigma and discrimination at the workplace:

“We also have cases of a disease that you are researching about” (S, Mat).

Acknowledgement

This work would not have been possible without the assistance and cooperation of many people to whom I am deeply indebted:

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List of Abbreviations

ACORD	Agency for Co-operation and Research in Development
AIC	AIDS information Centre
AIDS	Acquired Immune Deficiency Syndrome
ARVs	Antiretroviral drugs
FAO	Food and Agriculture Organization
FHI	Family Health International
HDN	Health & Development Networks
HEMIL	Research Centre for Health Promotion
HIV	Human Immune Deficiency
ICRW	International Center for Research on Women
IFC	International Finance Corporation
ILO	International Labour Organisation
IOE	International Organisation of Employers
KANCO	Kenya AIDS Non governmental organisation Consortium
KFF	Kaiser Family Foundation
MoH	Ministry of Health
MoPS	Ministry of Public Service
NGOs	Non-Governmental Organisations
PLWHA	People Living With HIV/AIDS
SADC	Southern African Development Community
SAN	Stop AIDS Now
SEs	Small Enterprises
SMEs	Small and Medium Enterprises
SSA	Sub-Saharan Africa
TASO	The AIDS Support Organisation
UBoS	Uganda Bureau of Statistics
UN	United Nations
UNAIDS	Joint United Nations programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNRISD	United Nations Research Institute for Social Development
UPDF	Uganda Peoples Defence Forces
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

Abstract

Background: In its third decade, the HIV/AIDS epidemic continues to affect many people's lives in affected nations. In the world of work, the epidemic has brought about loss of productivity, increased labour costs, and loss of employment due to stigma and discrimination. Many people in the affected countries have lost their jobs due to their HIV positive status. HIV-related effects like stigma and discrimination lead to its denial. HIV-related stigma and discrimination present barriers to HIV prevention and treatment in different settings including the workplace. HIV stigma affects both large and small enterprises. However, small enterprises are more affected by stigma than large enterprises. Less attention has been paid to small enterprises in the fight against HIV/AIDS and its related effects.

In an effort to mitigate HIV stigma at the workplace, integrating effective HIV workplace programmes plays a big role. These programmes are enhanced by a clear and effective HIV workplace policy. However, many affected countries have not been successful in implementing these programmes due to unclear policies. Uganda is one of the African countries without a clear national HIV policy, an environment that may account for the lack of a clear national HIV workplace policy. Nevertheless, in Uganda a few large organisations have their individual HIV workplace policies. There is no either published information that shows any small enterprise with a HIV workplace policy in place or any research study about HIV- related stigma and small enterprises in Uganda. These are some of the factors behind this study's rationale.

This study sought to explore employers' and employees' knowledge and attitudes about HIV workplace policy and its impact in reducing HIV-related stigma in small enterprises in Uganda. To obtain the expected data, the following main research question was asked: how can small-scale entrepreneurs and their employees overcome the challenge of HIV-related stigma and discrimination at the workplace according to their knowledge and attitudes about HIV workplace policy? The following sub research questions were also asked in an effort to obtain enriched and diversified data:

- How can employees' and employers' knowledge and attitudes about HIV/AIDS help them in dealing with HIV-related issues at the workplace?

- What is the effect of integrating HIV workplace policy in the fight against HIV-related stigma among small enterprises?
- Which approaches do small-scale entrepreneurs and their employees use in managing HIV-related stigma and discrimination at the workplace?
- What are the challenges faced by both employers and employees due to HIV-related stigma and discrimination at the workplace?

Methods: The study employed a qualitative study design utilising a collective case study approach. Data were collected using in-depth interviews and observation. The transcribed data were analysed by coding it into themes from which units of meaning were derived.

Results: This study has confirmed the lack of HIV workplace policy in the participating small enterprises. There were few cases of HIV/AIDS denial in the visited small enterprises. Employees in small enterprises have limited knowledge about HIV workplace programmes. Some small-scale entrepreneurs do not bother to find out health-related problems from their workers. The majority of HIV support organisations have not reached out to small enterprises. Counselling and guidance, cautioning stigma perpetrators and cooperation are some of the approaches to stigma confirmed by this study. Unexpectedly, findings of this study have indicated that employees in the visited work sites do not fear HIV testing and disclosing their HIV status at the workplace although their perceptions towards HIV testing and disclosure are theoretical.

Conclusion: There is a need for effective HIV workplace programmes among small enterprises in an effort to mitigate HIV-related stigma. In this era of HIV/AIDS, enabling small enterprises to integrate a clear HIV workplace policy is one way of empowering small-scale entrepreneurs and their employees with skills and knowledge in the fight against HIV-related stigma at the workplace.

Chapter One

Introduction

1.1.0 Background

Globally, the HIV/AIDS epidemic continues to present an enormous impact in the affected societies. The latest Joint United Nations programme on HIV/AIDS (UNAIDS) epidemic update estimated the global HIV infection at 33.4 million as at the end of 2008 (UNAIDS, 2009a, p. 11). The International Labour Organisation (ILO) (2006, p. 3) estimated 24.5 million labour force participants (aged between 15 and 64 years) in 60 affected countries to be living with HIV/AIDS by the year 2005.

Sub-Saharan Africa (SSA) remains the region worst hit by HIV/AIDS epidemic. According to ILO (2004, p. 75), in the SSA region alone 18, 610, 517 people in their productive age were estimated to have been infected with HIV at the end 2003. In 2008, it was estimated that 72 percent of the world's AIDS-related deaths were in the SSA region (UNAIDS, 2009a, p. 21). According to Rosen et al (2004), in SSA, the epidemic has negatively impacted businesses in terms of increased labour costs and loss of customers. In respect to size, small enterprises in SSA face a big challenge as far as HIV/AIDS is concerned (Durier, 2007). However, the informal sector (small and medium enterprises) in SSA accounts for over 80 percent of the total job opportunities (ILO, 2002). On the other hand, small enterprises in SSA have been recognised for their role in the economic development (Murphy, 2002).

Uganda¹ is one of the worst hit countries by the HIV/AIDS epidemic among the Central and East African countries (Sengendo & Sekatawa, 1999). Research has revealed that the first HIV/AIDS case in Uganda was identified in 1982 (Asingwire, Kyomuhendo, Lubanga, Kakuru, & Kafuko, 2003; Kaiser Family Foundation, 2005). According to Asingwire & Kyomuhendo (2003), the first HIV/AIDS prevention programmes were established in 1986. The epidemic has brought about many related effects in the country including reduced labour force (Asingwire & Kyomuhendo,

¹Uganda is a SSA country situated in East Africa. It is a landlocked country bordering with Kenya to the east, Tanzania and Rwanda to the south, the Democratic Republic of Congo to the west and Sudan to the north (see appendix, I). In the year 2007, Uganda's population was projected at 28 million people (Uganda Bureau of Statistics, 2007).

2003), insecurity in employment and discrimination (Asingwire & Birungi, 2006; Garbus & Marseille, 2003) among others. Research studies show that by 1996, Uganda ranked first in the whole world with a high HIV prevalence rate (Cardwell (2000) and Boahene (1996) cited in Kironde & Lukwago, 2002). According to ILO (2007b), it is estimated that over 90 per cent of people living with HIV/AIDS (PLWHA) in Uganda were adults of working age as at the end of 2006. To date, UNAIDS estimates the number of PLWHA in Uganda to be between 870 000 and 1 000 000 (UNAIDS, 2009b).

In some parts of Uganda, HIV/AIDS has invaded certain communities and workplaces with alarming effects of loss of human lives, employment insecurity, HIV-related stigma et cetera. According to Ntozi, Mulindwa, Ahimbisibwe, Ayiga, & Odwee (2003), in Kabale district (South Western Uganda) the youths who are perceived to be the economic backbone of the country believe in having multiple sexual partners, a situation that puts them at risk of contracting HIV/AIDS. The same study revealed that barmaids in Kampala city (Central Uganda) mainly indulge in sexual activities to supplement their inadequate monthly salaries. Based on the above revealed HIV/AIDS trends, the business sector in Uganda ought to pay attention to the issue of HIV epidemic at the workplace, most especially amongst small workplaces.

1.2.0 HIV-Related Stigma and Discrimination at the Workplace.

World wide, research has shown that HIV-related stigma has hampered HIV/AIDS prevention, treatment, care and support (Aggleton, Wood, Malcolm, & Parker, 2005; Campbell, Foulis, Maimane, & Sibiya, 2005; Ickovics, White, Stasko, & Ghose, 2007; Piot & Seck, 2001). “HIV-related stigma has been deemed one of the greatest challenges to the fight against HIV infection” (Aggleton (2000) and Mann (1987) cited in Anderson et al., 2008, p. 791). Research findings show that HIV-related stigma prevents workers from disclosing their HIV/AIDS status to their employers and co-workers (Aggleton et al., 2005; Bharat, Aggleton, & Tyrer, 2001; Durier, 2007; Hadjipateras, Abwola, & Akullu, 2006; ILO, 2007b). PLWHA especially workers tend to perceive HIV status disclosure as a “signature” to one’s termination of employment by employers and harassment from co-workers (Werth, Borges, McNally, Maguire, & Britton, 2008). According to UNAIDS (2007), HIV-related

stigma refers to a process of devaluation of people either living with or associated with HIV and AIDS. Besides HIV/AIDS epidemic, HIV-related stigma has also been referred to as an epidemic on its own (Chesney & Smith, 1999; MacIntosh, 2007).

HIV-related stigma and discrimination have been revealed as the main obstacles that are slowing down the HIV/AIDS prevention, care and support in the SSA region (Greeff et al., 2008; Ogden & Nyblade, 2005). According to Rankin, Brennan, Schell, Laviwa & Rankin (2005, p. 702), “fear of stigma limits the efficacy of HIV- testing programmes across sub-Saharan Africa”. In respect to the workplace setting, it has been documented that HIV-related stigma presents major barriers to HIV/AIDS prevention, treatment, care and support to HIV positive employees (Fesko, 2001; ILO, 2007b; Miller, 2008; Stewart, Pulerwitz, & Esu-Williams, 2002) such as fear for HIV testing (Chesney & Smith, 1999). Worst of all, some studies have indicated that stigma prevents HIV positive employees from accessing antiretroviral drugs (ARVs) (Hadjipateras et al., 2006).

In Uganda, enterprises are impacted by HIV-related stigma too. Employers in particular are terrified by reduced productivity due to stigma-related effects like absenteeism and employee turn-over (Asingwire & Birungi, 2006; International Organisation of Employers, 2009). Considering how Ugandans have been affected by the epidemic, it is alarming to note that in a study done by the Uganda ministry of Health about Knowledge, attitude, behaviour and practice 53.5 percent of the study participants were against PLWHA to continue working with the uninfected (Uganda Ministry of Health (1995) cited in Monico, O-Tanga, Nuwagaba, Aggleton, & Tyrer, 2001). Similarly, in Garbus & Marseille (2003) and Monico et al (2001) some firms in Uganda dismissed PLWHA after falling sick due to HIV. However, the ILO code of practice is against any employer who dismisses a worker on grounds of their HIV status (ILO, 2002). It is probably due to an unclear national HIV/AIDS policy that the government of Uganda has not yet put in place clear guidelines to deal with HIV issues at the workplace. But, some few large enterprises and NGOs have implemented their own HIV workplace policies (Hadjipateras et al., 2006) and a few have got comprehensive HIV workplace programmes in place (Kironde & Lukwago, 2002).

In other parts of the world, HIV-related stigma continues to challenge different levels in society. In Kenya, it was revealed that some people fear to test for HIV/AIDS due to stigma and discrimination (Kenya AIDS NGOs Consortium, 2007). Likewise, in India many HIV positive workers fear to disclose their HIV status at the workplace due to fear of HIV-related stigma and discrimination (Bharat et al., 2001). In Puerto Rico, PLWHA experienced loss of social support, persecution and isolation et cetera as a result of HIV-related stigma (Varas-Diaz, Serrano-Garcia, & Toro-Alfonso, 2005). In fact according to Rau (2002) HIV-related stigma has hindered HIV/AIDS prevention efforts which in turn disrupts the firm's operations. A firm's operations may be disrupted if some workers start stigmatising their co-workers perceived to be HIV positive by refusing to work with them (Coetzee, 2003). However, positive employees ought to continue working because they need to earn a living as they interact with other people (Brooks and Klosinski (1999) cited in Werth et al., 2008).

Positively, HIV support organisations, policy makers and other actors have pledged to address HIV stigma at all levels including the workplace (Global-Unions, 2006; Seale, 2004; UN, 2008). It is noted that stigma affects people more than the epidemic itself (Kenya AIDS NGOs Consortium, 2007), thus, unless it is reduced, efforts directed to HIV/AIDS prevention may not succeed (Holzemer et al., 2007).

1.3.0 Statement of the Problem.

In the face of the HIV/AIDS epidemic, the majority of workers in developing countries like Uganda find work in the informal sector (ILO, 2009). However, like the large enterprises, research has revealed that small enterprises are equally affected by the HIV/AIDS epidemic (Durier, 2007; ILO, 2007b) but the majority of national and international HIV support organisations have not paid attention to them (ILO, 2007b). According to Stockols, McMahan, and Philips (2002), small enterprises are the most understudied organisations. In their book, "Researching the small enterprise", Curran and Blackburn (2001), also denote that small enterprises are under researched. This may provide an explanation for the existence of HIV-related stigma levels at the workplace (ILO, 2007b; Ogden & Nyblade, 2005; UNAIDS, 2007).

HIV-related stigma presents a critical hindrance to HIV/AIDS prevention, treatment, care and support (Fesko, 2001; ILO, 2007b; Miller, 2008; Stewart et al., 2002). Hence, if left unattended, HIV stigma will continue to hamper HIV/AIDS prevention strategies. Unless we realise and accept HIV-related stigma as a big challenge in the fight against HIV/AIDS, chances of succeeding will continue diminishing (ILO, 2007a). “It is time to make a concerted effort against stigma and discrimination in order to progress in the fight against HIV and AIDS” (Ogden & Nyblade, 2005, p. 7).

1.3.1 Purpose of the Study

To explore employers’ and employees’ knowledge and attitudes about HIV workplace policy and its impact in reducing HIV-related stigma in small enterprises in Uganda.

1.3.2 Research Questions

My overarching research question is: how can small-scale entrepreneurs and their employees overcome the challenge of HIV-related stigma at the workplace according to their knowledge and attitudes about HIV workplace policy?

This is supported by more specific research questions:

- How can employees’ and employers’ knowledge and attitudes about HIV/AIDS help them in dealing with HIV-related issues at the workplace?
- What is the effect of integrating HIV workplace policy in the fight against HIV-related stigma among small enterprises?
- Which approaches do small-scale entrepreneurs and their employees use in managing HIV-related stigma and discrimination at the workplace?
- What are the challenges faced by both employers and employees due to HIV-related stigma and discrimination at the workplace?

1.3.3 Relevance/Significance of the Study.

The study may benefit the health promotion field by exploring approaches that may be applied in the processes of enabling and empowering employees and their employers to overcome HIV-related stigma and discrimination at the workplace.

The study may play a role of creating awareness among different government sectors, non-governmental organisations (NGOs), policy makers, national and international

agencies (such as TASO, UNAIDS, WHO) et cetera by bringing to their attention the challenges of small enterprises and the integration of HIV workplace policy.

This study might fill up the existing information/literature gap. That is, whereas there is a large literature on HIV/AIDS in Uganda, the area of HIV-related stigma and small enterprises remains inadequately researched.

1.5.0 Thesis Structure.

This thesis is systematically organised into five chapters. The structure of this thesis follows the synopsis below:

Chapter One: Introduction

This chapter states the general overview of the study and all it entails including the background of the study, introduction of the problem, purpose of the study, research questions, and the significance of the study.

Chapter Two: Literature Review

This chapter provides general information published by other scholars about the study concepts. I will mainly discuss data about some countries (may narrow down to particular organisations) that have or have tried to implement HIV workplace policy. Challenges faced by small enterprises in implementing the policy will be discussed in relation to their impact in reducing HIV stigma. The chapter will end with the conceptual model of this study.

Chapter Three: Methodology

This chapter delineates research methods and procedures employed to obtain the required information including; research design, sampling strategy, data management, analysis, quality assurance, ethical considerations and limitations to the study.

Chapter Four: Presentation of Results

In this chapter, the study findings are presented. Other processes involved here include analysis of data.

Chapter Five: Discussion of Results

In this chapter, research findings are discussed. The link is made between the findings and the existing literature but mainly interpreting research findings. The chapter gives outlines policy recommendations and the study's main conclusions.

1.6.0 Definitions of Key Concepts

HIV-related Stigma and discrimination: HIV-related stigma refers to prejudice, negative attitudes, abuse and maltreatment directed at PLWHA (AVERT, 2009).

Small enterprises (SEs): In this study SEs are viewed in terms of organisation size, that is, the firm's number of employees. SEs in Uganda employ 5 – 50 employees (Kazooba, 2006). The definition of small enterprises varies from country to country.

HIV Workplace policy: The ILO code of practice (2002), describes HIV workplace policy as a guideline that provides a basis for putting in place a comprehensive workplace programme, combining prevention, care and protecting rights of PLWHA.

Policy: This refers to a purposive course of action followed by an actor or set of actors in dealing with a problem or matter of concern (Anderson (1975, p. 3) cited in Hill & Hupe, 2009, p. 5).

Chapter Two

Literature Review

2.1.0 Introduction.

In this chapter, I review and discuss the existing literature on HIV/AIDS and the world of work with emphasis on: successes and failures in the integration of HIV workplace policy in small enterprises; modes used by small enterprises in approaching HIV-related stigma; stigma challenges faced by employees and employers; and lastly strategies for overcoming HIV-related stigma. As mentioned earlier, less literature on HIV stigma and small enterprises exists than is the case with large enterprises.

2.2.0 Small Enterprises and the Integration of HIV Workplace Policy.

Globally, the workplace has been recognised as an important setting for health promotion in general (Eriksson, Jansson, Haglund, & Axelsson, 2008; Pritchard, 2004; WHO, 2009) and HIV/AIDS prevention, treatment, care and support in particular (Asingwire & Birungi, 2006; Global-Unions, 2006; ILO, 2007b). It is documented that efforts to prevent the epidemic have been hampered by HIV-related stigma (Aggleton & Parker, 2002; Aggleton et al., 2005; Baggaley et al., 1995; Herek, 1999; Ickovics et al., 2007). However, research studies show that the issue of HIV-related stigma has received little attention in regard to HIV/AIDS prevention (Ogden & Nyblade, 2005; Parker & Aggleton, 2003). Nevertheless, management in some firms might not be in position to track some of the HIV/AIDS-related effects such as HIV-related stigma (Forsythe, 2002). Hence, according to Forsythe:

“One way to address the indirect effects of HIV/AIDS is to establish a workplace policy that explains how the needs of infected workers should be addressed. Such a policy should promote a positive relationship among infected workers, their employer, and their colleagues” (Forsythe, 2002, p.34).

In addition, according to Phororo (2003) the HIV workplace policy can play an important role in protecting employees in small enterprises against HIV stigma.

Similarly, research findings reveal that many SSA countries have paid less attention to HIV-related stigma, a scenario that may contribute to the high prevalence rates of over 20 percent in the region (UK Consortium on AIDS and International Development, 2003). For instance, according to van der Borgh et al (2010), generally

there is a diminishing uptake of voluntary counselling and testing (VCT) services in the SSA region. As a result, Heineken brewing company through its HIV workplace programmes devised a strategy of confidential in-house VCT services among its employees and their spouses as one way to overcome fear for VCT at the workplace (van der Borghet et al., 2010). Due to high mortality rates caused by HIV/AIDS epidemic, in 2004 the government of Botswana called for the integration of HIV workplace policy in all enterprises especially the mining industry (SADC HIV and AIDS Unit, 2004). In Tanzania, the government implemented an informal sector development policy in 2002 with a priority of reducing HIV/AIDS-related effects (ILO, 2007b). According to Connelly & Rosen (2005), due to the devastating effects of HIV/AIDS epidemic in South Africa, some large enterprises were more or less forced to integrate HIV workplace programmes.

To realise a significant reduction in HIV-related stigma in both large and small workplaces, any country will require certain guidelines to follow. However, as noted earlier, many enterprises in Uganda do not have HIV workplace policies in place (Asingwire & Birungi, 2006; Kironde & Lukwago, 2002) due to limited resources to run these programmes (Asingwire & Birungi, 2006; Phororo, 2003) and lack of knowledge on workplace programmes (ACORD, 2004). Similarly, a study done in Uganda and South Africa revealed that even policy makers lack knowledge of HIV workplace programmes to address HIV related effects in the informal sector (Sabrina, 2004). In fact, according to ILO (2002) small enterprises in particular probably fail to integrate workplace programmes due to their limited access to important services from both national and international HIV support organisations. However, in Uganda the “neglected” small enterprises form the informal sector that employs majority (over 90 percent) of the workforce (ILO, 2009; UNDP, 2008).

In other parts of the world, concerning the HIV workplace policy integration, the trend is slightly different. According to Jorgensen et al (1996), in the US, only 16 percent of employers provide workplace HIV/AIDS education programmes and just 22 percent of the total workforce has attended such programmes. According to a Business Responds to AIDS (2004) survey, 73 percent of the American workforce revealed that it is the employers’ obligation to provide HIV workplace programmes to

their employees. However, it should be noted that small businesses comprise 99 percent of all employers in the US (USSBA (1998) cited in Stockols et al., 2002). Yet, in the US, a small enterprise employs 2-500 employees (Muchnick-Baku & Orrick (1992), USSBA (2000) cited in Stockols et al., 2002), unlike in Uganda where small enterprises employ up to a maximum of 50 employees (Kazooba, 2006). Other than social inequalities (Parker & Aggleton, 2003), studies done in the US (Herek, 1999) and in Nigeria (Adeyemo & Oyinloye, 2007) indicate that the integration of HIV workplace programmes results in health inequalities at the workplace.

In respect to the above reviewed literature, businesses/enterprises are called upon to join the fight against the HIV epidemic (Rau, 2002), that is, designing and implementing policies that enable them to effectively address HIV workplace issues (Miller, 2008). However, research indicates that small entrepreneurs are left behind as far as HIV/AIDS prevention programmes are concerned (ILO, 2007b; McKay & Romm, 2008) and this probably accounts for the limited data about small enterprises and HIV workplace related issues.

2.3.0 The Approach of Small Enterprises to HIV-related Stigma and Discrimination.

To a certain extent, HIV-related stigma has received world wide attention in as far as efforts directed to HIV/AIDS prevention are concerned (Aggleton et al., 2005; Hadjipateras et al., 2006; ILO, 2007b; International Centre for Research on Women, 2006; Stewart et al., 2002). Scholars like Heijnders & Van der Meij (2006), believe that cooperation in form of coming together as colleagues to help each other socially, psychologically and financially can solve the problem of stigma at the workplace.

Positively, there is documented information revealing that some SSA countries have responded to HIV-related stigma through HIV awareness and sensitization campaigns (International Centre for Research on Women, 2006). Studies done in South Africa (Dickinson, 2003; Heijnders & Van der Meij, 2006; van der Borghet et al., 2010) and Zimbabwe (Corbett et al., 2006) show that the option of VCT services at the workplace is being utilised as one way of checking on HIV/AIDS and its related effects such as stigma. According to Pulerwitz, Greene, Esu-Williams, & Stewart,

(2004), the majority of South African companies have responded to HIV-related stigma through anti-discrimination policies. Nevertheless, small enterprises have been reluctant to join the band wagon of integrating HIV workplace policy due to their financial constraints (Connelly & Rosen, 2005) and limited well informed human resources (Connelly & Rosen, 2005; Heijnders & Van der Meij, 2006; Sabrina, 2004).

In Uganda, some organisations have made a radical shift from exacerbating stigma to reducing it as one way of responding to any form of stigma at the workplace (Otolok-Tanga, Atuyambe, Murphy, Ringheim, & Woldehanna, 2007). One way in which small enterprises may effectively tackle HIV-related effects is probably through unionisation as union members are able to participate in some workplace programmes (Sabrina, 2004). Still, Sabrina goes ahead to reveal that small enterprises in Uganda have failed to form a labour union due to lack of government support. However, according to Pakkiri (2006) workplace programmes play an important role in mitigating HIV-related stigma and discrimination at the workplace.

Overall, as noted earlier, when it comes to understanding the role of organisations in the fight against HIV/AIDS epidemic, a large number of studies cite large enterprises whereas studies about small enterprises and HIV/AIDS remain scanty. In particular, I did not come across any study about how small workplaces are responding to HIV-related stigma and discrimination in Uganda. Small workplaces are lagging behind large enterprises in as far as HIV/AIDS intervention strategies are concerned (Ellis, 2006). However, in line with a study done by ESKOM South Africa, “to successfully address HIV-related stigma and discrimination, interpersonal aspects, such as social isolation, must also be directly addressed” (Pulerwitz et al., 2004, p. 10).

2.4.0 The Workplace and Challenges of HIV-related Stigma and discrimination.

Unlike other infectious diseases, globally HIV/AIDS has become a challenge to various levels of society in general and to the workplace in particular (Morisky, Jacob, Nsubunga, & Hite, 2006; O'Connor et al., 2009). It is argued that HIV-related stigma has serious individual and public health consequences like reluctance to test for HIV (O'Connor et al., 2009; Pulerwitz et al., 2004) and violation of human rights/workers rights at the workplace (Aggleton et al., 2005; Kohi et al., 2006; Seale, 2004). Due to

stigma, some positive workers fail to access treatment and end up losing their lives (Hadjipateras et al., 2006). On the other hand, some HIV positive workers have been fired from their jobs (Herek & Cogan (1995) et al cited in Devine, Plant, & Harrison, 1999) and at times denied the chance of going for further studies (Dieleman et al., 2007). In general, positive workers may suffer from stigma by co-workers and employers (Dodds et al., 2004; Pulerwitz et al., 2004).

In SSA, HIV-related stigma and discrimination continue to pose a big challenge to all countries in the region. In Southern Africa, mining companies were using screening to determine the HIV sero status of their workers (Malcolm et al., 1998). This implies that those found HIV positive were discriminated against in employment (ACORD, 2004). In South Africa, a volunteer worker was beaten to death for bringing shame to a certain community by disclosing her HIV status as positive (McNeil (1998) cited in Herek, 1999). In Botswana, a study done among HIV patients and health workers revealed stigma as one of the barriers in accessing ARVs (Weiser et al., 2003). In Kenya, HIV-related stigma hindered HIV positive nurses and doctors from disclosing their HIV status to patients (Waterman et al., 2007).

According to a few studies done in Uganda, HIV-related stigma and discrimination are critical hindrances to HIV/AIDS prevention and other related services (Hadjipateras et al., 2006; Kironde & Lukwago, 2002; Kyakuwa, 2009; Morisky et al., 2006; Tumushabe, 2006). Some of these studies have condemned HIV-related stigma for hampering workplace settings in the fight against the epidemic (Hadjipateras et al., 2006; Kyakuwa, 2009) especially the impeding of the integration of HIV workplace policy (Hadjipateras et al., 2006; Pulerwitz et al., 2004). On a positive note, the Uganda Ministry of Public Service recognises that unnecessary stigmatisation of HIV positive workers brings about reduced performance (Uganda Ministry of Public Service, 2007). Equally, Uganda's 1995 constitution prohibits any form of discrimination - which can be broadly interpreted to include HIV-related discrimination (Republic of Uganda, 1995). However, it is surprising to note that the current president of Uganda who has been praised for fighting HIV/AIDS (Allen & Heald, 2004) supported the policy of dismissing or not promoting any HIV positive army officer of the Uganda Peoples Defence forces (UPDF) (Tumushabe, 2006).

HIV-related stigma challenges are not confined to the SSA region alone, other parts of the world follow suit. In India, informal operators (like food vendors) suspected to be HIV positive are kicked out of the streets by police (Bharat et al., 2001). In the UK those believed to be HIV positive face violence at the workplace and are discriminated against in the employment setting (Anderson et al., 2008). A study done in two cities of Canada indicates that HIV positive workers and PLWHA are not welcomed at the workplace, “He [employer] came to me and basically said it would be better if I left. He said the others did not want an HIV-person around” (Maticka-Tyndale, Adam, & Cohen, 2002, p. 1360). A study done among HIV positive Puerto Ricans revealed their experiences of depression, guilt and isolation due to HIV stigma (Varas-Diaz et al., 2005). In the US, “AIDS-related stigma and discrimination in employment, health care, insurance, education and other realms has been widely reported since the early days of the epidemic” (Herek, 1999, p. 1108).

HIV/AIDS activists, the media and other actors all over the world have optimally expressed their discontent to HIV stigma. WHO (2009) argues that HIV stigma has had a profound effect by preventing people from getting tested and accessing ARVs. According to the UN Secretary General Ban Ki Moon, “[...] stigma is a main reason why too many people are afraid to see a doctor. People fear the social disgrace of speaking about it. [...]” (UN, 2008). For instance, in a Ugandan newspaper, Namaganda (2009), reported that Noerine Kaleeba a former employee with UNAIDS and co-founder of TASO feared to test for HIV after losing her husband due to HIV/AIDS in 1986, Noerine says “*I lived, planned and worked as if I had HIV [...]*”.

The above challenges imply that HIV-related stigma ought to be addressed at all levels (International Centre for Research on Women, 2009) including the workplace to realise improved productivity and economic development (Asingwire & Birungi, 2006; Habiyambere & Narain, 2000; Hadjipateras et al., 2006; ILO, 2007b).

2.5.0 Overcoming HIV-Related Stigma and discrimination at the Workplace.

There is ample evidence to show that a good number of HIV positive workers in many parts of the world have been stigmatised due to HIV&AIDS (Adeyemo & Oyinloye, 2007; Anderson et al., 2008; Dieleman et al., 2007). Based on research publications

ILO is among a few international organisations that have come up to support the informal sector in the fight against HIV/AIDS while using the workplace setting (ILO, 2007b). At large, the ILO through its Code of Practice on HIV/AIDS and the World of Work (2002) has vowed to conquer stigma at the workplace using one of its key principles: non-discrimination principle. The principle states;

HIV/AIDS is a workplace issue, not only because it affects the workforce, but also because the workplace can play a vital role in limiting the spread and effects of the epidemic. There should be no discrimination or stigmatisation against workers on the basis of real or perceived HIV status (ILO, 2002, p. 9).

SSA region will require clear workplace policies, if it to realise reduced HIV-related stigma. According to Habiyambere & Narain (2000), improving the quality of life for PLWHA in resource-constrained settings requires clear policies. Probably due to clear policies, home-based care services in Kenya have played a significant role in reducing HIV stigma in some parts of the country most especially among the self employed (Waterman et al., 2007). In Zambia a study done by Dieleman et al (2007) indicated a need for a national HIV workplace policy in reducing stigma and other AIDS-related issues among health care workers. According to Piot and Seck (2001), the South African government enacted the Employment Equity Act to check on the practice of HIV screening as a pre-employment condition. There are a few research findings which have indicated that self-isolation, avoiding and withdrawing from social situations reduce HIV stigma (Greeff et al., 2008; Maman et al., 2009). However, a study done in one of the South Africa's multinational companies revealed that the strategy of creating an open environment to reduce the fear attached to HIV testing failed due to lack of clear national policies (Dickinson, 2003). Equally, a survey done in four African countries revealed that the implemented policy among the selected companies did not meet the intended goal due to unclear guidelines (D'Cruz, 2003).

In Uganda, the Ministry of Public Service (MoPS) adopted HIV workplace policy in an effort to reduce HIV-related stigma and other HIV-related effects affecting its employees (Uganda Ministry of Public Service, 2007). In the context of HIV-related stigma, the policy stipulates that “public officers living with HIV/AIDS shall be protected against stigmatisation and discrimination at the workplace” (Uganda

Ministry of Public Service, 2007, p.04). As noted earlier, unless there is an unpublished policy, to-date, the Ugandan government has not enacted a national HIV workplace policy neither is there any small enterprise in the country with an HIV/AIDS workplace policy in place. Perhaps this is due to poor out reach of small enterprises by HIV support organisations in some parts of the world (ILO, 2007b).

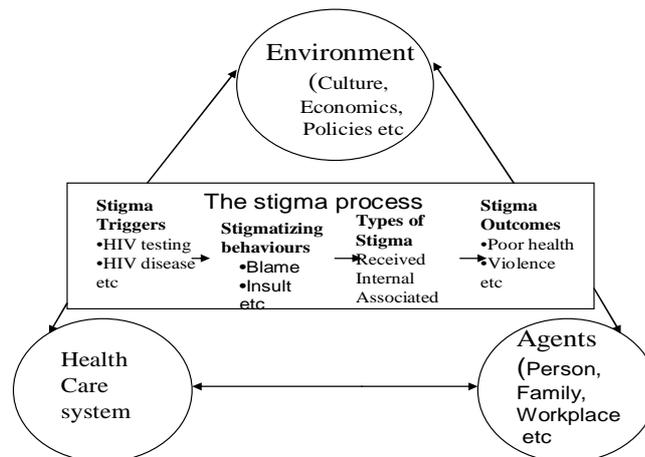
In the developed world, the issue of overcoming stigma has taken a new shape. In the US, HIV activists advocated for transparency or openness (such as a national register for PLWHA) as one measure of surmounting the impact HIV/AIDS in general and stigma in particular (Gostin, Ward, & Baker, 1997). However, this was seen to cause delays in HIV testing (Herek, 1999). Instead a study done in Florida state revealed that high knowledge levels on HIV are important in preventing anxiety, distress and fear that may be caused by the epidemic among workers (Keeton, 2004).

To sum up, when HIV/AIDS first made headlines around the world, acquiring it meant an inevitable early death. In Uganda, HIV/AIDS was stereotyped as a “death ticket”. Some groups perceived or continue to perceive it as “evidence” to sinning or immoral behaviours (Hadjipateras et al., 2006; Herek & Capitanio, 1999; Muyinda, 1997; Waterman et al., 2007). Whereas PLWHA like Retired Major R. Ruranga have lived with the virus for more than two decades (Ross, 2004), “denial and stigma still stand in the way of fighting the disease” (The Monitor, 2010). At the workplace, HIV-related stigma continues to slow down the efforts directed at overcoming the epidemic (ILO, 2001). Hopefully, “African enterprises are beginning to assume greater responsibility for HIV/AIDS in the workplace” (Murphy, 2002, p. 65).

2.6.0 Conceptual Model

Figure one below depicts that the interaction between environment, health care system, and agents has an influence on the stigma process.

Figure 2.1: Original Model of Dynamics of HIV/AIDS Stigma.



Source: Holzemer, L.W., et al (2007): A conceptual model of HIV/AIDS stigma from five African countries. *Journal of advanced nursing*, P.546.

The model above (fig. 1) was developed out of the study carried out among PLWHA and nurses in five African countries by Holzemer and colleagues (2007). In their study, environmental factors including culture, politics and policy among others are said to have an influence on agents. The authors assert that politics in form of power relationships may influence the approach taken towards people living with HIV/AIDS in their cultural, legal and policy environment. The model predicts gains by those who use the power status to stigmatise others. However, they note that there is limited understanding about the elements that increase and decrease stigma. In their study, healthcare settings are seen as primary settings for triggering stigma, nonetheless, they are said to be potential sites for anti-stigma interventions. Agents of stigma include family members, work colleagues et cetera. Holzemer et al (2007) denote that individuals may at times self-stigmatise. Their results indicate that co-workers, family members and community members also stigmatise people living with HIV/AIDS. The stigma process forms a chain of four elements including stigma triggers, stigmatizing behaviours, types of stigma and outcomes of stigma.

However, for the purposes of this study, emphasis was put on one of the environment factors (HIV workplace policy), stigma in general and one form of stigma agents (Individual level encompassing only employees and employers). On the other hand,

there is enough evidence of HIV-related stigma incidents in the health care setting (Anderson et al., 2008; Green, 1995; Kohi et al., 2006; Paxton et al., 2005; Surlis & Hyde, 2001; Varas-Diaz et al., 2005). However, the health care setting is not within the boundary of this study as illustrated in the modified model below.

Figure 2.2: Modified Model of Dynamics of HIV/AIDS Stigma

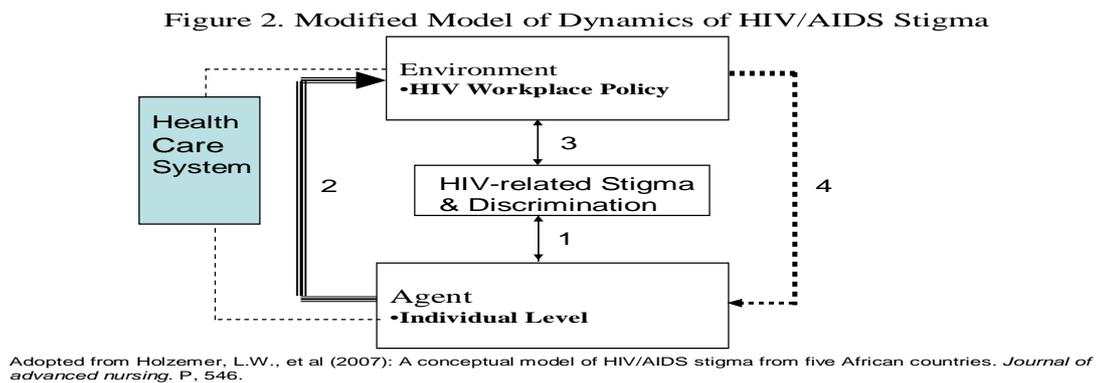


Figure 2 above guided me in approaching my research questions. I used the model of dynamics of HIV/AIDS because it is more or less in line with my main study theme - HIV/AIDS and the workplace. Because some variables in the original model such as the health care system were not targeted by my study, I had to come up with a modified model (fig. 2). Linking my study to the modified model, I explored how the agents (employees and employers) approach HIV-related stigma (1), which interventions have the individual put in place to check on HIV-related stigma (2), the challenges faced at the individual level and the limitations to the environmental factors (HIV workplace policy) (1&3) were also explored. The two-way arrows (1 and 3) imply that whereas HIV-related stigma has an effect on the individual, the individual also responds in trying to overcome it (\Leftrightarrow) and; whereas the policy tries to reduce HIV-related stigma, HIV-related stigma may also in turn hinder its implementation effectiveness (\Leftrightarrow). This reciprocity is also theoretically illustrated in the in the ILO's non-discriminatory principle above (see the quote in section 2.5.0). Lastly, this study is built on the assumption that maximum cooperation between employees and their employers results in an effective workplace policy that can assist the individual (employees and their employers) in overcoming the problem of HIV-related stigma (4) at the workplace as shown above.

Chapter Three

Methodology

3.1.0 Introduction.

This chapter presents the study's procedures including study design, sampling strategy, data collection, data analysis, quality assurance methods and ethical issues.

3.2.0 Study Design.

The nature of this study - HIV workplace policy integration - called for a qualitative research design that utilised a case study approach. According to Stake (1995), a case study is a study of the particularity and complexity of a single case coming to understand its activity within important circumstances. Stake goes ahead to state that the three main elements of a case study are description, issue and interpretation.

I chose a case study design because it enables the researcher to explore and understand the meaning of individuals or groups that ascribe to a social or human problem (Creswell, 2009). Although this study possesses the above three mentioned elements according to Stake, it is not a single case study but a collective/multiple case study involving three workplaces (cases) though embedded/holistic in design (Yin, 2009). According to Miles & Huberman (1994b, p. 157) "the purpose of a collective case study is to increase generalizability, reassuring oneself that the events and processes in one well-described setting are not wholly idiosyncratic [...] seeing processes and outcomes that occur across many cases or sites and understanding how such processes are bent by specific local contextual variations". In another edition, Miles and Huberman (1994a, p. 26) argue that "multiple case studies offer a researcher an even deeper understanding of processes and outcomes of cases [...] and a good picture of locally grounded causality". I chose a collective case study approach because I wanted to explore people's knowledge and attitudes towards HIV workplace policy in more depth and to acquire a complete picture by using multiple workplaces/cases.

3.3.0 Sampling Strategy

This study used purposive sampling. Purposive sampling allows researchers to choose a case (or cases) because it illustrates some feature or process of their interest

(Silverman, 2006). This study was conducted in three small enterprises (three cases). Generally, in Uganda small enterprises employ up to a maximum of 50 employees (Kazooba, 2006). I chose enterprises that I was able to access and also considered the issue of replication (Yin, 2009) as recommended especially in collective case study approaches (Stake, 1995; Yin, 2003). Considering the issue of language and other circumstances, I decided to carry out this study in my home district (Kabale) in which I am familiar with the language. The majority of workers in Kabale speak my mother tongue (Rukinga).

3.4.0 Data Collection

Data for this study were collected from eighteen study participants selected from three small-scale enterprises in Kabale district, South Western Uganda (appendix, I).

3.4.1 Methods of Data Collection

For the purposes of this study, the emphasis was put on primary data. Data were obtained from participants by use of in-depth interviews and observation methods. However, I mainly used in-depth interviews (Eighteen interviews) whereas observation was intermittently applied due to limited time. According to Kvale (1996), interviews are conversations where the outcome is a coproduction of an interviewer and a participant. Two common methods of interviews include structured and unstructured/open-ended interviews. Elizabeth Hoffmann looks at open-ended interviewing as a method that often uses a simple, straightforward structure of a predetermined set of questions (Hoffmann, 2007). The open-ended interview guide employed in this study comprised of open-ended questions like; what is HIV-related stigma and discrimination? Why do you think some employees fear to test for HIV? What is the relevance of HIV workplace programmes to your health? Et cetera.

3.4.1 Data Management

While in the field, I made sure each interview was recorded. I did this by noting down main points and key examples/quotes on rough copies during the actual interview. I would embark on rewriting the interviews every evening, an exercise that enabled me to produce fair interview scripts that were later used in the data transcription process.

3.5.0 Data Analysis

Data collected using in-depth interviews were coded (Gibbs, 2007) and grouped into themes that were analysed manually in line with Creswell's six steps of qualitative data analysis (Creswell, 2009) (see appendix, G). This study was designed to explore employees' and employers' knowledge and attitudes about HIV workplace policy in relation to its role in reducing HIV stigma in small workplaces. Being a qualitative case study in nature, methods of data analysis utilised a qualitative data analysis. According to Creswell (2009, p. 183), "the process of qualitative data analysis involves making sense out of the text and image data". In his earlier edition, he argues that during this process, the researcher, through continual reflection about the collected data, moves deeper to understanding [...] and deriving an interpretation [...] (Creswell, 2003, p. 190).

As earlier mentioned, I collected data using qualitative methods of in-depth interviews and observation. Data were then transcribed into texts, coded and tabulated to ease the data analysis process (Gibbs, 2007). The transcribed data were then categorised into both descriptive and analytical codes using the themes developed earlier in the interview guides such as the demographic information (table. 4.1), integration of HIV workplace policy et cetera. In line with Creswell's second step (organising and preparing data for analysis), the categorized data consisting of tables (displaying descriptive and analytical codes) were meant to simplify the study's final analysis and interpretation processes (for the sample, see appendix, H).

Finally, my interpretations were linked to the modified conceptual model of dynamics of HIV/AIDS stigma (fig. 2.2) adopted from (Holzemer et al., 2007). This comparison enabled me to come up with valid study conclusions (see end of chapter five).

3.6.0 Quality Assurance Methods

This study's data quality was guaranteed through validating the interview guide, checking the study's reliability and paying attention to the positionality of the researcher. The three methods are explained further in the following subsections:

3.6.1 Validity

According to Kvale (1996, p. 88), validity means whether an interview study investigates what is intended to be investigated. My experience in interviewing

obtained while working with different lecturers at the Institute of Psychology, Makerere University as a research assistant, motivated me to carry out the interviews myself as another way of increasing data validity. My decision is supported by Kvale (1996, p. 225) who says that, “The strengths of qualitative studies are their detailed descriptions and use of the researcher as an instrument”. Furthermore, I endeavoured to control my effect as a researcher by trying as much as possible to be objective. Lastly, in another way of ensuring data validity, questions of “what” and “why” were asked before the questions of “how” (Kvale, 1996; Stake, 1995; Yin, 2003, 2009).

3.6.2 Reliability

Reliability is concerned with how a study can be replicated in another setting. Before I commenced with the actual fieldwork, I tested my interview guide using a small grocery shop, which was employing 5 - 10 employees at the time of interviews. According to Kvale (1996, p. 88), reliability refers to the consistency of research findings. However, Kvale notes that reliability issues need attention during interviewing and other preceding stages. While in the field, I also ensured reliability by sometimes using leading questions (Kvale, 1996) such as, “since you have ever been stigmatised tell me the challenges you went through?” after an interviewee had referred to a stigmatising incident. Kvale (1996, p. 286), asserts that “the qualitative interview is well suited to systematically using leading questions to check the reliability of the interviewee’s answers”.

3.6.3 Role and Effect of the Researcher

In addition to designing this study, I was fully involved in the study by playing a role of an interviewer and observer. This enabled me to capture the real meaning of the whole study problem. After the interviews, I went ahead to analyze the collected data from the field and wrote a thesis. Because I chose to carry out this research in my home district, some of the participants may have not felt free to share their views with me. However, I tried to be neutral in the whole research process so that I could get unbiased data. In addition, I presented myself as a learner and also treated my study participants as experts. However, doing this study in my home area granted me flexibility in language use. That is, I never had any problem with participants who did not understand English. That is, I was able to ask questions in my mother tongue

(Rukinga) and English depending on the participant's choice. In addition, my gender (as a male) probably influenced this study's findings in a positive manner. This is because as a male, I stood a good chance of getting a big chunk of unbiased data as one of the sites was composed of males only. My argument is line with Lewis (1970) who notes that both females and males disclose easily to same sex counterparts. Unintentionally, in all the three visited worksites, the total number of females came out small compared to their male counterparts.

3.7.0 Ethical Issues

According to Kvale (1996) ethical decisions do not belong to a separate stage of interview investigations but they can arise at any time. It is important to consider these issues from the beginning of the study to the end (dissemination). For instance, while in the field, an imbalance between my interests as a researcher and the perceived benefits to my study participants arose and resulted in demand for financial incentives. To my surprise, when I called a certain woman while trying to request an appointment, her first response was, "Will you give me money equal to what I earn a day?" With my research experience and creativity, I unravelled the financial incentive misconception among my study participants by telling them that my study was purely an academic research that cherishes voluntary participation rather than market research (Krueger & Casey, 2000).

Another vital ethical issue considered while in the field was about participants' HIV status. Based on the sensitivity of my study (HIV-related stigma and discrimination), asking a participant if he/she has tested for HIV may instead appear to be a source of stigma. I approached the sensitivity issue by use of indirect questioning. For instance, questions like (have you ever advised your co-workers to test for HIV? If yes, why?) led to answers like; "[...] after testing positive that is when I got courage to start advising others to take HIV test so that they can know their status [...]" (see chapter four). Furthermore, based on Lee's (1993) argument, my main data collection method - interviewing, which in most cases guarantees a researcher's presence - enabled me to overcome possible negative emotions in my participants that would be caused by my study. As mentioned earlier in the validity section, I did the interviewing myself

hence, my presence/interaction with my study participants was guaranteed. In his book “Doing research on sensitive topics” Lee states:

On one hand, it can be argued plausibly that when an interviewer is not present respondents are less likely to feel threatened by questions about sensitive questions. On the other hand, it can also be argued that the presence of an interviewer encourages respondents to feel relaxed and therefore more forthcoming (Lee, 1993, p. 98).

Details of other ethical issues considered in this study include the following:

3.7.1 Study Participants’ Rights and Welfare

My study participants were guaranteed a right to know the purpose and findings of this study. My study participants held a right of terminating the interview in case one wished to do so (see informed consent: appendix, D). My study could raise some emotions amongst my study participants while in the field. Hence, it was necessary to advise them to visit the AIDS Information Centre (AIC), Kabale branch for some counselling services as anticipated and planned. However, whenever responding to some few questions asked by any study participant after the interview, I always based my argument on the premise that both employees and employers are responsible for HIV-related stigma issues at the workplace.

3.7.2 Informed Consent

I informed my respondents about the purpose of my study orally and in text by giving them a written consent form (appendix, D). According to Kvale (1996), through briefing and debriefing, study participants should be informed about the purpose and procedure of the study. Frankfort-Nachmias and Nachmias (1996), refer to an informed consent as the procedure by which individuals choose whether to participate in an investigation after being informed of facts that are likely to affect their decisions. The written consent form requires a signature from a potential participant as an agreement to participate in the study. The consent form stipulates one’s right to withdraw his/her involvement in the study at any time irrespective of signing it.

3.7.3. Confidentiality

During this study, I endeavoured to extend adequate confidentiality to my study participants due to the sensitivity of the topic and the dynamics of small workplaces.

According to Kvale, (1996), confidentiality in interview research implies that private data identifying the subjects will not be reported. The protection of subjects' privacy by changing their names and identifying features is an important issue in the reporting of interviews (Kvale, 1996). In addition, I ensured my participants' confidentiality by considering some guidelines given by Krueger & Casey (2000) including describing the purpose of the study to participants, telling them the target audience, describing how results will benefit small enterprises in general, and telling them how interview texts will be used and kept et cetera.

3.7.4 Protection of Disrespected Groups

A certain group in any enterprise may be marginalised and/or disrespected. For instance, both the employer and employees may undervalue a group of cooks. During this study, I tried to extend extra care to such groups especially when it came to thesis writing. For instance, in this thesis I generalise all employees as casual workers so that I do not lead a certain unit of employees to be further disrespected/marginalised or even be stigmatised and discriminated as result.

3.7.5 Ethical Clearance

All fieldwork preparations started while I was still in the University of Bergen, Bergen-Norway. I obtained an introductory letter (appendix A) from my supervisor after handing in my research proposal to the Research Centre for Health Promotion (HEMIL), University of Bergen. On arrival in Uganda, I applied to the Uganda National Council for Science and Technology (UNCST), a national body that is responsible for clearing whoever wishes to do research in the country. In my application to UNCST, I attached my introductory letter to ease the clearance process. Within few days, both the president's office (appendix B) and the UNCST office (appendix C) approved my study. Having been cleared by UNCST, I proceeded with seeking permission from the entrepreneurs of the identified three enterprises that served as cases for my study. I did this by giving them copies of my introductory letter from my supervisor and a clearance from UNCST.

Chapter Four

Presentation of Results

4.1.0 Introduction

This chapter presents results of the study including four sections, namely, knowledge and attitudes about HIV/AIDS in the workplace, HIV workplace policy integration, approaches to HIV-related stigma, challenges of HIV-related stigma and the perceived strategies for overcoming HIV-related stigma at the workplace.

4.2.0 Demographic Information

Table 4.1: Demographic variables

Variable	Category	Number	Total
<i>Gender</i>	Male	11	18
	Female	7	
<i>Level of operation</i>	Casual	14	18
	Supervisor	1	
	Entrepreneurs	3	
<i>Type of SE</i>	Carpentry	5	18
	Matchbox factory	7	
	Bakery	6	

This study comprised eighteen participants who were purposively selected from Kabale district, South Western Uganda. Study participants were categorised into two groups of employees and employers as shown in table 4.1 above. The employee's group was composed of nine males and six females whereas the employers group had two males and one female. Out of eighteen participants, fourteen were casual workers, one supervisor and three entrepreneurs as indicated in the table above. The types of workplaces visited were Carpentry, Matchbox (small-scale) factory and a Bakery. All these enterprises were employing 9-25 employees at the time of the interviews. The following sections present views from the selected study participants. Although their views cannot represent all small-scale workers in Uganda, some lessons concerning worker's knowledge and attitudes about the integration of HIV workplace policy and reduced HIV-related stigma can be learnt from this study.

4.3.0 Theme One: To Explore Employees' and Employers' Knowledge and Attitudes about HIV/AIDS at the Workplace.

4.3.1 Employees:

Considering the main theme of this study (HIV and the Workplace), it was deemed vital to scan the participant's general knowledge and attitudes about HIV/AIDS in the workplace. Contrary to my expectations, few participants mentioned HIV/AIDS when asked to name common diseases affecting them at the workplace. Out of the fifteen employee participants, only four participants cited HIV/AIDS. However, out of the eleven participants who did not cite HIV, later in the interview, one of the participants denied the epidemic's presence and another participant feared to mention the word HIV/AIDS as seen below:

"HIV is not a threat to this enterprise, it may be in other enterprises" (M. Cap).
"We also have cases of the disease that you are researching about" (S. Mat).

Nevertheless, participants reported to have had positive and negative HIV status disclosures from close relatives and friends. Alarming, out of the fifteen employee participants, only one participant revealed to have had a negative HIV status disclosure leaving the twelve participants with positive disclosures and two participants with none. Fortunately, of the twelve employee participants with positive disclosures, none indicated signs of stigma to the victims:

"One friend of mine has ever disclosed to me his status; actually, I [...] advised him to test [...] he was ever off and on. [...] I continued taking him as a friend" (U. Mat).

In respect to the workplace setting, employee participants were asked about their attitudes to a co-worker who would disclose his/her status. All the fifteen employee participants indicated that they would persist with a positive co-worker:

"If a co-worker disclosed HIV positive, [...] would extend extra care [...]" (O, Cap)
"If working in a section with chemicals, [...] advise him/her to change the job because with such a disease, contact with chemicals puts one at risk" (S, Mat).

Nonetheless, one of the employee participants raised something I did not expect in the workplace but I have always perceived it in families with an HIV positive person:

“If a co-worker did so, I would not hate him/her but he/she would have made me lose hope, such disclosures make you feel as if everybody is going to die of HIV” (M, Cap)

In an effort to understand the culture of disclosure, participants were asked about how they interact and why they discuss health-related issues at work. Interestingly, out of the fifteen employee participants, twelve admitted to have had health-related talks:

“We do discuss health issues so that we can get a way of protecting ourselves against HIV and other related diseases” (N. Cap).

On the contrary, the majority of employee participants indicated lack of HIV testing guidance and blamed their employers. Out of the fifteen employee participants, only four participants revealed to have been advised about HIV testing by their employers. Of these four employee participants, one employee participant went ahead to substantiate that the advice given was out of informal conversations:

“He advises us but he does it informally [...] just talk about these issues in a joking way. [...] no organised meeting with our boss telling us about HIV issues (R. Mat).

Participants were then asked about taking an initiative to advise a co-worker to test for HIV. Of the fifteen participants, majority revealed to have advised their co-workers:

“I tell them to test, [...] I even tell them about testing while in church” (O, Cap).

“I have never advised my co-workers [...] I know they are safe” (M. Cap).

As noted earlier in the ethics section, knowing a participant’s HIV status was not my focus in this study. However, I was concerned with the drives or motivations behind “HIV/AIDS testing advice”. When asked about reasons for giving HIV testing advice, more than half of the employee participants revealed that they wanted co-workers to

be aware of their status. In addition, a few participants gave me extreme justifications for knowing one's status and willingly disclosed their status to me as seen below:

“It is after testing HIV positive that I got courage to start telling others to go for HIV testing so that they can know their status too” (T, Mat).

The meaning of HIV-related stigma raised mixed ideas both expected and unexpected. The majority described it in terms of disgrace, ignorance or backwardness. That is, employee participants implied that some people are stigmatised because they are perceived to be infected due to immoral acts. Likewise, some employee participants indicated that certain stigma perpetrators lack knowledge about the effects of stigma due to low levels of education, locally contextualised as backwardness:

“HIV-related stigma is a sign of ignorance because [...] how do you start stigmatising others [...] HIV has become a universal problem!” (V. Bak).

“HIV-related stigma and discrimination mean that people who stigmatise and discriminate others would not wish to stay with HIV positive people” (U. Mat).

One of the employee participants working in a bakery revealed that HIV-related stigma is a form of protection against those infected from infecting other people:

“HIV-related stigma and discrimination means that an infected person should face it so that he does not infect others” (Z. Bak).

4.3.2 Employers:

The focus here was to discover the extent to which employers were knowledgeable about HIV epidemic and its related effects to their enterprises at large. Unfortunately, results indicated poor knowledge sharing between employers and their employees as far as HIV epidemic is concerned. Out of the three employer participants, through probing, only one participant cited HIV as a common disease in his/her enterprise:

“They include cough, flu [...] HIV is also a threat [...] including this enterprise” (B).

Contrary to the above findings, employer participants revealed to have provided guidance and counselling services about HIV testing. It should be noted that from the previous findings, out of the fifteen employee participants, only four participants revealed to have been advised about HIV testing by their employers.

“[...] even the boss (my spouse) usually does it by telling them to test for HIV” (C).

Like the employee participants, employer participants also perceive HIV-related stigma and discrimination as an act done out of ignorance coupled with disgrace:

“[...] it would mean isolating someone in each and every aspect of life like not eating with him, not sharing overalls [...]” (C).

4.4.0 Theme Two: To Explore whether some Small Enterprises could Succeed in Integrating HIV workplace policy at the Workplace.

4.4.1 Employees:

The main objective of this study was to explore employees' and employer's knowledge and attitudes about the integration of HIV workplace policy in Uganda. It was therefore important to find out from participants why some small enterprises may fail or succeed in integrating the policy. This study revealed that employees in small enterprises have limited knowledge about HIV workplace policy. Of the fifteen employee participants, eleven participants revealed lack of information about the policy. However, a vast majority of employee participants shifted the blame onto their employers for not availing them with such information as seen in the quote below:

“[...] our boss has not bothered telling us about these issues, sincerely speaking our boss seems to only mind about how much profits he gets” (W. Bak).

Nevertheless, those who did not blame their employers revealed that the government (policy makers) was responsible for their lack of information about the policy:

“[...] policy makers have not reached us here in small enterprises. [...] may be we are not part of their target group” (U. Mat).

“[...] I think it is because we lack people or NGOs to visit us in our workplaces so that they can tell us something about the policy [...]” (V. Bak).

Besides holding their employers and government accountable for their lack of policy knowledge, the entire group of participants revealed that they were determined to support their employers in implementing the policy though they held some misconceptions about it as evidenced in the following quote:

“I would welcome and support my boss [...] the policy may go ahead to help us get help in form of treatment which many employees may not handle” (L. Cap).

In addition to perceiving the policy as a source of medical care, one of the participants revealed that the policy may act as an epidemic prevention strategy at the workplace:

“I would welcome and [...] it can help us in terms of protecting ourselves against HIV while at work. In case of the infected ones, the policy may enlighten them on how to live positively, in harmony with the rest of co-workers [...]” (Q. Mat).

Likewise, employee participants revealed that they would still support the policy even though it mandated them to test for HIV. Interestingly, all the fifteen employee participants concurred that all employees in workplaces ought to test for HIV:

“I would [...] If all staffs get to know their status, then they discover ways of handling their lives. That is, changing on the tasks, start good diet in case [...]” (S. Mat).

“I would personally welcome [...] the policy” (M. Cap).

Participants' openness towards HIV test results was also revealed. Out of fifteen employee participants, twelve were prepared to share their results at the workplace:

“I would share my results [...] you never know these are the right people to help you when in problems. May be if you feel pain they already know and may help” (Z. Bak).

However, out of the twelve employee participants who agreed to share their results with everybody, three participants objected to sharing results with co-workers:

“I would [...] with my boss but not my co-workers. If he/she knows my status, he may give me simple tasks like simple machines in case I am HIV positive” (R. Mat).

On the other hand, two out of the three employee participants that were against sharing HIV test results raised a critical issue of concerning HIV-related stigma:

“No, I would not share my results with the employer. In case of any [...] he/she may end up tarnishing your name by disclosing your HIV status to everybody” (L. Cap).

In relation to openness and HIV testing by employers, all the fifteen participants consented that their employers should also test for HIV as seen in the quote below:

“[...] in my view, everybody in this world should test. Bosses need to test because they also indulge in sexual activities, [...] also need to know their status” (S. Mat).

On a positive note, each employee participant concurred with the fact that maximum cooperation between employers and employees results into an effective HIV-related stigma reduction strategy. However, they called for back ups as seen in the quotes:

“That is fine but this cooperation ought to be accompanied by mutual understanding between employees and employers hence an effective workplace policy” (M. Cap).

“This cooperation needs to be supplemented by effective awareness and sensitization. NGOs ought to visit us and give lectures concerning HIV related policies” (W. Bak).

One of the fifteen employee participants introduced a new phenomenon of social support to the study as evidenced from the quote below:

“With maximum cooperation, we need to form a group of workers, contribute some money [...] support the infected staff, if he/she fails to raise some funds” (N. Cap).

4.4.2 Employers:

Study findings revealed that some small entrepreneurs are relatively knowledgeable about HIV workplace policy and its relevance. On the contrary to the above findings (from employee participants), all the three employer participants revealed to have heard about the HIV workplace policy and its importance as seen in the quote below:

“I have heard it [...] this is a policy for reducing harassment in workplaces [...]” (B).

Like the employee participants, all the three employer participants were willing to implement the policy at the time of the interviews as witnessed from the quote below:

“I have heard about it [...] I have no problem in implementing it. I like such programmes that promote workers’ health while at work...” (A)

In the light of the above willingness to implement the policy, employer participants revealed that they would still support the policy even if it mandated HIV testing:

“I will still support [...] employers should always serve as examples to their employees and ought to be open to their employees [...]” (A).

Their determination to implement the policy was further revealed in their decision of not supporting employers who deny jobs to some PLWHA:

“I do not support such employers, when one is denied employment due to his HIV status; one may completely lose hope. If you do not work, how do you survive?” (B).

4.5.0 Theme Three: To Assess how Small Enterprises Approach HIV-related Stigma and Discrimination at the Workplace.

4.5.1 Employees:

Under this theme, I sought to explore how employees and employers approach HIV-related stigma and discrimination at the workplace. The majority of employee participants depicted counselling and guidance; and financial support as some of the services ought to be extended to HIV-related stigma victims at the workplace. Of the

fifteen employee participants, seven cited financial support as a service to be offered to HIV positive staffs and the other eight participants cited counselling and guidance:

“[...] provide advice or if possible we can accompany the sick to the hospital because as employees we do not have enough resources [...]” (N. Cap).

“[...] counselling and guidance should actually be the first service to those suffering from HIV and its related effects [...]” (S, Mat).

In addition to the above, participants were also asked about services ought to be extended to co-workers experiencing HIV related stigma in particular. Besides counselling HIV-related stigma victims, findings revealed that workers in small enterprises also deal or are dealing with stigma by guiding and cautioning stigma perpetrators. Out of the fifteen employee participants interviewed, thirteen participants revealed that cautioning perpetual stigmatisers yields a positive change:

“[...] we need to call those people who are stigmatising others and warn them by telling them to stop the behaviour” (Y. Bak).

“[...] bring the person being stigmatised closer to the whole group so that he/she feels that he/she is part of the bigger group [...]” (R. Mat).

Although HIV-related stigma proved to prevail in the three workplaces visited, despite the absence of HIV workplace policy, workers have managed to live in harmony, a fact attributed to the culture of “ignore and concentrate on your job”. Out of the fifteen employee participants, twelve agreed that workers stigmatise each other:

“[...] such people need to be left alone because they do not understand. Even if you advise them to change, people are funny, and they will always talk. Even those with HIV positive relatives at home also stigmatise others [...]” (T. Mat).

Employee participants were asked to assume that they were employers being stigmatised by their own workers. Responding as employers, the majority of employee participants revealed that they were ready to ignore anything to do with stigma from their subordinates provided they (subordinates) are working normally:

“If I was the employer, I would leave them alone [...] it is better to call the person spreading rumours and talk to him first. Firing such worker is bad” (N. Cap).

On the other hand, one of the employee participants working in a matchbox factory revealed that if he/she was an employer, he/she would not tolerate such behaviours:

“[...] If I were the boss, I would chase away/fire such a culprit [...]” (R. Mat).

Then the employee participants were asked about their advice to a worker being stigmatised by his/her employer. Persistence and concentration emerged as some of the advice to HIV-related stigma victims. Out of the fifteen employee participants interviewed, fourteen participants called for persistence and concentration:

“I would advise the person to have hope and persist [...] being paid well” (S. Mat).

“I would advise the [...] to leave the boss alone and concentrate on his job” (L. Cap).

However, one employee participant working in the bakery recommended the opposite to the above fourteen employee participants’ ideas as seen in the following quote:

“I would advise the person being stigmatised to leave the current job and look for another one instead of working with people who make your life hard” (W. Bak).

4.5.2 Employers:

In relation to the above findings, employer participants also revealed that counselling and guidance are good services ought to be applied while approaching the problem of HIV-related stigma at work. On a positive note, all the three employer participants supported counselling and guidance services as seen in the following quote:

“[...] Counsel or advise them to take multiple tests, advise them to stop taking alcohol, advise them to take treatment seriously, tell them to eat well [...]” (C).

On the other hand, findings revealed that employer's openness and cooperation with their employees is another way of approaching HIV-related stigma at the workplace. All the three employer participants revealed that they are open to their staff:

"I am very open [...] I do not have any problem with my staff. We are like brothers, I talk to them and they talk to me freely [...] we do not fear each other [...]" (A).

"We are open [...] because sometimes when a worker wants to do something bad (or steal) something, they come and report such a person [...]"(C).

4.6.0 Theme Four: To Explore HIV-Related Stigma and Discrimination Challenges Faced by Employees and their Employers at the Workplace.

4.6.1 Employees:

Under this theme, employee participants revealed that HIV-related stigma and discrimination inflict quite a number of challenges to employees and employers. Out of the fifteen employee participants, fourteen revealed fear for fearing to test as one of HIV-related stigma challenges as seen from the following quote:

"The majority of employees in many enterprise like this are youths and so they fear to test because they do not want co-workers to find out their HIV status" (L. Cap).

In addition, the remaining one employee participant working in a bakery introduced an extreme form of HIV stigma challenges that I did not expect, that is, suicide:

"These youths fear to commit suicide in case one tested positive, I have heard that from the youths in this company during our informal conversations" (W. Bak).

Other challenges revealed by employee participants included; loneliness, isolation, misunderstandings, loss of jobs, job dissatisfaction and stress among others.

On the other hand, employee participants revealed that employers too face the challenge of HIV-related stigma at the workplace though some are indirect. Out of the fifteen employee participants, six participants confirmed that HIV-related stigma is a challenge to entrepreneurs, staff and prospective employees:

“Due to HIV-related stigma, employers may end up losing hard working staff after being stigmatised and discriminated. Prospective employees may shun an enterprise after observing that some employees are leaving due to HIV stigma [...]” (Q. Cap).

Participants were also asked about their perceptions of testing for HIV from the workplace. Out of the majority who supported the workplace as a good environment for HIV testing, two employee participants called for a universal HIV disclosure at the workplace as seen below:

“[...] as workers we need to know our status as a group that we are safe or not, [...]” (Y. Bak).

4.6.2 Employers:

Employer participants consented that challenges of HIV-related stigma were prevailing in their enterprises. All three employer participants revealed that their employees fear to test and to disclose their HIV status due to fear for being stigmatised and discriminated by their employers or superiors at the workplace:

“Workers do not want any person [...] to know about their HIV status. Some workers do not want to disclose their status due to fearing discrimination by their employers. One may fear that if the boss gets to know, he/she may be fired from the job [...]” (A).

Among other challenges cited by employer participants is on-site HIV testing and lack of confidentiality at the workplace. An employer participant who was against workplace testing revealed that onsite testing needs maximum confidentiality:

“The workplace is not a good place for one to take an HIV test. One testing may think that those carrying out the test may disclose the results to the employer [...]” (B)

Lastly, employer participants also revealed that sustaining the two groups (HIV negative and positive staffs) of staff while keeping them productive is challenging. In

the face of HIV/AIDS, the challenge of employee turnover may necessitate the employer to make hard choices like disclosing his/her HIV status to staffs:

“[...] befriending all employees so as to reduce on the employee-employer gap, discussing HIV-related issues with staff. In case some staff are HIV positive, employers ought to disclose their health related problems to their staff. Employers should not always look at themselves as bosses in everything [...]” (A).

Considering the above challenges, employer participants were asked about their perceptions on HIV-related stigma and their enterprises. All the three participants indicated HIV-related stigma as a threat to their enterprises. One of the employer participants revealed that employers lose staff due to HIV-related stigma:

“I do [...] due to stigma, we may lose a good staff. One may not come back to work after he/she has been stigmatised and discriminated while at the workplace...” (C).

4.7.0 Theme Five: To Find out how Small Enterprises may Overcome HIV-related Stigma and Discrimination.

4.7.1 Employees:

As revealed earlier, employee participants agreed that maximum cooperation between employees and their employers yields a positive change in as far as overcoming HIV-related stigma at the workplace is concerned as witnessed in the following quote:

“An employer needs to cooperate, get closer to his employees so that by the time he plans to integrate the policy, all the employees are already free with him” (L. Cap).

In relation to the above, employee participants revealed that implementing the workplace policy while involving all employees reduces HIV-related stigma at the workplace. Out of the fifteen employee participants, five participants revealed that employers should involve all employees as they implement the policy:

*“Integrating the HIV workplace policy will reduce HIV-related stigma [...]” (Z. Bak
“Workers need to get highly involved in the policy implementation process” (N Cap)*

Besides policy implementation, employee participants revealed that employers should liaise with offsite health care centres as another way of overcoming HIV-related stigma brought about by on-site HIV testing and other HIV-related health services:

“Employers ought to make sure that their enterprises are affiliated to certain health centres so that workers use these places for some HIV-related services” (L. Cap).

“I would advise our boss to make sure that our enterprise gets affiliated to one of the clinics in the near by so that if a worker gets a problem, he/she visits it” (T. Mat).

Again, employee participants revealed that employers ought to be sensitised about HIV and workplace issues as one way of overcoming HIV-related stigma. Of the fifteen employee participants, five participants called for government intervention in sensitising all employers in an effort to overcome HIV-related stigma in workplaces:

“Employers ought to be sensitised so that they start sharing HIV-related issues with their workers. Governments should try to reach all small-scale entrepreneurs and all religious leaders in order to reduce HIV and its related effects” (O. Cap).

On the other hand, HIV-related stigma prevailing in some of the visited workplaces was again evidenced in an employee participant’s response by opting not to avail employment to PLWHA. Nonetheless, out of the fifteen employee participants, only one participant revealed that screening new applicants for HIV would reduce stigma at the workplace:

“[...] Employers ought to set up guidelines in their workplaces so that whoever is looking for a job is first tested for HIV [...]” (M. Cap).

4.7.2 Employers:

Like the employee participants, all the three employer participants revealed that openness and cooperation between employers and their employees reduces HIV-related stigma at the workplace as seen in the following quote:

“[...] employers should always have time for their employees, get a day to teach them about health issues especially those who are HIV positive, [...]” (C).

In agreement with employee participants, employer participants revealed that another way of reducing HIV-related stigma in small workplaces is through increased outreach with effective HIV/AIDS awareness campaigns. However, out of the three employer participants, one participant revealed that small enterprises are not reached by national HIV support organisations that offer HIV-related services:

“[...] Governments and various NGOs should make sure that employees in small workplaces are fully sensitised about HIV/AIDS epidemic [...]” (A).

Chapter Five

Discussion of Results

5.1.0 Introduction

In this chapter, results are discussed in the context of existing literature and by elaborating on the findings of this study. Methodological considerations are delineated, policy recommendations are suggested and valid conclusions are stated.

5.1.1 General Findings

This study has confirmed that small enterprises in Uganda have failed to integrate the HIV workplace policy due to lack of government support (in terms of lack of a clear national HIV/AIDS policy, HIV education resources et cetera). This study has found that employees and employers in small enterprises are willing to implement the HIV workplace policy although they have misunderstandings about what it entails. Findings of this study indicate a need for effective sensitization and awareness in an effort to curb the prevailing HIV-related effects like stigma at the workplace. Positively, all study participants acknowledged that cooperation between employees and employers enhances knowledge sharing at the workplace. In Uganda, the majority of HIV/AIDS support organisations have not reached out to small enterprises.

5.2.0 Knowledge and Attitudes about HIV/AIDS

This study has found that some employees in the participating small enterprises are still afraid to mention the word HIV/AIDS. These findings imply a level of denial about the disease that is surprising given that Uganda has been acknowledged for her success in reducing HIV/AIDS prevalence rates (Allen & Heald, 2004). Similarly, a study done in a small fish landing site in Uganda by (Tanzarn & Bishop-Sambrook, 2003) revealed that the fishing folk could not mention the disease's name due to the fear attached to it. In some parts of South Africa, due to the fear of mentioning its name, HIV/AIDS is referred to as "ulwazi" which means "that thing" (Stein, 2003).

However, this study has indicated that employees in the visited worksites are comfortable with anybody who discloses his/her HIV status to them including co-workers. This means that the majority of employees in the participating enterprises are ready to live and work alongside PLWHA. In contrast, in their study of "HIV and the

Workplace: Organisational consequences of hiring persons with HIV and attitudes towards disclosure of HIV-related information”, Lim & Loo (2000), revealed that 39 percent of respondents felt that having an HIV/AIDS positive co-worker affects other workers’ concentration levels and 14 percent of respondents felt that having an HIV/AIDS positive co-worker causes one to resign.

Equally, this study has indicated that HIV-related knowledge sharing amongst employees at the workplace would be ideal although this is theoretical because there is no participant who reported an HIV/AIDS positive employee. The implication of this is that some employees are motivated and committed at saving their co-workers from contracting the HIV epidemic, as put by one of the participants that willingly disclosed their status to me: **“It is after testing HIV positive that I got courage to start telling others to go for HIV testing so that they can know their status too”** (T, Mat). These findings are in line with a study which revealed that knowledge sharing plays a big role in reducing stigma among co-workers (Keeton, 2004). Similarly, Barr, Waring, & Warshaw (1992), also found out a clear association between HIV knowledge and HIV-related stigma at the workplace.

However, it should be noted that in this study, some participants’ attitudes towards HIV/AIDS and its related stigma are theoretically positive but may be negative in practice. Despite the presence of a few HIV positive participants, the vast majority of participants demonstrated willingness to test for HIV and disclose their status to every one at the workplace, but there was no participant who had disclosed his/her status at the workplace at the time of interviews. For instance, one of the employee participants indicated that he/she does not bother to advise his/her co-workers to test for HIV because he/she “knows” that they were not infected. **“I have never advised my co-workers [...] they are safe”** (M. Cap). The same participant indicated willingness for the policy implementation. **“I would personally welcome [...] the policy”** (M. Cap). However, the attitude changed as it came to the issue of carrying out HIV testing at the workplace, **“The workplace is not good [...] for HIV testing”** (M. Cap) and overcoming stigma. **“Employers ought to set up guidelines [...] job seekers should first test for HIV”** (M. Cap).

5.3.0 Integration of HIV workplace policy

This study has found that the majority of employees in the visited small workplaces have limited information on the HIV workplace policy and its related workplace programmes. However, employee participants held their employers (who in theory revealed to be conversant with the policy and its programmes) accountable for the information mismatch as seen in the quote: [...] **our boss does not bother to tell us about these issues, sincerely speaking our boss seems to only mind about how much profits he gets [...]**” (W. Bak). This is an indication that information gap between employees and their employers may in turn hamper HIV workplace policy implementation in some enterprises. In line with these findings, a study done by ACORD (2004) revealed that many organisations in Uganda fail to implement the HIV workplace policy due to lack of sufficient knowledge of HIV workplace programmes.

Another implication is that the employers’ familiarity with the policy is theoretical. This is because all three employer participants reported that they communicate and share health-related knowledge with their workers. However, responses from the employee participants show that their employers lack HIV-related knowledge too. For instance, this study has found that small-scale entrepreneurs show little interest in finding out the existence of HIV-related stigma among their workers at the workplace. This means that integrating HIV workplace programmes will empower employees and their employers in one way or another to confront HIV/AIDS and its related effects at the workplace. Similarly, Forsythe (2002) notes that management may not be in position to discover some HIV-related effects and implementing HIV workplace policy would be one way to address challenges hidden from the employer like stigma. In contrast, according to Lie and Biswalo (1995), while conducting counselling services in one of the villages in Arusha-Tanzania, some small-scale entrepreneurs exhibited interest in having AIDS education extended to their employees.

On the other hand, other study participants indicated that the government and NGOs - HIV support organisations - are also responsible for the existing information gap at the workplace: **“Policy makers have not reached us here in small enterprises [...] we are not part of their target group [...]**” (U. Mat). **“[...] we lack people or NGOs to visit us in our workplaces to tell us something about the policy [...]**” (V. Bak). In general, the majority of

Ugandans (especially the illiterate) expect almost all health-related services to come from the government. On the contrary, a survey done in the US revealed that 73 percent of the American workforce expected their employers to avail them with HIV workplace programmes (Business Responds to AIDS, 2004). However, this study has confirmed that employees, employers and the government are all perceived to be responsible for HIV/AIDS-related issues at the workplace. Even so, small enterprises lack workplace programmes because of their limited access to resources (ILO, 2002) but not necessarily the employer's negligence as it is perceived by some employees.

Despite the employers' lack of interest in their workers' health as indicated above, this study has found that both employees and employers are willing to implement HIV workplace policy into their enterprises. The employees' and employers' willingness to implement the policy is an indicator that the availability of government support will make it simple for small enterprises to have the policy in place. However, as depicted in the modified conceptual model (fig. 2.2), the HIV workplace policy in turn enhances workplace programmes in reducing stigma (Holzemer et al., 2007). Other studies have confirmed that HIV workplace policy plays a big role in reducing HIV-related effects at the workplace (Barr et al., 1992; Hadjipateras et al., 2006; van der Borgh et al., 2010). On the other hand, this study has confirmed that some employees in small workplaces have misconceptions about the workplace policy such as policy-related provision of medical services, financial assistance to the infected employees et cetera, a reflection for limited knowledge available to small enterprises.

5.4.0 Approaches to HIV-related Stigma and Discrimination

In this study, participants indicated that counselling and financial support are the most suitable services that ought to be extended to workers experiencing HIV-related stigma at the workplace. The implication of these findings is that counselling services can create positive attitudes among employees experiencing stigma and discrimination at the workplace. In line with the above findings, Van der Borgh and colleagues (2010) noted that comprehensive counselling and testing services among employees supplement the effectiveness of some HIV workplace programmes in tackling HIV-related effects like stigma at the workplace.

Substantially, this study has found that employees are willing to deal with stigma and discrimination by cautioning stigma and discrimination perpetrators at the workplace rather than isolating them. Dealing with stigma and discrimination issues at the workplace requires a firm's management to first establish a good working relationship among its workforce which includes minimising the traditional employer/employee gap, creating a supportive atmosphere et cetera. In contrast, some studies have revealed that HIV positive employees are at times stigmatised and discriminated by co-workers and their employers at the workplace (Fesko, 2001; Herek, 1999; Kohi et al., 2006; Paxton et al., 2005; Studdert, 2002).

This study has confirmed that employers' openness and cooperation with their employees play a big role in mitigating stigma and discrimination at the workplace. In this study, all study participants called for openness and cooperation about HIV/AIDS status, a call that can generally be interpreted to mean that everybody at the workplace ought to declare his/her HIV status. It is possible that a large number of participants supported compulsory HIV status disclosure at the workplace without knowing its implications. Correspondingly, research studies have indicated that cooperation between employees and their employers brings about social, emotional and most importantly financial support (Heijnders & Van der Meij, 2006).

Employer participants in this study indicated that even HIV positive workers ought to work and earn a living. This implies that some employers have realised that terminating an employee due to HIV positive status is of no use either to the enterprise or to the expelled employee. In fact, HIV-related stigma might affect employers more than their employees through increased labour costs associated with recruitment and placement procedures, reduced productivity et cetera. These findings are in line with studies which have revealed that work provides emotional, social and psychological support to HIV positive workers as they interact with co-workers (Fesko, 2001; Maticka-Tyndale et al., 2002; Werth et al., 2008).

In reference to the above findings, the employer participants' positive attitude towards HIV positive workers is still theoretical. Whereas some few HIV positive workers participated in this study, none of the employer participants revealed that he/she knew

of an HIV/AIDS positive employee in his/her enterprise. This means that employers of the participating enterprises have not bothered to find out HIV positive staff (as revealed above) and devise means to retain them at work.

5.5.0 Challenges of HIV-related Stigma and Discrimination

This study has found that a large number of employees in the visited workplaces do not fear to test for HIV/AIDS at the workplace. This indicates a level of sensitisation about the importance of HIV testing, a factor that may account for the low levels of stigma and discrimination experiences in the visited workplaces. In contrast, studies done by Devine et al (1999) and Kohi et al (2006) assert that employees fail to test for HIV due to fear for being dismissed by their employers. However, as noted earlier, the willingness to test for HIV is theoretical because later in the interviews, some participants opted for taking HIV test outside their worksites.

Equally, this study has indicated that participants in the visited small workplaces are willing to disclose their HIV status to everyone at the workplace although this attitude is still theoretical because some participants that are HIV positive did not report to have disclosed their status at the time of the interviews. Ideally, these findings imply a level of trust and confidence among employees and their employers, which could probably be in position to neutralise HIV stigma practices. On the contrary, a study done by Fesko (2001) revealed that only a third of the eighteen employee participants were willing to disclose their status to everybody in the workplace. Feasibly, some employees fail to disclose their status to co-workers and their employers because of not being sure of the outcomes in return (Simoni, Mason, & Marks, 1997).

However, this study has indicated that HIV-related stigma creates a hostile working environment characterised by interpersonal effects such as loneliness, isolation, misunderstandings, loss of jobs, occupational stress et cetera. Stigma and discrimination have greatly affected people's lives to the extent of having destabilised workplaces. These findings are in agreement with other research studies which revealed that interpersonal effects enhance stigma and discrimination at the workplace (Pulerwitz et al., 2004) which in turn disrupts the firm's operations (Rau, 2002).

On a hopeful note, some employer participants have indicated that some employees fail to disclose their status due to fear of stigma from “bad” employers. This is an indication that some employers themselves are aware of the negative effects of stigma. In light of these findings, some inadequate data have indicated that HIV-related stigma might cause health inequalities (Adeyemo & Oyinloye, 2007; Herek, 1999) as it is with social inequalities (Castro & Farmer, 2005).

5.6.0 Overcoming HIV-related stigma and discrimination

Employee participants in this study indicated that employers ought to be sensitised about HIV and workplace issues as one way of overcoming HIV-related stigma. Coincidentally, employer participants indicated that one way of reducing HIV-related stigma in small workplaces is through increased outreach with effective HIV/AIDS awareness campaigns. Findings of this study present hopes for reduced stigma if effective sensitisation/awareness programmes are to be constantly rolled out to the target populations. In line with employee participants, studies have indicated that some health-related problems exist in some workplaces due to management’s negligence of not being equipped with relevant information (Forsythe, 2002).

In this study, both employee and employer participants called for employee participation/involvement in the policy implementation process. Participation and involvement principles are among the five principles of health promotion that came out clearly in this study. These findings show how certain small workplaces in Uganda are prepared to fight the epidemic at the workplace. Likewise, the ILO code of practice denotes that an effective policy requires employee involvement in the implementation process (ILO, 2001). In a workplace setting, “(...) ascertaining what employees know and think can be useful in designing programmes responsive to their needs and concerns” (Barr et al., 1992, p. 225). In other words, any health promotion programme’s effectiveness rests on its key five principles including empowerment, enabling, participation, involvement and advocacy.

In this present study, one of the employee participants “ignorantly” indicated that one way of overcoming HIV-related stigma is through subjecting new applicants to HIV testing. These findings imply that some unemployed people are perceived to be at risk

of being infected with HIV, a situation that might render them to continuously be denied employment hence going through a vicious circle of stigma (Parker, Aggleton, Attawell, Pulerwitz, & Brown, 2002). Likewise, a study done in the US indicated that over 30 percent of respondents were in favour of screening new employees for HIV/AIDS (Barr et al., 1992).

Another implication is that there is a need for comprehensive HIV/AIDS-related education at the workplace in an effort to counteract employees who might unintentionally practise stigma and discrimination. Particularly, this study has confirmed that limited knowledge of HIV-related stigma outcomes (Herek & Capitanio, 1993) is indirectly fostering the “stigma epidemic” in many parts of the world most especially at the workplace where some workers might “unknowingly” stigmatise co-workers and their employers. Today, certain jobs in some enterprises require a new entrant to first interact with the already hired employees. However, some PLWHA have been kicked out of employment at this stage as it happened in Canada when a prospective employee perceived to be HIV positive was told by the employer to go away because employees were not comfortable with his presence (Maticka-Tyndale et al., 2002).

5.7.0 Methodological Considerations

In this study, I mainly relied on primary data. Like in secondary data, primary data are also subjected to limitations such as employees failing to share some information. In this regard, possessing some experience in research (see validity section, p. 20) enabled me to apply various research skills such as use of probing in an effort to obtain enriched data characterised by real life experiences of employees at the workplace. However, as anticipated, some study participants would ask some health-related questions after the interview. In addition to my explanation, participants who asked questions were referred to AIC Kabale branch for more information and possibly other HIV-related services like counselling (see ethical issues, p. 23).

One of the initial stages upon entry into the field is meeting the head of the institution/community that is one’s sample. Inevitably, this ought to rank high on every researcher’s agenda. Despite a few hurdles, I was able to meet some employers. However,

I sensed some stigma experiences from a certain employer while delegating one of his/her managers to attend to me. Part of the statement includes *“That [...] is the one who knows their health problems better than me [...]”* This a clear indication that some employers are not interested in finding out health-related problems affecting their employees at the workplace. Conversely, this is reflected in some participant’s responses as they blame their employers for not being bothered about their health.

Another methodological consideration is that most of the employees were employed on a part-time basis at the time of the interviews. In addition, the majority of the employees were residing in distant places from their workplaces. A combination of these factors brought about undesirable outcomes such as; failure to access a good number of participants, rushing through the interviews due to limited time et cetera. However, the time factor was a two-way obstacle. As a researcher, I also had limited time allocated to the fieldwork hence not able to access more of those willing to sacrifice some few minutes for the interviews after work. Out of eighteen interviews, almost half of the interviews were held in the evenings. In addition to the participant’s consent (of attending to the interview after work), I managed to locate illuminated space near each worksite which enabled me to record the interviews through writing and hopefully provided a conducive interviewing environment to the interviewees. All this was done with an aim of not compromising this study’s data quality.

In addition to the time element as mentioned above, I was unable to make certain observations in all the three visited sites. Most importantly, I failed to move around and observe some sanitation and hygiene facilities like toilets, urinals among others as anticipated. Furthermore, I was sometimes unable to create instant questions: for instance, when some employee participants did disclose their status to me, I did not ask them if they had disclosed their HIV status to co-workers and their employers. On the other hand, in all the three sites visited, none possessed any HIV/AIDS posters, HIV/AIDS magazines et cetera. But some study participants expected me to distribute free boxes of condoms of which I did not possess. This necessitated my explanation that I was just a student (not a trained counsellor) who could not be entrusted with condoms by any HIV support organisation like The AIDS Support Organisation (TASO), AIC, et cetera.

It is due to some of the above problems that I encountered during my fieldwork that forced me to increase on the number of cases/sites from one to three as opposed to my proposal. This flexibility of qualitative case study design (Kvale, 1996) saw my approach shift from a single case study to a collective case study design. Despite the above hitches, I was able to obtain adequate data due to the use of in-depth interviews in a sample that reached saturation. I also attribute this success to the 'spirit of sacrifice' by my study participants. As mentioned above, my study participants were willing to sacrifice their evening time and attend to my a bit lengthy interviews. Study participants that showed up for the interviews looked interested in my study and were cooperative. All this including my creativity and experience enabled me to obtain enriched data.

5.8.0 Recommendations

There is a need to address the problem of HIV-related stigma and discrimination faced by both employees and employers in Uganda especially among the small workplaces. A large study specifically exploring the effect of stigma on HIV/AIDS prevention, treatment, care and support at the workplace in many districts of Uganda would be of great importance policy makers.

The Ugandan government, national and international NGOs (HIV support organisations) and other actors should take a stand in the fight against stigma in the country starting with small workplaces that employ majority of Ugandan workforce. A great initiative in this context would be the enactment of a clear national HIV workplace policy that will possibly advocate for workers' rights at the workplace.

The various groups of actors mentioned above ought to serve as example to all workers. The politicians in particular should learn from the Tanzanian president who recently tested for HIV perhaps to set an example for the public. With such social modelling, many Ugandans who are still afraid of testing for HIV may overcome their concerns and test, a point of departure for treatment should one be found positive.

At the workplace, employers should endeavour to test for HIV to serve as an example to their employees. Based on their experience, they can go ahead to advise their employees to test for HIV/AIDS.

NGOs working under the umbrella of fighting HIV/AIDS epidemic should reach out to a large number of small enterprises in Uganda.

Largely, employers should involve their employees in certain decision-making processes especially those targeting their health-related needs.

It is assumed that this research will fill the knowledge gap about the effects of HIV stigma in small enterprises in Uganda, but the lack of clear policies such as a national HIV/AIDS policy in particular will continue to hinder even the dissemination of the available information. For instance, presenting these research findings in a small workplace that has or has no HIV workplace policy in place is one effective way of enhancing awareness and sensitisation among employees and their employers.

In the light of above findings, a great contribution to effective stigma management may require the following studies to be carried out, that is, the influence of cultural differences on stigma and the role of gender in stigma management at the workplace.

5.9.0 Conclusions

The lack of a clear HIV workplace policy in Uganda is reflected in the knowledge and attitudes of participants that are still only theoretical. Whereas a non-discriminatory attitude towards HIV positive employees may be generalised among participants, there was one participant who would not allow any HIV positive employee at the workplace. This study's findings have indicated that an effective HIV workplace policy could play a big role in slowing down stigma and discrimination practices among co-workers and their employers at the workplace.

This study has found that employees in the visited workplaces are not severely affected by stigma and are ready to support their employers to implement workplace policies that will enable them manage the epidemic and its related effects at the workplace. There are very few effective strategies (such as HIV sensitisation and awareness, workplace-based voluntary counselling and testing) in place to reduce HIV-related stigma. Availability of HIV-related information, outreach programmes by

NGOs and above all government support in form of a clear HIV/AIDS policy will greatly contribute to efforts directed at reducing stigma at the workplace.

Some people may fear to test and disclose their status to others because they are not sure of the perceptions and treatment in return. At the workplace, some employees fear to test and disclose their status due to fear of being stigmatised and discriminated by co-workers and their employers. However, employees and their employers in the visited small workplaces do not fear to test and disclose their status at the workplace. This study has confirmed that implementing workplace programmes while involving all stakeholders such as employees yields low levels of stigma. Therefore, empowering employers and their employees in small enterprises with knowledge and skills to enable them keep stigma at a low level is a tremendous package.

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Appendix: A, Introductory Letter



UNIVERSITY OF BERGEN

Research Center for Health Promotion

Bergen, Norway, 29.05.09

To whom it may concern

Clearance and support of Benedict Twinomugisha's proposal :
Integrating HIV Workplace Policy in Small Scale Enterprises to Realise Reduced HIV Related Stigma and Discrimination in Kabale/Kampala – Uganda. A Case Study of One Small Scale Enterprise

This letter is to document that Benedict Twinomugisha is a Master student in a two year Master of Philosophy Programme in Health Promotion at the University of Bergen, Norway. Part of the requirements is to do field research and write a master thesis. Benedict Twinomugisha will do his research under my supervision. His research work has been well prepared and ethical issues have been seriously addressed from several relevant angles.

The University of Bergen and Makerere University has a comprehensive link arrangement, formalised in a Frame Agreement, signed in November 1999, by the two universities. Relevant collaborating body at Makerere University in connection to Benedict Twinomugisha's research is the Institute of Psychology. Benedict Twinomugisha has his Bachelor of Industrial and Organisational Psychology from Makerere University. Benedict Twinomugisha is thus a student under the Frame Agreement.

It is our hope that the necessary clearance and practical support will be given as soon as possible because of the time constraints that students are under in order to finish their thesis within the allocated time.

If you need further documentation or other information You are kindly asked to contact me. You may contact me on e-mail: Gro.Lie@psyhp.uib.no

Sincerely,


Gro Th. Lie
Professor
Student supervisor

Christiesgt. 13 N-5015 Bergen, Norway Phone: +47 55 58 28 08 Fax: +47 55 58 98 87
Established in cooperation with the National Norwegian Health Association 1988
World Health Organization Collaborating Center

EMAIL:



Appendix: B, Clearance from the Office of the President



THE REPUBLIC OF UGANDA

OFFICE OF THE PRESIDENT

PARLIAMENT BUILDING P.O.BOX 7168 KAMPALA, TELEPHONES: 254881/6, 343934, 343934, 343926, 343943, 233717, 344026, 230048, FAX: 235459/256143

ADM 154/212/01

July 10, 2009

The Resident District Commissioner
Kampala District

This is to introduce to you **Benedict Twinomugisha** as a Researcher who will be carrying out a research entitled **“Integrating HIV workplace policy in small scale enterprises to realize reduced HIV related stigma and discrimination in Kampala-Uganda. A case study of one small scale enterprise”** for a period of $1\frac{1}{2}$ (one and a half) months in your district.

He has undergone the necessary clearance to carry out the said project.

Please render him the necessary assistance.

A handwritten signature in blue ink, appearing to read 'Alenga Rose'.

Alenga Rose
FOR: SECRETARY, OFFICE OF THE PRESIDENT

Appendix: C, UNCST Clearance



Uganda National Council For Science and Technology

(Established by Act of Parliament of the Republic of Uganda)

Your Ref:.....

Our Ref:.....SS.2239

Date:.....20/07/09....

Mr. Benedict Twinomugisha
C/o Institute of Psychology
Makerere University
P.O Box 7062
Kampala

Dear Mr. Twinomugisha,

RE: RESEARCH PROJECT, "INTEGRATING HIV WORKPLACE POLICY IN SMALL SCALE ENTERPRISES TO REALISE REDUCED HIV RELATED STIGMA AND DISCRIMINATION IN KAMPALA-UGANDA: A CASE STUDY OF ONE SMALL SCALE ENTERPRISE"

This is to inform you that the Uganda National Council for Science and Technology (UNCST) approved the above research proposal on **June 18, 2009**. The approval will expire on **September 18, 2009**. If it is necessary to continue with the research beyond the expiry date, a request for continuation should be made in writing to the Executive Secretary, UNCST.

Any problems of a serious nature related to the execution of your research project should be brought to the attention of the UNCST, and any changes to the research protocol should not be implemented without UNCST's approval except when necessary to eliminate apparent immediate hazards to the research participant(s).

This letter also serves as proof of UNCST approval and as a reminder for you to submit to UNCST timely progress reports and a final report on completion of the research project.

Yours sincerely,

Leah Nawegulo
for: Executive Secretary
UGANDA NATIONAL COUNCIL FOR SCIENCE AND TECHNOLOGY

LOCATION/CORRESPONDENCE

Plot 3/5/7, Nasser Road
P.O. Box 6884
KAMPALA, UGANDA.

COMMUNICATION

TEL: (256) 414-250499, (256) 414 705500
FAX: (256) 414-234579
EMAIL: uncst@starcom.co.ug
WEBSITE: <http://www.uncst.go.ug>

Appendix: D, Written Informed Consent Form
Informed Consent Form

Dear participant,

Your enterprise has been purposively identified to participate in this study entitled: *HIV-related Stigma and Discrimination in Small Enterprises: Employers' and Employees' Knowledge and Attitudes about HIV workplace Policy in Kabale, Uganda*. Various researchers, scholars and health practitioners recognise the *workplace* as a key point in reaching out to many people probably including those living with HIV/AIDS. However, some studies show that small-scale enterprises are often by-passed by both national and international HIV support organisations in the fight against the epidemic.

The purpose of this study is to explore employers' and employees' knowledge and attitudes about HIV workplace policy and its impact in reducing HIV-related stigma in small enterprises in Uganda.

The information that will be obtained from all participants in this enterprise will be used for academic purposes only. I believe your experience in this enterprise will be of great importance to my study. You are free to agree or disagree to participate in this study and your name is not required. I will write the final report anonymously so that no reader can identify the interviewees. In addition, personal views or comments that may reveal any person's identity will not be passed to other study participants and other people during the interviews and while presenting the findings respectively. Research Centre for Health Promotion, Bergen University will keep interview scripts. **Note:** If you agree to participate in this study, you are free to withdraw at any time or you may object to answering some questions.

Please read and sign the statement below. Thank you very much for your time.

Researcher. Benedict Twinomugisha

Written Consent form

The purpose of this study has been explained to me and I have understood what the study is all about. I will be involved in the study by participating as an interviewee.

It is clear to me that my participation in this study is voluntary. The researcher has clearly informed me that my name is not required. The researcher will write his report in a way that no reader will be able to identify who said this and that. My personal views or comments that may reveal my identity or my co-workers' identities will not be passed to other participants during interviews or to other people while presenting the findings. The researcher will hand over the interview scripts to the Research Centre for Health promotion, University of Bergen, Norway for storage purposes.

I hereby declare to participate in this study but I remain free to withdraw at any time or refuse to answer some questions.

Interviewee's name

Signature

Date

Appendix: E, Interview Guide for Employees

INTERVIEW GUIDE FOR EMPLOYEES

HIV-related Stigma and Discrimination in Small Enterprises: Employers' and Employees' Knowledge and Attitudes about HIV workplace Policy in Kabale, Uganda.

01. Knowledge and Attitudes about HIV/AIDS

- Introduction: How are you? How do you find the job? [...]
- Generally, what do you think are the common diseases that affect workers in this type of enterprise? **Probe for HIV.** Are the mentioned diseases common here? If yes, how do you go about them?
- Do you have any friend who has ever disclosed to you his/her HIV status? If yes, how do you relate with that person since the time of disclosure?
- If a co-worker disclosed to you his/her HIV status, how would you perceive and treat him/her?
- Have you ever advised your co-workers to go for HIV testing? Yes or No, why?
- Do you discuss health issues with your employer? Yes or No, why?
- Has your employer ever advised you to go for HIV testing? If yes, why do you think he did so?
- Have you heard of any rumour about your co-worker's HIV status? If yes, how do you feel about it?

01. Integrating HIV Workplace Policy in Small-scale Enterprises

- Have you heard of workplace health programmes? If yes, what are they? Tell me the ones you know. [**Probe:** HIV workplace programmes].
- Have you ever heard of HIV workplace policy? If yes, what is it? (If no, as a worker what do you think makes you miss or lack information about such a policy?)
- Would you welcome and support your employer to implement a policy in this workplace that addresses HIV-related effects like stigma and discrimination by family members, co-workers and employer(s)? If yes/no, qualify your answer?
- Again if the policy above mandates all employees in this workplace to test for HIV? Would you still support it? If no, why?
- If yes above, would you be willing to share the results with your co-workers and employer?
- Should this policy also include employer(s) to test for HIV? If yes/no, justify your answer?
- In your own words, what is HIV-related stigma and discrimination? Do you think the rumours can stigmatise a worker with HIV and lead him/her to be discriminated? If yes, how?
- *“For HIV workplace policy to be effective in combating HIV-related effects at the workplace like stigma and discrimination, there is a need for maximum cooperation between employees and employers”.* What is your comment on this statement?

02. Approaches to HIV-related stigma and discrimination.

- What do you think are the common HIV-related effects in small-scale enterprises?
- In your view, which services should be offered to HIV positive staffs at the workplace?
- [Probe for Counselling and guidance, VCT, Free condoms]
- Do you think co-workers at workplaces stigmatise each other due to HIV? If no, why?
- If yes above, how should people who stigmatise others be handled? [Should staff who stigmatise others be reported to the employer? If yes, why?]
- Have you ever been stigmatised by your co-workers? If yes, how did you feel and what did you do?
- Are you aware that workers stigmatise each other and stigmatise their employers too due to HIV? If you were the employer being stigmatised by your workers, what could you do?
- Are you aware that workers are sometimes stigmatised by their employers due to HIV?
- Have you ever been stigmatised by your employer? If yes, how did you feel and what did you do?
- What is your advice to workers who are stigmatised and discriminated by their employers due to HIV?

03. Challenges of HIV-related stigma and discrimination

- Are you aware that many people in the world have not tested for HIV? Briefly, qualify your answer?
- Why do you think employees in workplaces may fear to test for HIV? [Probe for Discrimination by co-workers, employers, lack of policy addressing HIV issues e.t.c]
- Do you think the workplace is a good environment for one to take HIV test? If yes, why?
- If no above, where would you recommend a worker who has planned to test for HIV?
- What would be the challenges to workers facing HIV-related stigma and discrimination at the workplace?
- Do you think small-scale entrepreneurs look at stigma and discrimination as a problem? Justify your answer.
- HIV workplace policy addresses issues like cooperation between employees and employers in the fight against HIV related effects. Do you think this policy applies to small-scale enterprises? Justify your answer?
- **If you were in position to give advice to entrepreneurs/employer, how would you advice them in relation to the integration of HIV workplace policy and reduced HIV-related stigma and discrimination?**

Lastly, having gone through almost all the issues concerning the integration of HIV workplace policy to reduce HIV-related stigma and discrimination at the workplace, what would be your final comment? [Anything to add or reduce].

Thank you very much for your time.

Appendix: F, Interview Guide for Employers

INTERVIEW GUIDE FOR EMPLOYERS/ENTREPRENEURS

HIV-related Stigma and Discrimination in Small Enterprises: Employers' and Employees' Knowledge and Attitudes about HIV workplace Policy in Kabale, Uganda.

01. Knowledge and Attitudes about HIV/AIDS

- Introduction: How are you? How is business going on? [...]
- Do you usually discuss health issues with your workers? If yes, why? Do you have those who usually fall sick, (off and on)? If yes, how do you go about it? In general, how do you rate your staff's health?
- Could you know diseases that usually affect workers in this type of business? Probe for HIV?
- Do you have cases of HIV positive staff? If yes, how did you come to know about that/those cases? How do you handle such cases? If no, How do you plan to go about it in case you get one?
- Have you ever advised your staff to test for HIV? If yes, why? Do you think every worker should disclose his/her HIV results to his/her employer? If yes, why?
- Do you have rules and regulations on testing and disclosing HIV results in this enterprise? In general, how do you manage your staff's health?
- Have you heard cases of rumour mongering about people's HIV status amongst your staff? If yes, how do you manage it?
- Have you heard of HIV-related stigma and discrimination? If yes, what is it?
- Do you think HIV status rumours create stigma and discrimination amongst co-workers? If yes how? Does stigma affect one's performance? If yes how? *Stigmatised staffs are also discriminated*, what is your say?

02. Integrating HIV Workplace Policy in Small-scale Enterprises

- Have you heard of workplace health programmes? If yes, what are they? Tell me the ones you know. [Probe: HIV workplace programmes].
- Have you ever heard of HIV workplace policy? If yes, what is it? (If no, would you wish to know it and probably implement it)?
- Would you welcome a policy that addresses HIV-related effects like stigma and discrimination by family members, workers and fellow entrepreneurs/employers? Qualify your answer?
- Would you still support the policy above if it also mandated employers to test for HIV? support your answer please?
- What do you think are such policy's relevance to your health, enterprise and staff in general?
- Do you support employers who deny some people employment or fire their staffs after realising that he/she is HIV positive? Justify your answer.
- Are you aware that some workers leave the job due to HIV-related stigma and discrimination by either co-workers and or employers? If yes, what would you do to prevent this?

03. Approaches to HIV-related stigma and discrimination at the workplace.

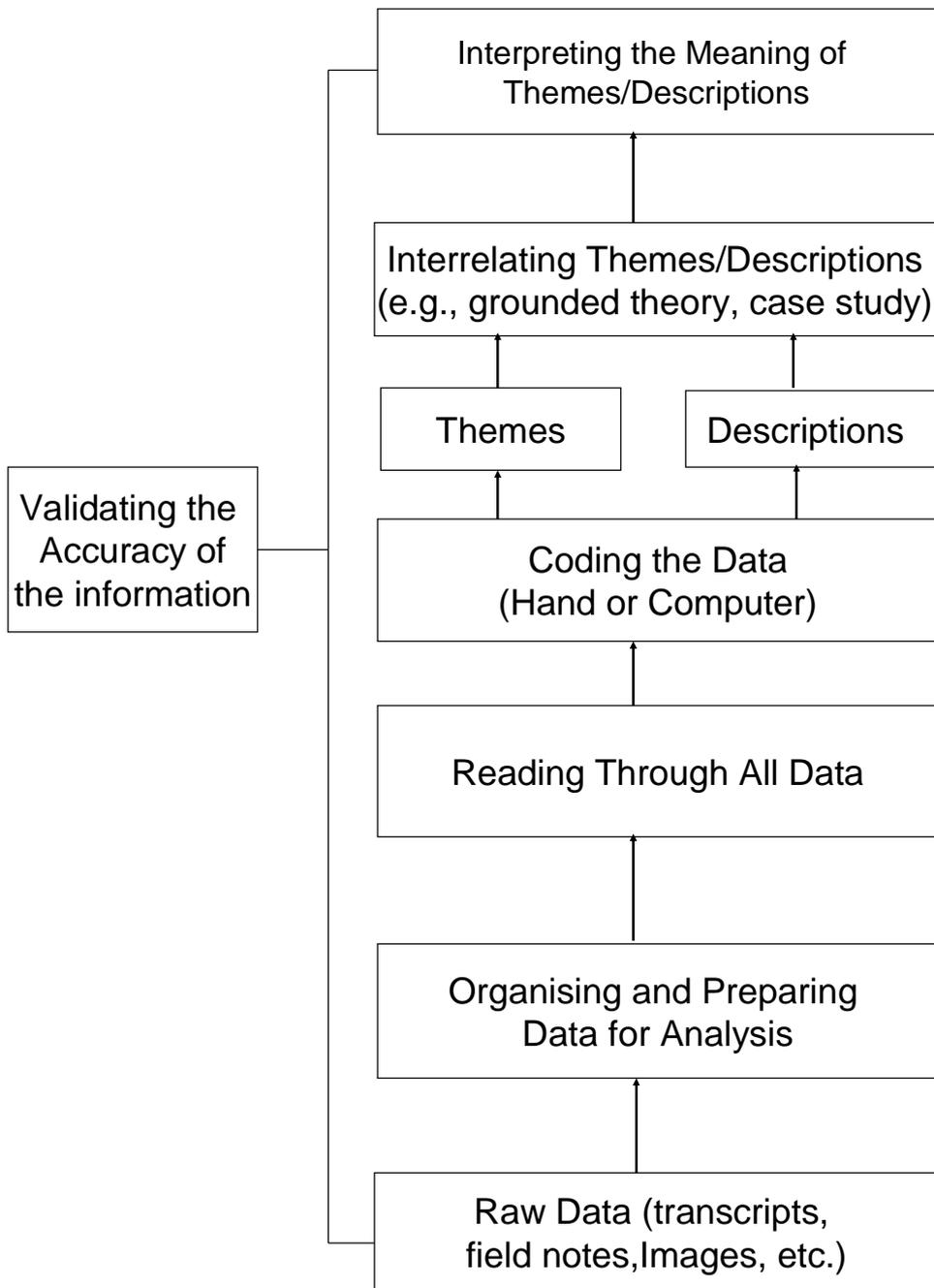
- What do you think are the common HIV-related effects that are faced by small-scale enterprises?
- In your own view, which services should be offered to HIV positive staffs at the workplace? [Probe for Counselling and guidance, VCT, Free condoms]
- Do you think your staff may be stigmatising each other due to HIV? If no, how would you solve such problems in case it happened in your enterprise?
- If yes above, how do you get to know these cases and how do you solve such?
- Would you say that your staffs are open to you or approach you easily? If yes, why do you think so?
- If no above, why do you think your staff do not find it easy in approaching you? What is your advice to employers who are not approachable?
- Are you aware that employees also stigmatise their employers due to HIV? Have you ever been stigmatised by your workers? If yes, how did you go about it?

04. Challenges of HIV-related stigma and discrimination

- b. Are you aware that many people in the world have not tested for HIV? Briefly, defend your answer?
- c. Why do you think your workers may fear to test for HIV? [Probe for discrimination by co-workers, employers, lack of policy addressing HIV issues e.t.c]
- d. As an entrepreneur/manager, do you think the workplace is a good environment for one to take HIV test? If yes, why?
- e. If no above, as a manager, which mechanisms would you put in place to make sure that workers take the test for HIV as their first choice?
 - What would be the challenges to an employer experiencing HIV-related stigma among his staff?
 - Do you think small-scale entrepreneurs look at HIV-related stigma as a problem? Justify your answer.
 - HIV workplace policy addresses issues like cooperation between employees and employers in the fight against HIV related effects such as stigma and discrimination. What is your say?
 - **Basing on your own experience, which advise would you give to other small-scale entrepreneurs to overcome HIV-related stigma and discrimination in their workplaces?**
 - *Lastly, having gone through almost all the issues concerning the integration of HIV workplace policy to reduce HIV-related stigma and discrimination at the workplace, what would be your final comment? [Anything to add or reduce].*

Thank you very much for your time.

Appendix: G, Data Analysis in Qualitative Research



Source: Creswell, J. W. (Ed.). (2009). *Research design: Qualitative, quantitative and mixed methods approaches* (3rd ed.). Thousand Oaks: CA: Sage. P, 185.

Appendix: H, Organisation of Data by Tabulation (Sample)

INTERVIEWS FOR EMPLOYEES

THEME 1. KNOWLEDGE AND ATTITUDES ABOUT HIV/AIDS.

SUB THEME	RESPONDENT	DESCRIPTIVE CODES	ANALYTIC CODES
HIV status disclosure	N, W, S, U, Q, X, T	A friend disclosed, continued treating her/him well, advised her etc	Close person's declaration, persistence & guidance.
	L, M, Z	A brother/sister/cousin disclosed HIV positive status, continuous good treatment	Relative's declaration & persistence
	R, Y	No chance of disclosure from a friend or a relative	No declaration
	P	A youth disclosed, counselled him	Declaration, guidance
	V	A friend has disclosed HIV negative	Negative Declaration
	O	Many have disclosed	Various declarations and guidance
Discussing health-related issues with employers	L, O, S, V, N, Q, R, Y	Discuss health related problems/issues, protect against diseases like HIV, positive living	Health Conversations, deadly epidemic prevention,
	T, U, W, Z	Mainly discuss sanitation issues, HIV unattended	Hygiene-oriented conversations, under look deadly pandemic
	P, X	No health discussion, boss is scarce	Unavailability, poor communication
	M	Omitted	Skipped
Advised about HIV testing by the employer	L, M, T, U, P	Never advised,	No guidance
	Y, Z, W, P, N	Never advised, unknown motives, ever busy, mature enough	No guidance, unavailability, individual initiative
	V, O, R, X	Informal HIV talk, loves us, our productiveness	Guidance, good working relationship
	Q, S	Never advised, mature enough to judge, one's origin	No guidance, individual initiative, cultural sensitivity
etc			

THEME 2. INTEGRATING HIV WORKPLACE POLICY

SUB THEME	RESPONDENT	DESCRIPTIVE CODES	ANALYTIC CODES
Information on HIV workplace policy	L, O, Y, M	Aware, condom use, trust, HIV positive concerns, test for HIV	Knowledgeable, preventive measures
Information on HIV workplace policy	N, P, Q, R, W, X, Z, T, U, V	Unaware, no time, directors not bothered, SEs not targeted	Lack information, mgt's irresponsibility, Poor outreach
	S	Unaware, policy giving rights to HIV positive people	Lack information, Pandemic victim's rights advocacy
etc			

