"WE ALSO HAVE CASES OF THE DISEASE THAT YOU ARE RESEARCHING ABOUT". SMALL-SCALE ENTERPRISES AND THE CHALLENGES OF HIV/AIDS-RELATED STIGMA AND DISCRIMINATION IN KABALE, UGANDA

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Abstract

At the workplace, the HIV epidemic has brought about loss of productivity, staff turnover and increased labour costs among others. HIV stigma presents barriers to HIV prevention in different settings including the workplace. Unlike large scale enterprises, small-scale enterprises have received less attention in the fight against HIV/AIDS. This study employed a qualitative case study design. Data were collected from eighteen participants in three small-scale enterprises in Kabale, Uganda. Findings indicate that although there are effectively no workplace policies in small-scale enterprises, employees in the visited workplaces do not fear HIV/AIDS testing and disclosing their HIV/AIDS status as main sources of HIV-stigma although their perceptions remain hypothetical. Integrating clear anti-discriminatory HIV/AIDS policies may empower some small-scale enterprises with related HIV knowledge and skills in an effort to overcome the challenges of HIV-related stigma and discrimination.

Key words: HIV/AIDS, Stigma, Discrimination, Small-scale enterprises, Uganda.

Background

Globally, the HIV/AIDS epidemic continues to present an enormous impact in affected societies. Unlike other infectious diseases, 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). The International Labour Organisation (ILO) (2006, p. 3) estimated 24.5 million labour force participants in 60 affected countries to be living with HIV/AIDS by 2005. Sub-Saharan Africa (SSA) remains the region worst hit by HIV/AIDS. Relative to their size, small-scale enterprises in SSA face a big challenge as far as HIV/AIDS is concerned (Durier, 2007). Small and medium scale enterprises in SSA account for over 80 percent of the total job opportunities (ILO, 2002). Positively, small-scale enterprises in the SSA region have been recognised for their role in economic development (Murphy, 2002). Uganda has been hit hard by HIV/AIDS. UNAIDS estimates the number of people living with HIV/AIDS (PLWHA) in Uganda to be between 870,000 and 1,000,000 (UNAIDS, 2009).

The epidemic has brought about many related effects in the country including a reduced labour force (Asingwire & Kyomuhendo, 2003), insecurity in employment and discrimination (Asingwire & Birungi, 2006; Garbus & Marseille, 2003) among others. According to Ntozi et al (2003), in Kabale – southwest Uganda the youths who are perceived to be the economic future of the country believe in having multiple sexual partners, a situation that puts them at risk of contracting HIV/AIDS which later subjects them to HIV-related stigma.

According to UNAIDS (2007), HIV-related stigma and discrimination mean a process of devaluation of people either living with or associated with HIV/AIDS. Besides the HIV/AIDS epidemic, HIV stigma has also been referred to as an epidemic on its own (Chesney & Smith, 1999; MacIntosh, 2007). Generally HIV-related stigma may result from fear of accessing health services, delayed treatment, testing without consent and breach of confidentiality among others (Foreman, Lyra, & Breinbauer, 2002). Consequently, research

has shown that stigma has hampered HIV prevention, treatment and support in many affected communities (Aggleton, Wood, Malcolm, & Parker, 2005; Campbell, Foulis, Maimane, & Sibiya, 2005; Ickovics, White, Stasko, & Ghose, 2007; Piot & Seck, 2001) through reluctance to test for HIV/AIDS (O'Connor, et al., 2009; Pulerwitz, Greene, Esu-Williams, & Stewart, 2004) and violation of workers' rights (Aggleton, et al., 2005; Kohi, et al., 2006; Seale, 2004). According to Rankin, Brennan, Ellen Schell, & Rankin, (2005, p. 702) "fear of stigma limits the efficacy of HIV-testing programs across Sub-Saharan Africa". In Kenya, it was revealed that some people fear to test for HIV/AIDS due to stigma (Kenya AIDS NGOs Consortium, 2007). In Uganda, stigma poses critical hindrances to HIV/AIDS related services (Hadjipateras, Abwola, & Akullu, 2006; Kironde & Lukwago, 2002; Kyakuwa, 2009; Morisky, et al., 2006; Tumushabe, 2006).

The HIV epidemic continues to impact different settings worldwide including the workplace setting (Rau, 2002). However, 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 in particular (Asingwire & Birungi, 2006; Global-Unions, 2006; ILO, 2007; UNIDO, 2010). This is due to the fact that in many affected communities, HIV/AIDS has become a workplace issue (IFC, 2002). In the face of the HIV/AIDS epidemic, the majority of workers in developing countries like Uganda find employment in small-scale enterprises (ILO, 2009). Based on the size of the organisation, in Uganda small-scale enterprises are firms that employ 5-50 employees (Kazooba, 2006). According to ILO (2007), it is estimated that over 90 percent of PLWHA in Uganda were adults of working age as at the end of 2006. But, like large enterprises, research has shown that small-scale enterprises are equally affected by HIV/AIDS (Durier, 2007; ILO, 2007) yet the majority of governments, national and international HIV/AIDS support organisations have not paid attention to them (ILO, 2007; Okou, 1998). For instance, the government of Uganda has not yet put in place clear guidelines to deal with HIV/AIDS issues at the workplace. This is probably due to an unclear national HIV/AIDS policy. Hence, this implies that a large number of enterprises in Uganda do not have HIV workplace policies in place (Asingwire & Birungi, 2006; Kironde & Lukwago, 2002) perhaps due to limited resources to run these programmes (Asingwire & Birungi, 2006; Phororo, 2003) or lack of knowledge on workplace programmes (ACORD, 2004). Nevertheless, some large enterprises and international NGOs in Uganda have implemented their own HIV workplace policies (Hadjipateras, et al., 2006) and a few have comprehensive HIV workplace programmes in place (Kironde & Lukwago, 2002) leaving small-scale enterprises to lag behind in responding to fighting against HIV/AIDS at the workplace.

In respect to the workplace setting, it has been documented that HIV-related stigma presents major barriers to HIV prevention, treatment and support (Fesko, 2001; ILO, 2007; Miller, 2008; Stewart, Pulerwitz, & Esu-Williams, 2002) including fear for HIV testing and disclosure (Chesney & Smith, 1999). In Southern Africa, some mining companies were using screening to determine the HIV sero-status of their workers (Malcolm, et al., 1998). This might lead those found HIV positive to be discriminated against in employment (ACORD, 2004). At the workplace the issue of stigma is a double-edged sword because even employers who are infected (or not infected) also fear to be stigmatized by their employees (Fesko, 2001; ILO, 2007). Employers in particular are afraid of the prospect of diminishing productivity due to stigma-related effects like absenteeism and employee turn-over (Asingwire & Birungi, 2006; International Organisation of Employers, 2009). At worst, stigma prevents HIV positive employees from accessing antiretroviral drugs (ARVs). For instance, in Botswana, a study done among HIV/AIDS patients and health workers revealed stigma as one of the barriers in accessing ARVs (Weiser, et al., 2003). In Kenya, fear of HIV stigma hindered HIV positive nurses and doctors from disclosing their HIV status to patients (Waterman, et al., 2007). In Uganda, a few studies have condemned HIV stigma for hampering workplace settings in the fight against HIV/AIDS (Hadjipateras, et al., 2006; Kyakuwa, 2009) especially impeding the integration of HIV workplace policies (Hadjipateras, et al., 2006). Lack of anti-discriminatory workplace policies in Uganda probably leaves some employers with mandate to terminate contracts of employees who fall sick due to HIV/AIDS (Garbus & Marseille, 2003; Monico, Tanga, Nuwagaba, Aggleton, & Tyrer, 2001). Similarly, those who are not dismissed end up being denied promotion as in the Uganda People's Defence Force (Tumushabe, 2006). In general, the informal and formal sectors in Uganda continue to face reduced productivity and other related outcomes due to HIV stigma-related effects (Asingwire & Birungi, 2006; International Organisation of Employers, 2009).

In their book, "Researching the small enterprise", Curran and Blackburn (2001), argue that small-scale enterprises are under researched. Whereas there is a large literature on HIV-related stigma and discrimination in many affected communities, the area of HIV stigma and small-scale enterprises remains inadequately researched. At present, there exists little published data about the impact of HIV-related stigma on HIV

interventions among workplaces in Uganda. This may explain why small-scale enterprises have been left out in the fight against HIV/AIDS in Uganda. Yet small-scale enterprises accommodate over 80 percent of Uganda's active workforce (ILO, 2009; UNDP, 2008). Therefore both international and national HIV/AIDS support organisations ought to pay maximum attention to the informal sector in Uganda. In an attempt to bridge the literature gap between large and small-scale enterprises on HIV/AIDS-related issues, this study explores HIV/AIDS stigma-related issues among small-scale enterprises in Uganda. Thus the rationale of this study was to find out how small-scale enterprises may overcome the challenges of HIV-related stigma and discrimination according to the employers' and employees' knowledge and attitudes about and towards the HIV workplace policy in Uganda.

Methods
Study Design, Data Collection and Analysis.
The nature of this study (HIV-related stigma and discrimination at the workplace) called for a qualitative case study design. According to Creswell (2007), a case study design appears to be an appropriate design because it involves the study of an issue (HIV workplace policy) explored through one or more cases (three small workplaces) within a bounded system (small-scale enterprises). Yin (2009, p. 04)) asserts that, "the case study method allows investigators to retain the holistic and meaningful characteristics of real-life events" such as attitudes and knowledge towards and about the HIV workplace policy. This study employed a purposive sampling method in which three small-scale enterprises were selected to illustrate knowledge and practice of HIV workplace policy in small-scale enterprises.

Data for this study were collected from eighteen study participants purposively selected from three small-scale enterprises in Kabale district, south-western Uganda. Study participants were categorised into two groups of employees and employers as shown in Table 1. The employee's group was composed of nine males and six females whereas the employers group had two males and one female. Out of the eighteen participants, fourteen were casual workers, one supervisor and three entrepreneurs. The types of workplaces visited were carpentry, bakery and a small-scale matchbox factory. The enterprises employed 9-25 employees at the time of the interviews. Data were obtained from participants by use of in-depth interviews and limited observation. Each interview was conducted in Rukiga-Runyankore (the local language) and recorded through taking notes during actual interviews. The notes were later transcribed to produce fair interview scripts which were later translated into English. Collected data 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).

Table 1: Demographic variables

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

Ethical Considerations
This study was approved by the Uganda National Council of Science and Technology, a body that authorises anybody wishing to carry out a study in the country. Our study participants were guaranteed a right to know the purpose and findings of the study and also held a right of terminating the interview in case one wished to do so. The purpose of the study was presented orally and in text by giving a written consent form to each participant. Due to the sensitivity of the topic and the dynamics of small-scale enterprises, adequate confidentiality and anonymity were assured to our study participants. For instance, each interview was conducted in a reserved room near each of the three selected workplaces. The identities were also masked by use of alphabetical letters such as employee M, N, O etc. and employer A, B and C. In addition, asking participants about their HIV status was thought to be another source of stigma. According to Lee's (1993) argument, our main data collection method - interviewing - enabled us to overcome possible negative emotions in our participants. As Kvale (1996, p. 110)) asserts that "ethical decisions do not belong to a separate stage of interview investigations […]", while in the field, an imbalance between our interests as researchers and the perceived benefits to our study participants yielded a demand for payment. We countered this misconception among our study participants by telling them that this study was purely an academic research that values voluntary participation rather than commercial research (Krueger & Casey, 2000).

Findings

Exploring Employees' and Employers' Knowledge and Attitudes about HIV/AIDS
Out of the three small-scale enterprises visited, none had any form of HIV workplace policy as revealed by both employee and employer participants at the time of the interviews.

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 and towards HIV/AIDS at the workplace. Contrary to our expectations, few participants mentioned HIV/AIDS when asked to name common health-related problems 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 participant denied the presence of people with the disease in the workplace while another feared to mention the word 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. Out of the fifteen employee participants, only one participant revealed to have had a negative HIV status disclosure leaving twelve participants with positive disclosures and two participants with none. Positively, of the twelve employee participants with HIV positive disclosures, none indicated signs of HIV stigma to PLWHA:

"One friend of mine has ever disclosed to me his status; [...] actually I am the one who advised him to test [...] ever off and on. [...] I continued treating him as a friend" (U. Mat).

In respect to perceptions about people living with HIV/AIDS, employee participants were asked about their attitudes towards a co-worker who would disclose his/her status. All fifteen employee participants indicated that they would continue relating to a positive co-worker:

"If a co-worker disclosed being HIV positive, [...] I would extend extra care [...]" (O, Cap)
"If working in a section with chemicals, [...] I would 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 unexpected in the workplace:
"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/AIDS"(M, Cap)

In an effort to understand the culture of disclosure, participants were asked about their reasons for discussing health-related issues and how they interact with each other. Interestingly, out of the fifteen participants, twelve admitted to have had health-related talks:

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

The majority of employee participants indicated a lack of HIV/AIDS testing guidance and blamed their employers. Out of the fifteen employee participants, only four participants revealed to have been advised about HIV/AIDS testing by their employers. Of these four employee participants, one participant went ahead to substantiate that the advice given was out of informal conversations with the employer:
"He advises us but he does it informally [...] just talks about these issues in a joking way. [...] no organised meeting with our boss to tell us about HIV/AIDS-related issues (R. Mat).
Participants were then asked about taking an initiative to advise a co-worker to test for HIV/AIDS. Of the fifteen employee participants, the majority revealed to have advised their co-workers to test for HIV/AIDS:
"I tell them to test, [...] I even tell them about HIV testing while we are in church" (O, Cap).
"I have never advised my co-workers [...] I know they are safe" (M. Cap).

When asked about reasons for giving HIV/AIDS testing advice, more than half of the employee participants revealed that they wanted their co-workers to know their own status. In addition, a few participants shared 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 HIV status too" (T, Mat).

The meaning of HIV-related stigma raised mixed ideas among our study participants. 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 immoral. 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 due to their HIV status [...] 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 revealed that HIV-related stigma is a form of protection against those infected from infecting other people as seen in the following quote:

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

Employers:
The focus here was to discover the extent to which employers were knowledgeable about HIV epidemic and its related effects on their enterprises at large. Unfortunately, results indicated poor knowledge sharing between employers and their employees as far as the 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, all employer participants revealed that they had 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 (of 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).

HIV Stigma Challenges Faced by Employees and their Employers at the Workplace
Employees
Under this theme, employee participants revealed that HIV-related stigma inflicts quite a number of challenges to employees and employers. Out of the fifteen employee participants, fourteen revealed being afraid to test as one of HIV-related stigma challenges as seen below:
"The majority of employees in many enterprises 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 introduced an extreme form of HIV stigma challenges that was unexpected, that is, committing suicide after testing HIV-positive:
"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 stigma-related challenges revealed by employee participants included: loneliness, isolation,

misunderstandings, loss of jobs, job dissatisfaction and occupational stress among others. On the other hand, employee participants revealed that employers, too, face the challenge of stigma at the workplace though some are indirect. Out of the fifteen employee participants, six participants confirmed that HIV stigma is a challenge to entrepreneurs, staff and prospective employees:
"Due to 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 at the workplace. Out of the majority who supported the workplace as a good environment for HIV testing, few employee participants called for a collective HIV disclosure at the workplace as seen below:
"[...] as workers we need to know our status as a group! We are safe or not, [...]" (Y. Bak).
However, some employees objected to the issue of testing at their workplaces as seen below:
"The workplace is not a good environment [...], one's results may be disclosed" (M. Cap).
"Some people do not want others to know that they have gone for testing. In such workplaces if one gets positive results, he/she may collapse in front of other co-workers, hence stigma" (Q. Cap).

Employers
The three employer participants consented that challenges of stigma were prevailing in their enterprises. They all revealed that their employees fear to test and disclose their HIV status due to fear of being stigmatised and discriminated against by employers or superiors:
"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 on-site testing needs maximum confidentiality:
"The workplace is not a good place for one to take an HIV test. Any one testing may think that those carrying out the test may disclose the results to the employer [...]" (B).

Employer participants also revealed that sustaining the two groups (HIV negative/positive) 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 staff:

"[...] befriending all employees so as to reduce the employee-employer gap, discussing HIV-related issues with staff. For infected staff, employers ought to disclose their health-related issues too and should not consider themselves as bosses in everything [...]" (A).

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

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

Discussion
Knowledge and Attitudes about and towards HIV/AIDS
There are very few studies on the impact of HIV/AIDS in workplaces most especially small-scale enterprises. Based on this study's findings, there is a lack of HIV workplace policy and a lack of HIV/AIDS-related knowledge among small enterprises in Uganda. The implication for the small-scale enterprises studied, was that they had received little attention from either government or civil society concerning HIV workplace policy.

This study has found that some employees in the participating small-scale 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). Likewise, a study done in a small fish landing site in Uganda revealed that the fishing folk could not mention the disease's name due to the fear attached to it (Tanzarn & Bishop-Sambrook, 2003). 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 although this remains hypothetical. This implies that the majority of employees in the participating enterprises are ready to live and work alongside PLWHA. In contrast, in a study done by Lim & Loo (2000), 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/AIDS knowledge sharing which largely implies HIV status disclosure amongst employees at the workplace would be ideal but still this is hypothetical because there is no participant who reported knowing of an HIV positive employee. The implication of this is that some employees are motivated and committed to save their co-workers from contracting HIV/AIDS, as put by one of the participants quoted above**. 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 a clear association between HIV/AIDS knowledge and HIV-related stigma and discrimination 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. For instance, despite the presence of a few HIV positive participants, the most of the participants demonstrated willingness to test for HIV/AIDS and disclose their status to everyone at the workplace, but there was no participant who had disclosed his/her status at the workplace at the time of interviews. A case in point was one of the participants who indicated that he/she does not bother to advise his/her co-workers to test for HIV/AIDS because he/she knows that they are not infected. The same participant indicated willingness for the policy implementation. But the attitude changed when it came to issues of carrying out HIV testing at the workplace.

Challenges of HIV-related Stigma and Discrimination
While most participants agreed that HIV testing in principle is good - people need to know their status - they also reported that they fear to test. This study has found that most employees in the workplaces visited are pro-testing at the workplace but a few remain hypothetical when it comes to testing. Similarly, studies done by Devine et al (1999) and Kohi et al (2006) assert that employees fail to test for HIV/AIDS due to fear for being dismissed by their employers. However, as stated earlier, the willingness to test for HIV is hypothetical because later in the interviews, some participants showed that they would prefer taking the HIV test outside their workplaces.

Equally, this study has indicated that participants in the small enterprises visited are willing to disclose their HIV status to everyone at the workplace. Still this attitude is hypothetical because those participants who are HIV positive did not report to have disclosed their status by the time of the interviews**. Ideally,

these findings imply a level of trust and confidence among employees and their employers which could neutralise 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. Likewise, employees fail to disclose their status to co-workers and employers because of not being sure of the outcomes in return (Simoni, Mason, & Marks, 1997).

However, this study has indicated that stigma is understood to create 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 relations enhance HIV-related 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 treating an infected employee differently from the one who is uninfected. Such discriminatory behaviour creates a gap between HIV positive and negative employees. In agreement with our findings, there are a few studies which indicate that stigma and discrimination cause health inequalities (Adeyemo & Oyinloye, 2007; Herek, 1999) as it is with social inequalities (Castro & Farmer, 2005).

Conclusion
This study's participants have indicated a lack of any HIV workplace policy and low levels of HIV/AIDS knowledge at the workplace. Both employees and their employers in the visited small-scale enterprises do not fear to test and to disclose their HIV status though their perceptions towards HIV/AIDS testing seem to be hypothetical rather than based on experience. However, this study clearly brings out the issue of limited HIV/AIDS knowledge among small-scale enterprises about the policy and the fact that small-scale enterprises in Uganda have received little attention from government and Non-Government Organisations concerning HIV workplace policy. Thus, this study suggests that implementing anti-discriminatory workplace programmes while involving all stakeholders could yield low levels of HIV stigma. Therefore, empowering employees and their employers in small-scale enterprises with HIV knowledge and skills may contribute to curbing HIV-related stigma.

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