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Business partnership, women empowerment and support to women living with HIV/AIDS in Kabale, Uganda

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Abstract
Purpose: This investigation stemmed from the need to support women living with HIV/AIDS using community approaches of business partnerships and women empowerment as opposed to government-and private sector-led support.
Research Methodology: This study adopted systematic sampling techniques for data collection from 123 women living with HIV/AIDS from a designated health center in Kabale Municipality. Women taking ARVs were identified from the points where they were collecting their ARVs, and were given questionnaires after consenting to participate in the study.
Results: Women empowerment increased decision-making power, while business partnerships decreased dependence on male partners. Women empowerment increases support for women living with HIV/AIDS compared with business partnerships. Business partnerships, as observed in this study, draw weak relationships from many women living with HIV/AIDS. Women empowerment programs that cut across all age groups are effective in supporting vulnerable women living with HIV/AIDS.
Limitations: This study encountered the challenge of interfacing with the respondents, since the information was collected by those in charge of the drug distribution center but not the researchers, and these affected in-depth investigations. Women accessing HIV/AIDS do not want to be identified because of stigma within the community.
Contributions: From a public health perspective, designers of intervention programs to support women living with HIV/AIDS should consider inclusiveness in design, driven by age categorizations. Designers of intervention programs to support women living with HIV/AIDS should target business partnerships among low-income earners to reduce vulnerability.
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1. Introduction

The global realities of HIV and AIDS reveal the need for increased study undertakings to analyze the disease and issues of gender, development, and women's contributions to human society (Scanlan, 2010). The effect of the Human Immunodeficiency Virus (HIV) in Uganda cannot be overemphasized, as it is evident in all the different corners of society, irrespective of gender, age, marital status, level of education, occupation, and religion (USAID, 2004). HIV/AIDS cases were first identified in the central

region near the shores of Lake Victoria in 1982, and then quickly spread throughout the country. A large majority of women living with HIV and AIDS in Uganda continue to battle the scourge amidst poverty and discrimination from their own families and society, which negates their capacity to lead meaningful and healthy lives. These women lack access to basic healthcare because of their economic dependence and the weakness of their countries' health systems. They endure acts of discrimination and violence, which expose them to unwanted pregnancies, sexually transmitted diseases including HIV and AIDS, and even death (Sambo 2008).

Emphasis on public information with policies emphasizing the mitigation of the impact and universal provision of ARVs yielded significant progress in reducing the prevalence, albeit an increasing percentage from 6.0% in 2003 to 7.3% in 2011 (UBOS, 2013). In 2015, HIV prevalence among adults (15–49 years) was 7.1%, with 8.3% among females (UNFPA, 2017). Currently, HIV prevalence in Uganda among adults aged 15–64 years is 6.2%, with 7.6% among females and 4.7% among males, which corresponds to approximately 1.2 million people aged 15–64 living with HIV in the country (UPHIA, 2019). This prevalence is almost four times higher among young women aged 15–24 years than among young men of the same age, and higher among women living in urban areas (9.8%) than in rural areas (6.7%). The issues faced by this demographic include gender-based violence (including sexual abuse) and a lack of access to education, health services, social protection, and information about how they cope with these inequities and injustices. Indeed, young Ugandan women who have experienced intimate partner violence are 50% more likely to have acquired HIV than women who have not experienced violence. The lack of sexual education is telling.

The adverse economic impacts of HIV and AIDS are related to their prevalence in the sexually active age, which coincides with the size and quality of the labor force. At the microeconomic level, valuable and skilled workers keep falling sick and some die (UNAIDS, 2003). Their skills and experience are not easily replaced by suppliers failing to deliver on time because of their stricken workforce, which reduces productivity and increases costs of recruitment and training over time. At the macro-economic level, HIV and AIDS destabilize markets and societies that threaten occupational safety, undermining nations' investments and resulting in decreased productivity and increased labor costs (UNAIDS, 2002). HIV and AIDS kill disabled adults in the most productive part of their lives, consequently affecting business, investment, industry, and agricultural sustainability, ultimately reducing families' income and economic growth (McCreanor, 2010). HIV and AIDS result in increased costs, loss of productivity, and overall threats to the economic foundations in which people living with HIV operate (McCreanor, 2010). The disease systematically erodes economic strength, shrinks productivity, precipitates a decline in savings, increases a country's debt load, and diminishes human capital (Zhira, 2014).

According to Economics (2002), HIV and AIDS impact the economy at the household, firm, and economy levels through three key avenues: reduction in the capacity of the labor force, which brings about a decline in the number of workers and worker productivity, and an increase in the cost of employment. The second avenue is through shifts in the composition of demand as households, and possibly the government, shift expenditure toward the health and medical sector, and meeting funeral costs. A final avenue is domestic savings feeding through to lower investment. Savings are expected to decrease as household resources are used to deal with the consequences of the disease. Businesses and agriculture have also been seriously affected by HIV and AIDS. Employers are hard-hit by the loss of workers, absenteeism, the rising costs of providing healthcare benefits (including expensive AIDS drugs), and the payment of death benefits (Ashford, 2006).

Despite such adverse effects, the current business response appears minimal, erratic, and uncoordinated (Zhira 2014). Individual companies lack awareness and understanding that HIV and AIDS can result in critical workplace conflicts, disruptions at managerial levels, and conflicts arising from unsuitable business responses (UNAIDS, 2002). In a related view, the Global Business Coalition on HIV and AIDS (2006), as cited in Gow and George (2011), indicated that the private sector lacks proactive prevention, treatment, care, and support interventions. However, the involvement of non-governmental organizations (NGO) in mitigating the effects of HIV/AIDS on the economy and well-being is

noticeable worldwide. The Global Business Coalition on HIV and AIDS, Tuberculosis, and Malaria encourages its members to develop HIV and AIDS policies for the benefit of employees, their families, and communities (Attawell, 2008). Such development initiatives must contribute to AIDS prevention and treatment in communities in which they work. The World Bank–supported Chad/Cameroon Pipeline Project, for example, supports HIV workplace interventions along the pipeline route, both for workers and affected communities (Piot et al., 2007). In Uganda, Federation of Uganda Employers (FUE) and Uganda Manufacturers Association (UMA) have provided direct services through provision of workplace programs (Koseki, Fagan, & Meno, 2016). At the core of their involvement is the philosophy that when one is unemployed and poor, one is more vulnerable to contracting HIV & AIDS and the period within which one may fall prey to the disease is shorter that the time it would take for a non-poor person who contracts the disease to become unemployed and poor as a result of the disease (Scott, Simon, La Foucadeb, Karl, & Gittens-Baynes, 2011).

1.1 Statement of the Problem

The government, private sector, NGOs, and the donor community have invested significantly in providing models to increase access to treatment and health care services to people living with HIV and AIDS. However, most of these models cannot be sustained by people living with HIV or AIDS. Any cut-off of support by the government, donor community, private sector, or NGOs leaves sufferers in great vulnerability. The burden is worse for women living with HIV and AIDS, whose vulnerability is escalated by societal marginalization of women and their disempowerment in terms of resource ownership and decision-making about their sexuality. Our approach to supporting women living with HIV and AIDS recommends a community approach through business partnerships and women's empowerment.

1.2 Hypotheses

H1: Business partnerships do not significantly contribute to supporting women living with HIV.
H2: Women's empowerment does not significantly contribute to supporting women living with HIV.
H3: Women's empowerment among women living with HIV does not differ across age.
H4: Business partnerships among women living with HIV differ across age groups.
H5: Women's empowerment among women living with HIV differs across monthly salary categories.
H6: Women's empowerment among women living with HIV differs across marital status categories.

2. Literature Review

2.1 Business partnership

AIDS affects businesses, as it causes expanding business costs and shrinking markets. Corporate action and strength can have an impact on the fight against HIV and AIDS (Annan 2001). Beyond the tragic agony of AIDS victims and their families, HIV hinders economic development, mostly in countries with a dire need to create jobs and stability. AIDS has a significant impact at every level of business, as valuable and skilled workers keep falling sick and some die (UNAIDS, 2003). However, their skills and experience are not easily replaced. Suppliers fail to deliver on time because of their strict workforce. Productivity declines and the costs of overtime, recruitment, and training increase at the macro-economic level, and HIV and AIDS destabilize markets and societies that threaten occupational safety, undermining the nation's investments and resulting in decreased productivity and increased labor costs. At the individual company level, a lack of awareness and understanding can result in critical workplace conflict, disruption at managerial levels, and conflicts arising from unsuitable business responses (UNAIDS, 2002).

Gow and George (2011) cited the Global Business Coalition on HIV and AIDS (2006) to indicate that the private sector lacks proactive prevention, treatment, care, and support interventions. The projected financial costs of future HIV infections in the workforce of the companies investigated provided the sums that, hypothetically, companies should invest annually in an HIV and AIDs reserve fund to cover the future costs to the company. Economic growth in countries heavily affected by HIV and AIDS has been reduced by the epidemic's effect on labor supply, productivity, investment, and employment. However, enterprises, households, families, communities, and economies can benefit if workers with

HIV and AIDs have access to effective ARVs (ILO 2008). The disease systematically erodes economic strength, shrinks productivity, precipitates a decline in savings, increases a country's debt load, and diminishes human capital (Zhira, 2014). HIV and AIDS kill and disabled adults in the most productive part of their lives, consequently affecting business, investment, industry, and agricultural sustainability, ultimately reducing families' income and economic growth. HIV and AIDS result in increased costs, loss of productivity, and overall threats to the economic foundations in which people living with HIV operate (McCreanor, 2010).

According to Economics (2002), HIV and AIDS impact the economy at the household, firm, and economy–wide levels through three key avenues: reduction in the capacity of the labor force, which brings about a decline in the number of workers and worker productivity, and a rise in the cost of employment. The second avenue is through shifts in the composition of demand as households, and possibly the government, shift expenditure toward the health and medical sector, and meeting funeral costs. A final avenue is domestic savings feeding through to lower investment. Savings are expected to decrease as household resources are used to deal with the consequences of the disease. Research on the social and economic implications of the epidemic has focused almost entirely on private and public-sector institutions in the formal sectors of the economy. Little attention has been paid to the impact of HIV and AIDS on business and production in the informal economy, and only a few initiatives on HIV and AIDS are targeting informal economy workers, despite their economic importance and growing numbers. The impact of HIV and AIDS on human resources capital and business is very pronounced; however, the current business response is minimal, erratic, and uncoordinated (Zhira, 2014). Businesses and agriculture have also been seriously affected by HIV and AIDS. Employers are hard-hit by the loss of workers, absenteeism, the rising costs of providing healthcare benefits (including expensive AIDS drugs), and the payment of death benefits (Ashford, 2006).

Many companies recognize the impact of HIV and AIDS on their operations, but they may not know how to mitigate this impact. Other companies are unaware that a problem exists in their workforce, even when it may already have a negative effect on their bottom line. At the macro level, AIDS reduces disposable income, savings rates, investments, and consumer spending. With treatment, HIV-positive individuals can continue to feel well and work productively in their jobs, but AIDS medicines are expensive (Dixon, McDonald, & Roberts, 2002). Research suggests that studies on HIV/AIDS fail to consider that by undermining human capacity, HIV and AIDS reduce productivity, disrupt organizations, and unravel institutions. The spread of HIV and AIDS reduces labor productivity and raises private and public consumption, thereby reducing income and savings. With lower savings, the investment rate decreases, reinforcing the decline in economic growth. The loss of labor productivity occurs because a larger share of the workforce becomes debilitated and dies, causing organizations to lose workers with critical skills (Barks-Ruggles, 2001).

In high-prevalence areas, companies that take no action see their revenues, and ultimately profits, decrease as a result of higher absenteeism and staff turnover, reduced productivity, declining morale, and shrinking consumer base (Foundation, 2017). Even companies that take action may find that their cost of doing business increases because suppliers and distributors are affected, leading to similar disruptions in the supply chain. However, these devastating impacts are not confined to households. They have knock-on effects on broader economies. The death and incapacitation of workers reduces household income and leads to reduced spending and lower demand for goods and services. Consequently, the business sector may suffer from decreasing sales, profits, and employment. Nationally, reduced business output and income inhibit economic growth. Ultimately, countries' international competitiveness declines, reducing investments and job opportunities. Labor shortages lead to higher wages and increased workforce turnover, resulting in higher domestic production costs. Firms may have to close or they may be unable to attract new investment (Eton, Mwosi, Ebong, & Ogwel, 2018; Program, 2001).

It is well acknowledged that HIV and AIDS have differential gender impacts, with females being more vulnerable. At the same time, it is also recognized that empowerment of women (through greater

economic independence) is associated with a lower HIV prevalence rate (Were & Nafula, 2003). Hence, the assessment of the impact of HIV and AIDS on economic development would be incomplete without recognizing their differential gender roles and effects. Gender is an issue across all sectors. The impact of HIV and AIDS on business can be summarized into four main concerns: the effect on the workforce, the threat to the customer base, the impact on brands and corporate reputation, and concern for the global good (Bloom & Mahal, 2001). Women's groups exist, but they have few materials or financial means to operate. There is demand for capital and access to loans. As a group, these women have access to loans from international institutions; however, the risks are such that they prefer not to apply.

Business partnerships with women living with HIV and AIDS can greatly enhance their financial muscle to address the economic challenges that come with this disaster. Business partnerships can provide business training, financial management, entrepreneurship training, and sources of cheap credit; create a friendly business environment; and demand government to extend incentives to this group of vulnerable women.

Businesses possess intellectual property, marketing expertise, public relations skills, distribution channels, expertise in pharmaceutical development, and project management skills. Businesses have experience with product launches, supply chain management, and manufacturing. If businesses are well-positioned, they can make important contributions to the fight against HIV/AIDS (UNAIDS, n.d.). As the Ministry of Education in Uganda has partnered with The Uganda Aids Support Organization to provide training to counselors (Attawell, 2008), the Ministry of Health can partner with the Uganda Manufacturers' Association and the Uganda Chamber of Commerce. Supporting improvements to rural water and irrigation systems, domestic energy, and rural transportation have substantial multiplier effects on creating jobs for women and men and reducing women's unpaid care work. Providing childcare facilities also tends to reduce women's burden of unpaid care work and provide opportunities for women to enter the labor market.

2.2 Women Empowerment

Women empowerment refers to the process of increasing the knowledge, awareness, improvement of skills, and participation of women with the objective of facilitating their roles in the decision-making process (Mishra, 2013), while Eton, Mwosi, Ogwel, Edaku, and Obote (2018) view women empowerment as granting women access to small and medium enterprises (SME) and other sustainable growth opportunities. Social networking, consignment, sale agreement and business analysis and financial capital boosts business strategies (Mabhanda, 2024) Studying the interrelationships between gender and HIV & AIDS and development and HIV & AIDS, Scanlan (2010) found that female empowerment and gender equality decrease the prevalence of the disease and reduces child mortality significantly. Needlessly, countless children and women die of preventable causes such as malaria, HIV, and AIDS, lack of proper child and maternal care, failure of women to realize their abilities, and the need for them to take an active part in decision making and policy formation (Oyelude & Bamigbola, 2013). Because many women have limited control over their sexual lives and contraceptive use, integrating gender issues into reproductive health and HIV and AIDS program interventions is critical. Active male involvement in reproductive and family caregiving enhances responsible parenthood and reduces gender-based violence that affects women's reproductive health and rights (Alemu & Asnake, 2007). A woman is economically empowered when she has the ability to succeed and advance economically, and the power to make and act on economic decisions. Decision-making in entrepreneurship design thinking is positively correlated with entrepreneurship intention in business partnerships (Eunah, Eta, & Shepherd, 2024). To succeed and advance economically, women need the skills and resources to compete in markets as well as fair and equal access to economic institutions (TechnoServe, n.d.).

Women's economic empowerment fuels economic growth, provides women with income to invest in their family's health and education, increases household food stability and resilience, and strengthens women's decision-making power in their homes, communities, and societies. However, a report by the State (2017), social and gender norms, and laws and policies often limit women's political participation,

restrict their access to land and other assets, and present barriers to women's entrepreneurship, including limiting their access to financial services, markets, and skills training, all of which translate to greater rates of poverty. Earning income or access to credit cannot be assumed to bring automatic benefits to women (Esplen & Brody, 2007). Increased access to resources should be translated into changes in the strategic choices that women make, at the household and community levels, as well as at work. Economic issues, law and policy, environmental and sociocultural issues are key challenges in women empowerment (Mbowa, Businge, Ssemaluulu, & Eton, 2023a), relatedly, Ekawati and Sari (2024) reveals that there is necessity for the appropriate implementation of community participation. Considering the numerous dimensions of women's empowerment, economic opportunities cannot be understood or pursued in isolation. SMEs proprietors rely heavily on social capital to harness business performance (Mbowa, Businge, Ssemaluulu, & Eton, 2023b). People living with HIV, particularly women, suffer disproportionally from discrimination and stigma in the workplace and job market, which undermines their economic security (International Labor Organization, 2009). Money lenders as well as friends and relatives, refuse to lend money to women who are known to be infected with HIV (Mutesigensi, Eton, Ebong, & Mwosi, 2017). These women are unable to pledge in cash or property titles for microfinance institution loans, and nobody stands as a co-signer for women who are known to be HIV positive.

Literature provides evidence on how women and girls suffer when the head of a family dies, particularly the husband or father (Tandipayuk & Akhrani, 2021; Willis, Mavhu, Wogrin, Mutsinze, & Kagee, 2018). When a family member falls ill with HIV and AIDS, women and girls carry an overwhelming majority of the burden of care. Mothers, grandmothers, daughters, and women from extended families provide home-based care, take in orphaned children, tend to the family's fields, find income-generating activities, and perform ongoing household duties in support of the family (Interagency Coalition on Aids and Development 2006). These responsibilities can limit their own opportunities for advancement, including pursuing education (many girls are withdrawn from school to care for sick family members), developing their skill sets, and earning financial independence. Despite their hard work, women still bear the enormous stigma attached to HIV and AIDS transmission. Women were depicted as the only transmitters of unborn children. Again, the role of heterosexual men as fathers was absent, which placed men in a privileged position. These discourses unfairly represent women as transmitters of HIV and AIDS and, consequently, run the risk of allowing blame to be disproportionately attributed to women while ignoring the complicity of their male partners (Chong & Kvasny, 2007).

2.3 HIV Support

The impact of HIV and AIDS on Africa is undoubtedly enormous, especially considering the percentage of the country's workforce living with HIV and AIDS. Udeh et al. (2014) found that many owners/managers are not aware of the challenges of HIV and AIDS in their business firms. Employees of business firms are not aware of issues pertaining to HIV and AIDS; business firms do not have a workplace policy on HIV and AIDS to minimize the impact of HIV and AIDS, and HIV and AIDS do affect the profitability of business firms in developing nations. The Global Business Coalition on HIV & AIDS, Tuberculosis and Malaria encourages its members to develop HIV and AIDS policies for the benefit of employees, their families, and communities (Attawell, 2008; Goin et al., 2020). Development initiatives must contribute to AIDS prevention and treatment in communities in which they work. The World Bank–supported Chad/Cameroon Pipeline Project, for example, supports HIV workplace interventions along the pipeline route, both for workers and affected communities (Piot et al., 2007). In other words, when one is unemployed and poor, one is more vulnerable to contracting HIV & AIDS and the period within which one may fall prey to the disease is shorter that the time it would take for a non-poor person who contracts the disease to become unemployed and poor as a result of the disease (Scott et al., 2011).

3. Research Methodology

This study was conducted among women living with HIV who had access to ARVs at designated health centers in the Kabale municipality. This study successfully collected data from 123 women with HIV. Systematic sampling was used as the sampling method. The researcher obtained records of HIV patients

registered on ARVs who picked drugs around March and April 2023. Patients were provided with a consent form, and participation was at will. Data were collected using a four-section questionnaire. Section A covered items on patients' demographic information, such as age, marital status, source of income, monthly income, and the main contributor to household income. Section B covers 13 items related to business partnerships. The patients were asked to indicate their opinions on sources of income and any assistance received. Section C: Twelve covered items on women's empowerment. Section D covers 12 items on HIV support. The items in Sections B, C, and D were measured on a five-point scale ranging from strongly disagree (1) to strongly agree (5). The researcher used counts and percentages to present patients' responses, and regression to estimate the role of business partnerships and women's empowerment in supporting women living with HIV. Cronbach's alpha, composite reliability (rho_a), composite reliability (rho_c), and Average Variance Extracted (AVE) were used to ascertain the instrument's internal consistency. For all constructs, the Cronbach's alpha coefficients were between 0.804 and 0.890. The rho_a and rho_c values were all above the cut-off value of 0.7 and 0.5 for AVE (See table 1). This implies that the instrument is consistent and valid. Moreover, all outer weight loadings were above 0.5, implying that all measurement items were significant measures of latent constructs). (Fig. 1).

Table 1. Construct reliability and validity

	Cronbach's alpha	Composite reliability (rho_a)	Composite reliability (rho_c)	Average variance extracted (AVE)
Business partnerships	0.890	0.912	0.913	0.574
Supporting women with HIV	0.872	0.817	0.872	0.630
Women empowerment	0.847	0.862	0.893	0.629

Source: Created by authors

4. Results and discussions

This study mainly focused on establishing the role of business partnership and women's empowerment in supporting women living with HIV and AIDS, using partial least squares equation Modelling (PLS-SEM). Here, the findings are explained based on the path coefficients to establish the predictive potential of exogenous variables on the endogenous variable.

4.1 Findings on business partnerships and supporting women living with HIV

The findings reveal that business partnerships positively and insignificantly predict supporting women living with HIV ($\beta = .177$, $p > .05$); hence, ***H1*** is supported. The results show a positive relationship between business partnerships and supporting women living with HIV, although this is insignificant. This implies that business partnerships do not significantly contribute to supporting women living with HIV.

4.2 Findings on women empowerment and supporting women living with HIV

The findings reveal that women empowerment positively and significantly predicts support for women living with HIV ($\beta = .560^{**}$ $\rho < .01$); hence, hypothesis ***H2*** is rejected. In other words, women's empowerment has a significant contribution to supporting women living with HIV. Based on these findings, an increase in women's empowerment results in an increase in support for women living with HIV.

4.3 Findings on interactive effect of age group on the relationship between women empowerment and supporting women living with HIV

The findings reveal a negative and significant interactive effect of age group on the relationship between women's empowerment and supporting women living with HIV ($\beta = -.194$, $\rho < .05$); hence, ***H3*** is rejected. The findings revealed that age groups alter the strength of the relationship between women's empowerment and supporting women living with HIV. In other words, empowerment among women living with HIV differs across age groups.

4.4 Findings on interactive effect of age group on the relationship between business partnerships and supporting women living with HIV

The findings reveal a negative and insignificant interactive effect of age group on the relationship between business partnerships and supporting women living with HIV (β = -.136, p >.05); hence, ***H4*** is rejected. The findings reveal that the age group does not alter the relationship between business partnerships and supporting women living with HIV. The results imply that the effect of business partnerships on supporting women living with HIV does not depend on age group.

4.5 Findings on interactive effect of monthly income on the relationship between women empowerment and supporting women living with HIV

Figure 1 shows a positive and insignificant moderating effect of monthly income on the relationship between women's empowerment and supporting women living with HIV (β = .001, p >.05); hence, ***H5*** is rejected. The findings reveal that marital status does not change the strength of the relationship between women's empowerment and support for women living with HIV. Therefore, the effect of women's empowerment on supporting women living with HIV does not depend on their total monthly income.

4.6 Findings on interactive effect of marital status on the relationship between women empowerment and supporting women living with HIV

The findings reveal a positive and insignificant interactive effect of marital status on the relationship between women's empowerment and supporting women living with HIV (β = .067, p >.05); hence, Hypothesis ***H6*** is rejected. The findings reveal that marital status does not alter the relationship between women's empowerment and support for women living with HIV. In other words, empowerment among women living with HIV does not differ according to marital status.

Table 2. Summary of statistics

Latent variables	Mean	Median	Min	Max	Standard deviation
Business partnerships					
BSP1: I have an income generating business	3.008	4	1	5	1.506
BSP10: I have many people who can guarantee me for a loan	3.398	4	1	5	1.317
BSP11: I have the required skills to compete in the labor market	2.935	3	1	5	1.378
BSP2: My income generating business is well established	2.585	2	1	5	1.349
BSP6: I find it easy to mobilize capital to establish a business	1.976	2	1	5	1.130
BSP7: I have adequate collateral security to pledge for credit	2.618	2	1	5	1.533
BSP8: I have easy access to credit	3.236	4	1	5	1.449
BSP9: I have some property titles to pledge in microfinances for loans	2.984	4	1	5	1.448
Women empowerment					
WOE2: When I contribute to the income of the family, I feel valued	3.886	4	1	5	0.998
WOE6: Women with proper jobs can renegotiate their relationships within marriage	3.187	3	1	5	1.232
WOE7: Women with proper jobs can challenge the practice of bride wealth	3.268	3	1	5	1.319

WOE8: Women with regular income have independence in making household decisions	3.561	4	1	5	1.282
WOE9: Many women are starving at home because they don't want to work	3.699	4	1	5	1.203
Supporting women with HIV					
HVS1: It is not necessary for me to tell people I am HIV positive if I only have safer sex	3.805	4	1	5	1.389
HVS2: I have the responsibility to let the people who I am going to have sex with know that I am HIV positive	3.756	4	1	5	1.358
HVS3: It would not bother me if someone didn't want to have sex with me because of my HIV status	3.618	4	1	5	1.259
HVS4: I have a responsibility to tell people whom I share drugs with that I am HIV positive	3.780	4	1	5	1.272
Marital	**2.154**	**2**	**1**	**3**	**0.699**
Monthly income	**2.163**	**2**	**1**	**5**	**1.271**
Age	**2.813**	**3**	**1**	**5**	**0.949**

Source: Created by authors

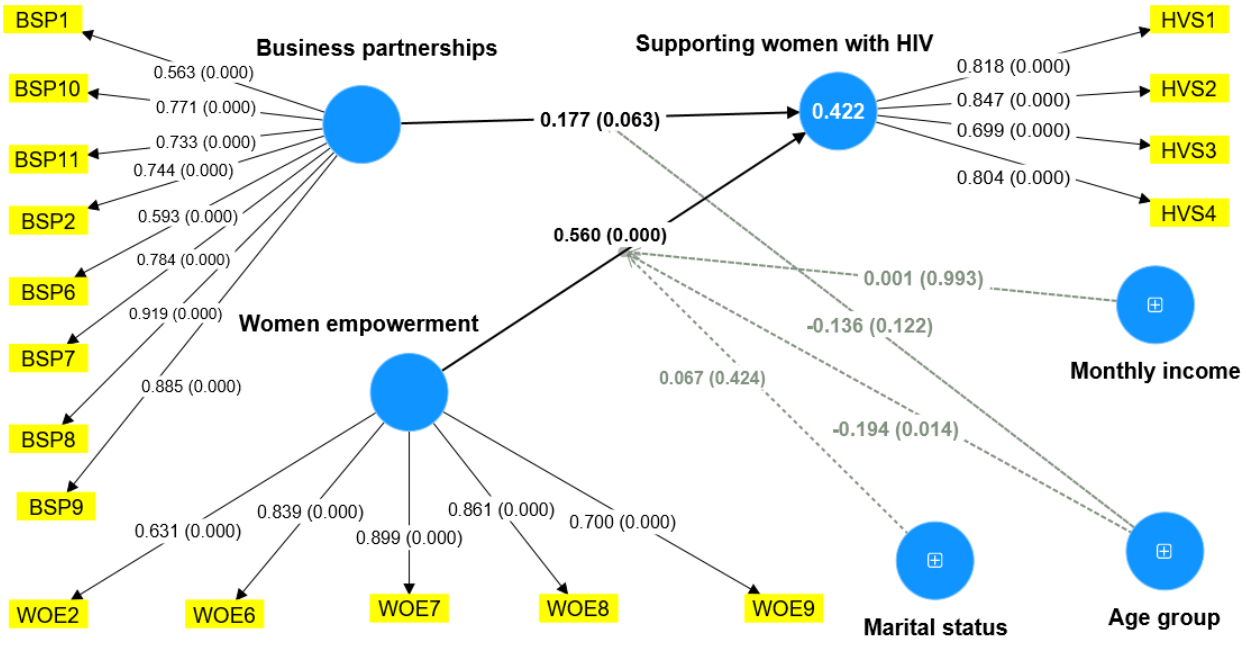

Figure 1. Structural model for supporting women living with HIV

The coefficient of determination (R^2) for supporting women living with HIV endogenous latent variable was .422, implying that exogenous variables (business partnerships, women's empowerment, age group, marital status, and monthly income) explained 42.2% of endogenous factors (supporting women living with HIV). The remaining 57.8% of the change in supporting women was influenced by factors outside the scope of this study. The inner model reveals that women's empowerment has a stronger effect on PCT (β = .560**) than on business partnerships (β = .177). (Fig. 1). Since all P value for women empowerment are less than .01, women empowerment is a significant predictor of supporting women living with HIV. The findings also show that the effect of women's empowerment on supporting women living with HIV varies by age group. Therefore, both women's empowerment and age groups are strong indicators of supporting women living with HIV.

Table 3. Measurement model estimates

Direct and Total effects	Beta	Sample mean	Standard deviation	T statistics	P values
Age group -> Supporting women with HIV	0.102	0.099	0.080	1.264	0.206
Business partnerships -> Supporting women with HIV	0.177	0.189	0.095	1.859	0.063
Marital status -> Supporting women with HIV	-0.057	-0.066	0.087	0.656	0.512
Monthly income -> Supporting women with HIV	0.093	0.092	0.082	1.128	0.259
Women empowerment -> Supporting women with HIV	0.560	0.563	0.077	7.227	0.000
Age group x Business partnerships -> Supporting women with HIV	-0.136	-0.131	0.088	1.548	0.122
Marital status x Women empowerment -> Supporting women with HIV	0.067	0.055	0.084	0.800	0.424
Age group x Women empowerment -> Supporting women with HIV	-0.194	-0.179	0.079	2.467	0.014
Monthly income x Women empowerment -> Supporting women with HIV	0.001	-0.008	0.087	0.008	0.993
Variance predictions	*R-square*		*R-square adjusted*		
Supporting women with HIV	0.422		0.376		

Source: Created by authors

4.7 Discussion of Results

This study examined the role of business partnerships and women's empowerment in supporting living with HIV and AIDS patients. The study found that business partnerships do not have a significant contribution to supporting women living with HIV and AIDS. Most of the women investigated were not in active business and depended on the casual labor form of employment. The findings are consistent with many previous scholars who have presented the agony of aid on families and sufferers. First, people living with HIV and AIDS cannot contribute to the productive labor force since they are ever off from work due to sickness (UNAIDS, 2003). Consequently, managers are left without option, but to replace HIV-affected employees. This can increase the financial and emotional burden on families and sufferers. Second, the costs that companies incur to keep aids suffering on the job have far-reaching impacts on labor supply, productivity, investment, and employment (ILO, 2008). This loss of productivity threatens the economic environment in which people living with HIV and AIDS operate. Apart from the loss observed in businesses as a whole, employers of aid sufferers incur huge costs in the loss of workers, absenteeism, expensive healthcare benefits, and payments of death benefits (Ashford, 2006; Zhira, 2014). While people living with HIV & AIDS can shake business partnerships, treatment with ARVs, care and support interventions, and pro-active prevention can help people living with HIV & AIDS live and work positively.

This study established that an increase in women's empowerment is instrumental in supporting women with HIV and AIDS. The findings support Scanlan (2010), who showed that empowering women helps them actively participate in policy formulation and decisions that reduce mortality arising from preventable diseases, including HIV and AIDS. Empowering women improves reproductive health and rights, helps them control their sexual lives, and actively participates in HIV/AIDS prevention programs (Alemu & Asnake, 2007; Oyelude & Bamigbola, 2013). Apart from helping women make sensitive decisions about sex, contraceptives, and enrolment in HIV and AIDS prevention programs, women empowerment builds the economic muscles of HIV and AIDS sufferers.

This study established that variation in age affects the relationship between women's empowerment and supporting women living with HIV. This is possibly because, although most of the participants were adults, they were earning below 200,000 shillings, besides surviving on casual employment. In this

case, dependence on a male partner is evident across all age groups. Young women living with HIV are more likely to gain employment status than older women living with HIV. The results agree with Kordovski, Woods, Verduzco, and Beltran (2017) who reported that older HIV+ are vulnerable in terms of work performance and employment status though the variations differ according to the economy of the country. In the US, older HIV+ patients are reported to age successfully due to psychological rehabilitation, which is largely lacking in developing economies. The benefits of empowering older HIV women include increased self-esteem, long-term health, and quality of life. However, there is no consistent evidence that psychosocial factors affect older HIV women given the increasing use of antiretroviral therapies (Rubtsova et al., 2017). While young women living with HIV have high chances of employment status and work performance, older women living with HIV continuously face marginalization and stigma, which affects their involvement in productivity and gainful employment. This is common in Uganda as reported by Narasimhan, Payne, Caldas, Beard, and Kennedy (2016). The results also agree with those of ILO 2008), who reported the effect of HIV on the labor force in sub-Saharan Africa. The report indicated that the 15–24 age group joined the labor force to replace workers who left due to Aids and death. The report further noted that many women living with HIV joined the labor force following the death of their husbands. However, the report does not reveal the direct role of business partnerships, as envisaged in this study.

The finding that the effect of business partnerships on supporting women living with HIV does not depend on age group disagrees with Burke et al. (2019), who show that strengthening women's economic status reduces the incidence of HIV, since few women will depend on their male partners. Girls who earn money are least likely to engage in transactional sex, which exposes them to HIV. In Tanzania, Pettifor, Wamoyi, Balvanz, Gichane, and Maman (2019) show how cash transfers helped young women to refuse transactional sex and dependence on male sex partners. From these studies, the current study argues that such programs can help young women startup businesses, produce income, and depend less on their partners.

This study shows that the effect of women's empowerment on supporting women living with HIV does not depend on their total monthly income. This is because of two reasons. First, most of the investigated women earned less than 200,000 Ugandan shillings. Therefore, there was little empowerment among these women. Second, most of the women investigated were casual laborers, who showed little economic dependence and dependence on male partners. The results agree with Moghadam et al. (2018), who used women living with HIV in Iran to show that exposing women living with HIV to empowerment programs and education can improve their quality of life both psychologically and spiritually. Similarly, evidence on adolescent women from South Africa by MacPhail et al. (2018). From these studies, the current study argues that the intervention provided to empower women living with HIV is not based on their monthly income.

This study established that empowerment among women living with HIV did not differ according to marital status. First, both married and unmarried women living with HIV suffer equally in terms of socioeconomic status. Second, many married women living with HIV are dependent on their male partners. Therefore, interventions based on marital status are likely to ignore some of the most affected categories of women living with HIV. The findings agree with Tokar, Broerse, Blanchard, and Roura (2018) who investigated the key barriers to HIV testing and counselling among Female Sex Workers. While most academic writings point to financial and time as key barriers, married sex workers point to social support from peers and managers. Related findings from Uganda show that extramarital relations, and living in a high prevalence stratum a risk factors to couple HIV infection (Nabukenya, Nambuusi, & Matovu, 2020). Drawing from this evidence, this study argues that women living with HIV need as much support as possible, irrespective of their marital relationship.

5. Conclusion

This investigation stemmed from the need to support women living with HIV and AIDS using community approaches of business partnerships and women empowerment as opposed to government- and private sector-led support, which are not sustainable. Aggregately, women's empowerment and

business partnerships are important predictors for supporting women living with HIV and AIDS. Women's empowerment increases decision-making power, while business partnerships decrease dependence on male partners. Adopted in isolation, women's empowerment appears to increase support for women living with HIV and AIDS, compared to business partnerships. Business partnerships, as observed in this study, draw weak relationships from many women livings with HIV and AIDS who survive casual labor and parents. Women empowerment is effective in supporting women living with HIV and AIDS. However, women empowerment programs that cut across all age groups are effective in supporting vulnerable women living with HIV and AIDS. Women empowerment programs that only target the poor (monthly income) and widowed or single (marital status) lack effectiveness. From a public health perspective, designers of intervention programs to support women living with HIV and AIDS should consider inclusiveness in design and be driven by age categorizations. From a business perspective, designers of intervention programs to support women living with HIV and AIDS should target business partnerships among low-income earners as this is likely to reduce vulnerability. Second, business partnerships should be extended to married women living with HIV and AIDS to reduce dependency on male partners. The main strength of this study is the analysis of variations in programs supporting women living with HIV and AIDS across sociodemographic domains. Therefore, future researchers should consider qualitative studies that compare programs that support women living with HIV and AIDS across demographic characteristics. The main drawback of this study was its cross-sectional design. Data were collected from March to May 2023. Therefore, future researchers should consider longitudinal studies that compare programs that support women living with HIV and AIDS, across demographic characteristics.

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5.2 Conflict of interest
The authors declare no conflict of interest

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References
Alemu, B., & Asnake, M. (2007). *Women's empowerment in Ethiopia: New solutions to ancient problems*: Pathfinder International.

Annan, K. (2001). *Address by Secretary-General Kofi Annan to the United Nations General Assembly*. Retrieved from https://www.un.org/sg/en/content/sg/speeches/2001-09-24/address-secretary-general-kofi-annan-united-nations-general-assembly

Ashford, L. S. (2006). How HIV and AIDS affect populations. *World*, 1, 38,600,000.

Attawell, K. (2008). Partnerships in practice.

Barks-Ruggles, E. (2001). *The economic impact of HIV/AIDS in Southern Africa*: Brookings Institution.

Bloom, D. E., & Mahal, A. (2001). HIV/AIDS and the private sector A literature review. *Dorset, UK, River Path Associates*.

Burke, H. M., Packer, C., González-Calvo, L., Ridgeway, K., Lenzi, R., Green, A. F., & Moon, T. D. (2019). A longitudinal qualitative evaluation of an economic and social empowerment intervention to reduce girls' vulnerability to HIV in rural Mozambique. *Evaluation and program planning*, 77, 101682.

Chong, J., & Kvasny, L. (2007). A Disease That``Has a Woman's Face": The Social Construction of Gender and Sexuality in HIV/AIDS Discourses. *Intercultural Communication Studies*, 16(3), 53.

Dixon, S., McDonald, S., & Roberts, J. (2002). The impact of HIV and AIDS on Africa's economic development. *BMJ*, 324(7331), 232-234.
Economics, C. f. I. (2002). Potential economic impacts of an HIV/AIDS epidemic in Papua New Guinea. Retrieved from https://www.dfat.gov.au/sites/default/files/hivaids_png.pdf
Ekawati, E., & Sari, Y. M. (2024). Financial governance: Cases at Village-Owned Enterprises (BUMDEs) in Lampung Province. *International Journal of Financial, Accounting, and Management*, 6(1), 105-116.
Esplen, E., & Brody, A. (2007). *Putting gender back in the picture: rethinking women's economic empowerment*: Institute of Development Studies: Bridge (development-gender).
Eton, M., Mwosi, F., Ebong, C. D., & Ogwel, B. P. (2018). Government interventions in supporting SME growth in Lira district, northern Uganda. *International Journal of Emerging Research & Development*, 1(2).
Eton, M., Mwosi, F., Ogwel, B. P., Edaku, C., & Obote, D. (2018). Financial inclusion and women empowerment in Uganda. A case of Lango Sub Region, Northern Uganda. *Economics, Commerce and Trade Management: An International Journal (ECTIJ)*, 2(1), 1-11.
Eunah, K., Eta, M. N., & Shepherd, M. (2024). Entrepreneurship pedagogy enhancing entrepreneurship intention in secondary school students in developing countries. *International Journal of Financial, Accounting, and Management*, 6(1), 117-133.
Foundation, T. H. J. K. F. (2017). *The Multisectoral Impact of the HIV/AIDS Epidemic – A Primer*. Retrieved from https://www.kff.org/wp-content/uploads/2013/01/7661.pdf
Goin, D. E., Pearson, R. M., Craske, M. G., Stein, A., Pettifor, A., Lippman, S. A., . . . Selin, A. (2020). Depression and incident HIV in adolescent girls and young women in HIV prevention trials network 068: targets for prevention and mediating factors. *American journal of epidemiology*, 189(5), 422-432.
Gow, J., & George, G. (2011). Business management of HIV/AIDS: Case study of a South African contract cleaning company. *African journal of business management*, 5(11), 4100-4106.
ILO. (2008). *HIV/AIDS and the world of work*. Retrieved from file:///C:/Users/acer/Downloads/wcms_090177.pdf
Kordovski, V. M., Woods, S. P., Verduzco, M., & Beltran, J. (2017). The effects of aging and HIV disease on employment status and functioning. *Rehabilitation Psychology*, 62(4), 591.
Koseki, S., Fagan, T., & Meno, V. (2016). *SUSTAINABLE HIV FINANCING IN UGANDA*. Retrieved from https://www.healthpolicyproject.com/pubs/2877_UgandaHIVFinancing.pdf
Mabhanda, W. (2024). Business resilience strategies for informal traders in the post-COVID-19 pandemic era in Gweru, Zimbabwe. *International Journal of Financial, Accounting, and Management*, 6(1), 75-91.
MacPhail, C., Khoza, N., Selin, A., Julien, A., Twine, R., Wagner, R. G., . . . Pettifor, A. (2018). Cash transfers for HIV prevention: what do young women spend it on? Mixed methods findings from HPTN 068. *BMC public health*, 18, 1-12.
Mbowa, H. S., Businge, M. P., Ssemaluulu, P., & Eton, M. (2023a). Effect of women empowerment on women-owned business performance in Wakiso District, Uganda. *International Journal of Financial, Accounting, and Management*, 5(3), 343-358.
Mbowa, H. S., Businge, M. P., Ssemaluulu, P., & Eton, M. (2023b). Influence of Social Capital on Small and Medium Enterprises Performance in Wakiso District, Uganda. *International Journal of Accounting and Management Information Systems*, 1(1), 81-95.
McCreanor, C. P. A. (2010). *Economic impact of HIV and AIDS on the business process outsourcing and offshore contact centre industry in South africa.* Stellenbosch: University of Stellenbosch.
Mishra, P. J. (2013). A Study of ELDERLY WOMEN With Special Reference to Empowerment-case studies. Retrieved from https://ifa.ngo/wp-content/uploads/2014/01/A-Study-of-Elderly-Women-with-Social-Reference-to-Empowerment-Case-Studies.pdf
Moghadam, Z. B., Rezaei, E., Sharifi, B., Nejat, S., Saeieh, S. E., & Khiaban, M. O. (2018). The effect of empowerment and educational programs on the quality of life in Iranian women with HIV. *Journal of the International Association of Providers of AIDS Care (JIAPAC)*, 17, 2325958218759681.

Nabukenya, A. M., Nambuusi, A., & Matovu, J. K. (2020). Risk factors for HIV infection among married couples in Rakai, Uganda: a cross-sectional study. *BMC infectious diseases*, *20*, 1-8.
Narasimhan, M., Payne, C., Caldas, S., Beard, J. R., & Kennedy, C. E. (2016). Ageing and healthy sexuality among women living with HIV. *Reproductive Health Matters*, 24(48), 43-51.
Oyelude, A. A., & Bamigbola, A. A. (2013). Women Empowerment through Access to Information: The Strategic Roles of Non-Governmental Organizations in Nigeria. *Online Submission*, 3(2), 103-115.
Pettifor, A., Wamoyi, J., Balvanz, P., Gichane, M. W., & Maman, S. (2019). Cash plus: exploring the mechanisms through which a cash transfer plus financial education programme in Tanzania reduced HIV risk for adolescent girls and young women. *Journal of the international AIDS society*, 22, e25316.
Piot, P., Greener, R., & Russell, S. (2007). Squaring the circle: AIDS, poverty, and human development. *PLoS medicine*, 4(10), e314.
Program, T. A. G. s. O. A. (2001). *HIV/AIDS AND DEVELOPMENT IN ASIA AND THE PACIFIC: A LENGTHENING SHADOW*. Retrieved from https://www.dfat.gov.au/sites/default/files/aids_in_asia_pacific.pdf
Rubtsova, A. A., Kempf, M.-C., Taylor, T. N., Konkle-Parker, D., Wingood, G. M., & Holstad, M. M. (2017). Healthy aging in older women living with HIV infection: a systematic review of psychosocial factors. *Current HIV/AIDS Reports*, 14, 17-30.
Sambo, L. G. (2008). Message of the WHO Regional Director for Africa on the Occasion of International Women's Day 2008, 8 March 2008. Retrieved from https://www.afro.who.int/regional-director/speeches-messages/message-who-regional-director-africa-occasion-international-0
Scanlan, S. J. (2010). Gender, development, and HIV/AIDS: Implications for child mortality in less industrialized countries. *International Journal of Comparative Sociology*, 51(3), 211-232.
Scott, E., Simon, T., La Foucadeb, A., Karl, T., & Gittens-Baynes, K.-A. (2011). Poverty, employment and HIV/AIDS in Trinidad and Tobago. *International Journal of Business and Social Science*, 2(15).
State, U. S. D. p. (2017). U.S. Global Strategy To Empower Adolescent Girls Retrieved from https://www.state.gov/u-s-global-strategy-to-empower-adolescent-girls/
Tandipayuk, G., & Akhrani, L. A. (2021). The existence of single parents who have careers. *Psychohealth: Scientific Journal of Psychology and Mental Health*, 1(1), 37-48.
TechnoServe. (n.d.). Women's Economic Empowerment. Retrieved from https://www.technoserve.org/our-work/womens-economic-empowerment/
Tokar, A., Broerse, J. E., Blanchard, J., & Roura, M. (2018). HIV testing and counseling among female sex workers: a systematic literature review. *AIDS and Behavior*, 22, 2435-2457.
UBOS. (2013). *Uganda Facts and Figures on Gender*. Retrieved from https://www.ubos.org/wp-content/uploads/publications/04_2018Uganda_Facts_and_Figures_on_Gender_2013.pdf
Udeh, C., Smith, W., & Shava, H. (2014). HIV/AIDS awareness and its impact on the profitability of business firms in developing nations. *Mediter. J. Soc. Sci*, 5(7).
UNAIDS. (2002). *Business taking action to manage HIV/AIDS*. Retrieved from https://data.unaids.org/topics/partnership-menus/pdf/asianbusinessfolder_en.pdf
UNAIDS. (2003). HIV/AIDS It's Your Business. Retrieved from https://data.unaids.org/publications/irc-pub06/jc1008-business_en.pdf
UNAIDS. (n.d.). HIV/AIDS and Business in Africa and Asia. Retrieved from https://www.hks.harvard.edu/sites/default/files/centers/mrcbg/programs/cri/files/report_2_HIV_AIDS_AGuidetoPartnerships.pdf
UNFPA. (2017). Uganda: The Status of HIV Prevention in 2017. Retrieved from https://uganda.unfpa.org/en/publications/uganda-status-hiv-prevention-2017
UPHIA. (2019). *UGANDA POPULATION-BASED HIV IMPACT ASSESSMENT (UPHIA) 2016-2017*. Retrieved from https://phia.icap.columbia.edu/wp-content/uploads/2019/07/UPHIA_Final_Report_Revise_07.11.2019_Final_for-web.pdf
USAID. (2004). *AIDS in Africa During the Nineties Uganda: Young people, sex, and AIDS in Uganda*. Retrieved from https://pdf.usaid.gov/pdf_docs/Pnada252.pdf

Were, M., & Nafula, N. N. (2003). An assessment of the impact of HIV/AIDS on Economic Growth: The case of Kenya. *Aids on Economic Growth: The Case of Kenya (September 2003)*.

Willis, N., Mavhu, W., Wogrin, C., Mutsinze, A., & Kagee, A. (2018). Understanding the experience and manifestation of depression in adolescents living with HIV in Harare, Zimbabwe. *PloS one*, 13(1), e0190423.

Zhira, P. (2014). *An analysis of the business response to HIV/AIDS in the catering industry in Zimbabwe: a case study for organisations affiliated to the National Employment Council for the catering industry*. Stellenbosch: Stellenbosch University.