Protecting the Rights of Workers Living with HIV/AIDS: A South African Case Study

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1. Introduction

In order to examine the specific impact that the principles set out in the ILO’s Code of Practice on HIV/AIDS and the World of Work have had on both the national and enterprise levels, South Africa will be used as a case study. For a number of reasons, the focus on South Africa is of particular interest. First, South Africa has one of the highest rates of HIV infection in the world. This brings the issues raised in the ILO Code into sharp relief. For example, the ILO recently projected that South Africa could lose up to 32.6% of its labour force to AIDS by 2020. The response of the South African government, South African employers and South African employee organisations is therefore of particular interest in assessing national and enterprise policies elsewhere in the world. Second, the South African Code of Good Practice and the relevant South African equality legislation preceded the adoption of the ILO Code by a few years. This means that South Africa has had relatively more time than many other jurisdictions to grapple with the difficult legal and ethical questions posed by HIV/AIDS in the workplace.

In this paper, I will examine how the primary (human) rights implicated in this context, namely the right to non-discrimination, privacy and confidentiality, a healthy work environment and the continuation of the employment relationship, have been incorporated into South African legislation and in the workplace policies and practices of selected South African employers. For a number of reasons (discussed in more detail below), the focus will be on the response of the South African mining industry to the epidemic. In doing so, I will highlight the ethical issues that are raised by these policies and practices, and also discuss the pros and cons of the various approaches that have been adopted. The overall aim of the paper is to contribute to the identification and development of a set of best practices in the area of HIV/AIDS and the world of work.

2. The Mining Industry and HIV/AIDS

2 According to the latest figures released by UNAIDS, over 11 percent of the population of 43.8 million in South Africa, are HIV-infected, see 'South Africa Says It Will Fight AIDS With A Drug Plan', New York Times, August 9, 2003.

The significance of the mining industry to employment and the economy of South Africa cannot be doubted. Even though the mining industry's share of gross domestic product (GDP) has declined in the last two decades, due primarily to the falling output of gold and uranium, it still contributes around 8% of the total GDP. In addition, mining continues to be South Africa's single most important earner of foreign exchange despite only employing a relatively modest 4.5% of the economically active population.

Mining and mining operations, especially in South Africa, also present a set of unique characteristics that make the industry particularly susceptible to the HIV/AIDS epidemic. The industry has traditionally been largely dependent on local and regional migrant workers, meaning that, in the words of a recent government position paper, 'the spheres of production of labour are spatially distinct from the areas of production and work.' Despite a recent increase of recruitment from within mining communities, a shortage of labour has meant that the workforce is still primarily drawn from communities outside the areas of operation. An important shift has taken place, however, as a result of the abolishment of the system of influx control. Because South African miners are no longer employed on the basis of annual contracts, they are not, as used to be the case, forced to return to the rural areas where they were recruited. Consequently, many South African workers have moved on a more permanent basis to the mining areas with their families.

Despite this, many factors still militate against family accompaniment. First, mining operational areas are often situated in inhospitable locations that make it unattractive for workers to bring their families along. Second, for many so-called marginal mines where the lifespan of operations may be limited, it may be too expensive to provide comprehensive family accommodation for workers. Third, foreign miners are still largely long-distance single migrant workers, employed on annual contracts and required to return home on the expiry of contracts. On the whole, this means that mining in South Africa still relies on young, single, male migrants who are housed in hostel accommodation on

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4 Chamber of Mines, *The South African Mining Industry Fact Sheet 2001* p.2
6 Currently slightly less than 60% of all mineworkers are of South African origin while the rest are recruited primarily from the neighboring countries of Mozambique, Botswana, Lesotho and Swaziland.
the premises of the employer.\textsuperscript{7} Isolated from their families and deprived of social support and community cohesion, many workers engage in activities that increase the risk of HIV-infection, such as excessive intake of alcohol, the use of commercial sex workers, multiple sexual partners and unprotected sex.\textsuperscript{8} This does not only impact on the individual worker and the surrounding community,\textsuperscript{9} but also on the communities of origin to which workers return on a regular basis. Labour migration and the mobility of workers in the mining industry is thus an important contributing factor to the spread of HIV-infection in South Africa and the region as a whole. But the impact on the communities of origin goes beyond an increased infection rate. Workers who become too sick to work normally return or are sent back to their homes and this, of course, shifts the burden of care and support to the immediate family members with the costs, both in emotional and economic terms, that this poses. In addition, since most male mineworkers are the sole breadwinners in their households, the consequent loss of income cannot but impact critically on the social cohesion and economic stability of these families.

It is apparent that HIV and AIDS also affect the sustainability of mining operations as a whole. It is currently estimated that between 8\% and 30\% of mineworkers in South Africa are HIV-positive.\textsuperscript{10} Morbidity, especially related to HIV-infection, often results in absenteeism and loss of production days. Not only does this have obvious cost implica-

\textsuperscript{7} As the government position paper points out, ‘the majority of the approximately 600 000 people who make up the labour force in the industry are […] young, almost exclusively male, and sexually active.’ See Departments of Mineral and Energy, Health and Labour \textit{Position Paper on the HIV and AIDS in the South African Mines} (2003), p.4

\textsuperscript{8} The migration of labour is not unique to South Africa. It is a feature of numerous industries around the world, including mining. Most research on migrancy and its role on the spread of infections have found that in general migration is a risk factor for HIV and other STIs (sexually transmitted infections) because migrants are more likely than non-migrants to have multiple sexual partners. See Chamber of Mines \textit{The Mining Industry and HIV/AIDS} (position paper prepared for the HIV/AIDS Mining Summit, Johannesburg, 30 April 2003), p.8 (available at \url{http://www.bullion.org.za/Level2/aids.htm})

\textsuperscript{9} Studies have indicated that women in the surrounding communities of mining operations are particularly vulnerable to HIV-infection. In one of these studies, more than 50\% of women who had multiple sexual partners were found to carry sexually transmitted infections (STIs). STIs increase susceptibility to HIV-infection and faster progression to AIDS. (Study conducted by AngloGold in collaboration with AIDS-SCAP, Harmony Hospital and the National Reference Centre for Sexually Transmitted Diseases in 1996 and 1997, referred to in AngloGold Limited \textit{Facing the Challenges of HIV/AIDS 2001/2002}, p.10). As a result, many mining companies have launched projects offering counseling and identification and treatment of STIs in surrounding communities.

\textsuperscript{10} Infection rates vary according to the type of mining operation and the province in which the mine is located. For example, the rate of infection amongst gold miners is estimated to be 30\%, amongst platinum miners between 20 and 24\%, and amongst coal miners the rate of infection is between 15 and 17\%. The lowest infection rates can be found in the diamond sector, where between 8 and 11\% of workers are infected. The Minister of Minerals and Energy, Phumile Mlambo-Ngcuka released the figures on 4 July 2003, in a written response to a parliamentary question.
tions for employers,\textsuperscript{11} it also affects the morale of the labour force that has to contend with an increased workload as a result of the absenteeism (and in some cases reduced output) of their HIV-positive fellow workers.

The mining industry has responded to the epidemic in a number of ways, ranging from policies on the protection of the fundamental rights of workers infected with HIV to programmes addressing prevention, awareness, treatment, care and support. In keeping with the philosophy of tripartism underpinning South Africa's labour relations system, these policies and programmes are often created in collaboration between the mining industry's social partners, namely government, employers and labour. As early as 1991, the Chamber of Mines\textsuperscript{12} signed an agreement with the National Union of Mineworkers (NUM) on HIV/AIDS that addresses issues such as pre-employment testing, confidentiality and the provision of benefits. In 2001, the Government, the Chamber of Mines and Labour signed an agreement establishing a Tripartite HIV/AIDS Committee for the mining industry, and in 2003, after a summit on HIV/AIDS in the mining industry, the three social partners (government, employers and labour) issued a declaration of intent in which, among other things, the partners commit themselves to ensuring that every workplace in the mining industry will have an HIV/AIDS policy in place by the end of 2004.\textsuperscript{13}

A number of individual mining companies have already entered into specific HIV/AIDS agreements with labour unions,\textsuperscript{14} and some have begun to provide antiretroviral treatment to their employees from 2003.\textsuperscript{15}

Before examining the extent to which the rights of HIV-positive mineworkers in South Africa are protected, a brief overview of the relevant legal and policy framework is, I believe, of value.

\textsuperscript{11} AngloGold estimates that HIV and AIDS will add between four (4) and six (6) dollars to the cost of each ounce it mines. If nothing is done to manage the impact of HIV/AIDS on its operations, the company expects the cost to rise to nine (9) dollars. See AngloGold Limited \textit{Facing the Challenges of HIV/AIDS 2001/2002}, p.7. In addition, medical costs for the treatment of occupational diseases, HIV-related morbidity (including antiretroviral therapy), medical and disability insurance and the cost of funerals all contribute to undermining the viability of the mining industry in general. See Departments of Mineral and Energy, Health and Labour \textit{Position Paper on HIV and AIDS in the South African Mines} (2003), p.6

\textsuperscript{12} The Chamber of Mines of South Africa is a mining industry employers' organization.

\textsuperscript{13} See \textit{Declaration of Intent: Mining HIV/AIDS Summit 2003}, p. 2 (hereafter Declaration); available at http://www.bullion.org.za

\textsuperscript{14} See, for example, the 2001 agreement between Goldfields and three trade unions (available at http://www.goldfields.co.za), the 2002 agreement between AngloGold Limited and five trade unions (available at http://www.anglogold.com), and the 2003 agreement between De Beers and the National Union of Mineworkers (available at http://www.debeersgroup.com)
3. Legal and policy framework

South Africa has arguably created one of the most progressive and far-sighted policy and legislative environments in the world for dealing with HIV/AIDS. Despite this, however, the rate of infection in South Africa continues to rise, and discrimination against and stigmatisation of workers living with HIV/AIDS continue to be documented.\(^{16}\) At least two conclusions can be drawn from this observation. The first is that a commitment to human rights on its own is not enough to impact on the epidemic. Protection of social, economic, political and civil rights together with effective implementation of laws, policies and programmes is only one, although important, strategy in HIV-prevention, treatment and care. The second conclusion is that the existence of laws protecting human rights does not prevent or even seriously reduce the incidences of discrimination and stigmatisation unless it is accompanied by effective public education about non-discrimination and human rights in relation to HIV.\(^{17}\) Fear and ignorance are constitutive elements of prejudice, which, when acted upon, often translates into discrimination.\(^{18}\) It is thus imperative, and this of course not only in South Africa, that legislation prohibiting discrimination and protecting the rights of those living with HIV/AIDS be combined with efforts that, in addition to educating and informing people about discrimination, human rights, enforcement of rights and the consequences of their infringement, also speak directly to the issues of fear and ignorance surrounding the virus.

Despite these problems relating to the efficacy of legal measures, legislation protecting the rights of people living with HIV/AIDS of course plays a vital role in the fight against the epidemic. In a recent study, Albertyn and Heywood demonstrate conclusively that there is a direct relation between the degree of respect for and promotion of human

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\(^{15}\) For example, currently AngloGold, AngloPlatinum (Angloplats) and De Beers provide antiretroviral therapy to its employees as part of a comprehensive HIV/AIDS treatment programme.

\(^{16}\) For example, the AIDS Law Project at the University of Witwatersrand has noted a disturbing rise in the number of unfair dismissals of those who are HIV-positive, in particular amongst domestic workers. As Jennifer Joni, an attorney with the Project notes: "We have one of the best legal frameworks around but this hasn't changed mindsets. People still get dismissed because of their HIV-status. I handle HIV/AIDS discrimination cases almost every day." See UN Office for the Coordination of Humanitarian Affairs, *South Africa: Stigma in the Workplace*, 29 November 2002, p.1

\(^{17}\) See Mark Heywood 'Analysing AIDS and Human Rights - A Plea for the Forgotten Ones' in *Everybody's Business - the Enlightening Truth about AIDS* (Cape Town, Metropolitan Group, 2000), p.116

\(^{18}\) For a discussion of this phenomenon, see Ross Jennings, Jowie Mulaudzi, David Everatt, Marlise Richter and Mark Heywood *Discrimination and HIV/AIDS* (October 2002), p.9 (paper researched and written for the South African Department of Health)
rights and the severity and epidemiology of the epidemic, as well as the capacity of a country effectively to address the epidemic.\textsuperscript{19} Lower rates of infection are thus related both to the degree of commitment to providing and protecting basic human rights as well as the actual enjoyment of such rights.\textsuperscript{20}

In South Africa, it is clear that the Constitution, and legislation like the Labour Relations Act (LRA) and the Employment Equity Act (EEA) has put a limit to the range of possible responses by employers to HIV/AIDS in the workplace. These and other acts of legislation, together with the Code of Good Practice on Key Aspects of HIV/AIDS in the Workplace, place a particular emphasis on non-discrimination and the rights of job applicants and employees living with HIV to fair and equal treatment, a point that is of particular interest for the discussion that follows.

The South African Constitution\textsuperscript{21} explicitly prohibits 'unfair discrimination' on a number of grounds, including race, gender, sex, pregnancy, marital status, sexual orientation, age, disability and religion.\textsuperscript{22} Even though HIV-status is not on this list, the wording of the provision makes it clear that the list is open-ended and could be expanded upon. In a seminal judgment, the Constitutional Court in \textit{Hoffman v South African Airways}\textsuperscript{23} ruled that 'HIV-status' was analogous to the listed grounds and that discrimination on that basis was unfair.

The EEA became the first piece of legislation that \textit{expressly} prohibits unfair discrimination on the ground of 'HIV status'.\textsuperscript{24} The Act also places a prohibition on HIV-testing - an issue discussed in more detail in 4.2 below. In addition, the Labour Relations Act protects employees from dismissal on a number of grounds, which, arguably, also includes dismissal solely on the basis of HIV-status.\textsuperscript{25} One weakness of both the EEA and the LRA is the fact that it expressly excludes from its ambit members of the South African National Defence Force (SANDF), National Intelligence Agency (NIA) and the South

\textsuperscript{20} Albertyn and Heywood, p.3
\textsuperscript{21} 108 of 1996
\textsuperscript{22} Section 9(3) and 9(4)
\textsuperscript{23} (2000) 21 ILJ 2357 (CC). For a discussion, see section 4.1.
\textsuperscript{24} Section 6(1)
\textsuperscript{25} Section 187(1)(f)
African Secret Service. This is significant because the SANDF in particular has become notorious for infringing on the rights of those living with HIV/AIDS.

Even though these persons could bring unfair discrimination matters before the High Courts and ultimately the Constitutional Court under the provisions of the Constitution, time and cost constraints have often made this a theoretical more than a practical option.

However, since June 2003, the Promotion of Equality and Prevention of Unfair Discrimination Act (PEPUDA) has provided relief to those excluded from the ambit of the EEA and the LRA, in particular independent contractors and members of the SANDF, NIA and Secret Service. Although HIV-status is not one of the prohibited grounds of discrimination, the Act clearly envisages a situation in HIV/AIDS status (in addition to socio-economic status, nationality, family responsibility and family status) could be added to the current list. The Act provides that the Equality Review Committee must make recommendations to the Minister regarding their inclusion within one year from the date that the Act comes into operation.

The Code of Good Practice on Key Aspects of HIV/AIDS and Employment (the Code), issued in terms of the EEA and the LRA, does not impose any legal obligation on employers over and above those already imposed by the applicable legislation, but was developed as a guide to employers, trade unions and employees on how to manage HIV/AIDS in the workplace. The Code seeks to assist with the attainment of the broader goals of eliminating unfair discrimination in the workplace based on HIV status, promoting a non-discriminatory workplace in which people living with HIV or AIDS are able to be open about their HIV status without fear of stigma or rejection, promoting appropriate and effective ways of managing HIV in the workplace, creating a balance between the rights and responsibilities of all parties; and giving effect to the regional obligations of South Africa as member of the Southern African Development Community.

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26 Section 4(3)
28 4 of 2000. Due to the fact that the structures set up under the legislation has taken some time to put into place, PEPUDA only came into operation on 16 June 2003 (see Proclamation R49, 2003).
29 See section 34.
30 Established by the Minster in terms of the Act (see section 32).
31 See section 34(1)(b). This means the recommendations must be made before 16 June 2004. However, until that time, the open-ended nature of the list provided in PEPUDA together with the Hoffman-decision nevertheless provides protection from discriminatory treatment for the otherwise excluded employees.
32 Promulgated in GG21815, 1 December 2000
(SADC). It touches, among other things, on the issues of HIV testing, confidentiality and disclosure, the promotion a safe workplace, compensation for occupationally acquired HIV, employee benefits, and dismissal.

Finally, other pieces of legislation that we will be concerned with in the following also have a bearing on employees living with HIV/AIDS. The Medical Schemes Act\textsuperscript{34} prohibits unfair discrimination on the basis of 'state of health', the Occupational Health and Safety Act\textsuperscript{35} and the Mine Health and Safety Act\textsuperscript{36} require employers to create safe working environments, the Compensation for Occupational Injuries and Diseases Act\textsuperscript{37} and the Occupational Diseases in Mines and Works Act\textsuperscript{38} provide for compensation to employees injured in the course of employment, and the Basic Conditions of Employment Act\textsuperscript{39} compels employers to ensure that all employees receive certain basic standards of employment, including a minimum amount of sick leave.

4. Human rights and the world of work

4.1 Non-discrimination

Discrimination against workers living with HIV/AIDS take many forms, including unwanted and unwarranted pre-employment testing, denial of employment to job applicants or employees who are HIV-positive, and reassigning or dismissing workers living with HIV/AIDS regardless of their capacity for work. Evidence suggests that this kind of HIV-related discrimination is practised on a significant scale in all sectors of the economy in South Africa.\textsuperscript{40}

In the mining industry, HIV-related discrimination and unauthorised testing were routinely practiced for many years.\textsuperscript{41} Before 1991, this was particularly widespread, mainly due to the fact that legislation barred non-South Africans with HIV or AIDS from enter-

\textsuperscript{33} Clause 1.6
\textsuperscript{34} 131 of 1998 and Regulations: GG 20556, 20 October 1999
\textsuperscript{35} 85 of 1993
\textsuperscript{36} 29 of 1996
\textsuperscript{37} 130 of 1993
\textsuperscript{38} 78 of 1973
\textsuperscript{39} 75 of 1997
\textsuperscript{40} See, for example, Charles Ngwena 'HIV in the Workplace: Protecting Rights to Equality and Privacy' (1999) 15 S.AJHR 513 at 517 and Ross Jennings, Jowie Mulaudzi, David Everatt, Marlise Richter and Mark Heywood Discrimination and HIV/AIDS (October 2002), pp. 15-18
ing the country. The practical implications of this extended not only to the migrant workers themselves, but also to their employers, who were by law prohibited from employing those who were HIV-positive. The provisions even gave immigration officers the power to submit any person suspected to be HIV-positive to compulsory medical examination. This approach of the South African government at the time was typical of the response of many governments around the world, namely the attempt by a country to insulate itself from the epidemic by establishing what is sometimes referred to as a ‘cordon sanitaire’ around the country. This immigration provision also in effect gave the mining houses a pretext for the mandatory testing and exclusion of black migrant workers irrespective of their fitness for work. In 1986, the Chamber of Mines announced the results of a study on the blood samples of 300,000 male mine workers. The study indicated that about 800 mineworkers were HIV-positive, and that of these more than 760 came from Central Africa. In response, the Chamber adopted a policy on HIV/AIDS that included pre-employment testing of all job applicants as well as regular testing of all workers suffering from sexually transmitted diseases. However, the policy made no provision for repatriation of HIV-infected miners. When the Chamber of Mines refused the government’s request to repatriate migrant workers who were HIV-positive, the government instead announced plans to repatriate almost 1000 Malawian miners who had tested HIV-positive and have all work applicants from Malawi, Zimbabwe, Zambia, Zaire (Democratic Republic of Congo) and Burundi tested for the virus. In 1988, the Chamber of Mines itself adopted a policy dictating that no person from ‘high-incident areas’ be employed by a mine ‘unless he has been tested and the employer is satisfied that he is free from HIV-infection.’ The policy was later withdrawn in response to pressure from the National Union of Mineworkers, who argued that it was totally out of keeping with international norms and standards.

Times have changed, however. Realising that coercive measures such as compulsory testing and the creation of immigration barriers are ineffective in stemming the spread of HIV, governments and employers in South Africa and elsewhere in the world have begun to accept the reality of the epidemic and have shifted attention to the accommoda-

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41 Ngwena, p. 517-518
42 See, for example, Edwin Cameron and Edward Swanson ‘Restrictions on Migrant Workers, Immigrants and Travellers with HIV/AIDS: South Africa’s Step Forward’ (1992) 13 ILJ 496
43 Cameron and Swanson, p.499
44 Ngwena, p.517.
45 Cameron and Swanson, p.499.
tion and treatment of those living with HIV/AIDS. And one of the most important aspects of this new approach is precisely an emphasis on the creation of a non-discriminatory environment.

In countries that have offered protection against discrimination to those living with HIV/AIDS, two distinct approaches have been adopted. In countries such as New Zealand, Canada and Australia there is comprehensive legislation that prevents unfair discrimination on the grounds of 'disability', and HIV-infection has there been held to fall under the definition of disability. In contrast, South Africa provides direct protection by explicitly recognizing that HIV attracts stigma and discrimination. As mentioned above, the EEA prohibits discrimination in the workplace on the basis of 'HIV-status', and PEPUDA makes provision for 'HIV/AIDS status' to be included as a prohibited ground. In addition, the government has introduced a number of policies and guidelines that explicitly seek to prevent HIV-related discrimination, the most significant of which is the Code of Good Practice on Key Aspects of HIV/AIDS and Employment.

In this context, it is of particular interest to note that even in those instances in which the non-discrimination provision does not specifically include 'HIV-status', most importantly in the South African Constitution, the non-exhaustive nature of the list of prohibited grounds has enabled applicants to argue that discrimination on the basis of HIV-status in practice amounts to a case of discrimination. Indeed, the South African Constitutional Court has preferred to treat HIV as an unlisted (although still prohibited) ground, rather than as an example of a 'disability'. A good example is Hoffman v South African Airways, in which the applicant argued that the airline's policy of not employing HIV-positive persons as cabin attendants amounted to unfair discrimination on the (listed) ground of dis-

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46 Cameron and Swanson, p.499.
47 See Albertyn and Heywood, p. 19 for details of these legislative provisions.
48 In addition to the Constitution, the LRA, EEA and PEPUDA all prohibit 'unfair discrimination' on 'one of more grounds, including race, sex …' etcetera.
49 The Constitutional Court has built up a substantial body of law around 'unlisted grounds', extending the protection against discrimination to, for example, unmarried persons, non-citizens, and people living with HIV/AIDS. In extending the grounds, the court has, among other things, investigated whether the group of which the complainant is a member is a 'vulnerable group in society' and whether the act complained of has impaired the fundamental human dignity of the complainant or the group to which he or she belongs. See Ockert Dupper and Christoph Garbers 'Employment Discrimination' in Clive Thompson and Paul Benjamin South African Labour Law Vol 1 (Juta 2002) CC 1-48 - CC 1-50.
50 Perhaps one reason for this is the difficulty of establishing that asymptomatic HIV constitutes a disability. See Charles Ngwena 'HIV in the Workplace: Protecting Rights to Equality and Privacy' (1999) 15 SAJHR 513 at 519.
The court decided in favour of the applicant, but chose to consider the matter as an instance of discrimination on an analogous ground, in this case precisely that of HIV-status. It is worth quoting its reasoning in full:

The appellant is living with HIV. People who are living with HIV constitute a minority. Society has responded to their plight with intense prejudice. They have been stigmatized and marginalized. As the present case demonstrates, they have been denied employment because of their HIV positive status without regard to their ability to perform the duties of the position from which they have been excluded. Society’s response to them has forced many of them not to reveal their HIV status for fear of prejudice. This in turn has deprived them of the help they would otherwise have received. People who are living with HIV/AIDS are one of the most vulnerable groups in our society. Notwithstanding the availability of compelling medical evidence as to how this disease is transmitted, the prejudices and stereotypes against HIV-positive people still persist. In view of the prevailing prejudice against HIV-positive people, any discrimination against them can, to my mind, be interpreted as a fresh instance of stigmatization and I consider this to be an assault on their dignity. The impact of discrimination on HIV-positive people is devastating. It is even more so when it occurs in the context of employment. It denies them the right to earn a living. For this reason, they enjoy special protection in our law.52

In the workplace, discrimination can of course take place in numerous ways. The EEA therefore prohibits unfair discrimination against employees living with HIV/AIDS in 'any employment policy or practice'. This is defined to include a wide range of employment-related aspects, such as recruitment procedures, advertising and selection criteria, appointments and the appointment process, job classification and grading, remuneration, employment benefits and terms and conditions of employment, job assignments, the working environment and facilities, training and development, performance evaluation systems, promotion, transfer, demotion, and dismissal.53 The legislature intentionally cast the net wide, including both obvious criteria and those criteria that have caused difficulties for plaintiffs in other jurisdictions. Also, as discussed earlier, the LRA complements the EEA by specifically prohibiting discriminatory dismissals, and the Medical Schemes Act prevents registered medical aid schemes from excluding any person from coverage on the basis of that person’s ’state of health’.

51 (2000) 21 ILJ 2357 (CC). In this case, the applicant relied directly on s 9(3) of the Constitution, which does not list HIV-status as a prohibited ground of discrimination.
52 At 2370-2371 (per Ngcobo J) (footnotes omitted).
53 Section 1
Of course, the question of discrimination against workers with HIV goes beyond its prohibition in legal and policy documents. To protect the rights of people living with HIV/AIDS is an essential component of the prevention and control of the epidemic. For, if employees cannot disclose their status and seek treatment without fear of stigmatisation and discrimination, workplace programmes are bound to be ineffective. The De Beers joint HIV/AIDS policy recognises this link between protection of the rights of those infected and the efficacy of prevention and treatment measures: 'It is acknowledged that individuals will only participate in VCT programmes if they are convinced that [...] they will not be discriminated against [...] if they are found to be HIV positive and [...] they stand to gain from doing so by having access to appropriate medical care relating to HIV/AIDS'.

Discrimination in the workplace does not of course emanate solely from the employer or from the policies and practices that exist. In a significant number of instances, discrimination against HIV-positive employees are perpetrated by fellow employees. One example of such discrimination is the refusal to work with an employee with HIV/AIDS. In this regard, the joint policy developed by De Beers and the National Union of Mineworkers makes for interesting reading. Both parties expressly recognise that on the basis of current medical and scientific evidence, HIV/AIDS is not transmitted through casual personal contact under normal working conditions. Therefore, co-employees are expected to continue working relationships with employees living with HIV/AIDS and discrimination will not be tolerated. In case an employee should refuse to work with a fellow employee with HIV/AIDS, counsel and adequate access to information on HIV/AIDS transmission should be provided. However, should the employee still continue to refuse to work with the infected employee, disciplinary action will be considered.

4.2 Privacy and confidentiality

The right to privacy comes to the forefront in the area of HIV-testing. In the workplace, two aspects of this right deserve to be highlighted. First, an employer may not lawfully

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54 The De Beers Consolidated Mines and National Union of Mineworkers Joint HIV/AIDS Workplace Policy, clause 9.2.3 (available at www.debeersgroup.com)
55 The De Beers Consolidated Mines and National Union of Mineworkers Joint HIV/AIDS Workplace Policy, clause 8.5
coerce any job applicant or employee to be tested for the presence of HIV. Second, an
employer may not disclose the HIV-status of a job applicant or employee without the
latter’s consent. These principles clearly enjoy broad recognition. In international human
rights law, the right to privacy encompasses obligations to respect bodily integrity, includ-
ing the obligation to seek informed consent to HIV-testing, and to respect the confidential-
ty of all information relating to a person’s HIV-status. In South Africa, however, studies indicate that breaches of confidentiality and privacy, in particular HIV-testing without a person’s knowledge or informed consent, are common practice. This is yet another example of the dissonance between law and practice, for the fact is that, as in the case of the right to non-discrimination, an elaborate and sophisticated set of laws and guidelines exist in South Africa to protect the right to privacy.

In the first place, South African common law recognises the right to privacy. The com-
mon law right to privacy and its relevance to HIV-status received endorsement in the
1993 decision of Jansen van Vuuren NO v Kruger. The Court there unanimously held that
disclosure of a patient’s HIV-positive status to a third party (in this case to two other
medical practitioners) without the patient’s authorisation amounted to a breach of pri-
vacy. Secondly, since 1994, there is an explicit recognition of the right to privacy in the
South African Constitution. Also recognised is the right of everyone to bodily and psy-
chological integrity, which includes the right to security in and control over the body and
the right not to be subjected to medical or scientific experiments without informed con-
sent. Thirdly, and finally, section 7(2) the EEA provides a specific safeguard against un-
authorized HIV-testing. It is these provisions relating to HIV-testing under the EEA that
are likely to have the greatest impact on the practice of coercive and surreptitious testing
by employers. To date, it has already been the subject of a number of Labour Court deci-
sions.

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56 See Marie-Claude Chartier ‘Promoting human rights through the ILO Code of Practice on HIV/AIDS
57 Ross Jennings, Jowie Mulaudzi, David Everatt, Marlise Richter and Mark Heywood Discrimination and
58 1993 (4) SA 842 (A). The case was heard before the existence of the interim Constitution, and the Ap-
pellate Division (as it was then known) had to rely on South African common law and delictual (tort) prin-
ciples of confidentiality.
59 Section 14 provides that ‘everyone has the right to privacy’.
60 See section 12(2)(b) and section 12(2)(c)
61 See Ex parte Ndebele Mining Co. Case no J1466/2001, 10 July 2001; Rand Water Board v SAMWU & others
Case no J5063/2001, 26 November 2001; Joy Mining Machinery, a division of Harnischfeger (SA) (Pty) Ltd v Na-
tional Union of Metalworkers of SA & Others (2002) 23 ILJ 391 (LC; Irvin & Johnson Ltd v Trawler & Line Fish-
Section 7(2) provides that '[t]esting of an employee to determine that employee's HIV status is prohibited unless such testing is determined to be justifiable by the Labour Court in terms of section 50(4) of this Act.' Section 50(4), in turn, states that in the event that the Labour Court declares that the HIV-testing of an employee is justifiable, it may issue any order that it considers appropriate, including imposing conditions relating to the provision of counselling, the maintenance of confidentiality, the period during which the authorisation for any testing applies, and the category or categories of jobs or employees in respect of which the authorisation for testing applies. Section 7(2) thus provides employees with an important safeguard as regards the right to privacy. Indeed, in practice, given the overwhelming evidence regarding the remote risk of workplace transmission of HIV, employers must have convincing and compelling evidence of the risk of transmission before approaching the Labour Court.62 There is one exception to this otherwise firm rule regarding the requirement for HIV-testing. Despite initial disagreement amongst commentators and some evidence to the contrary,63 the Labour Court has authoritatively ruled that this only applies to HIV-testing conducted by or on behalf of an employer, and that no authorisation is required for voluntary and anonymous testing.64

This is also the view of the Code of Good Practice on Key Aspects of HIV/AIDS and Employment. Clause 7.1.5 provides that it is permissible for an employer to provide testing of an employee who has requested a test in the following circumstances:

- as part of a health care service provided in the workplace65
- in the event of an occupational accident carrying a risk of exposure to blood or other body fluids
- for the purposes of applying for compensation following an occupational accident involving a risk of exposure to blood or other body fluids.

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63 See Joy Mining Machinery, a division of Harnischfeger (SA) (Pty) Ltd v National Union of Metalworkers of SA & Others (2002) 23 ILJ 391 (LC) at 398
64 See, for example, Irvin & Johnson Ltd v Trawler & Line Fishing Union & others [2003] 4 BLLR 379 (LC) at 380; PFG Building Glass (Pty) Ltd v CEPPAWU & others [2003] 5 BLLR 475 (LC) at 493
65 In my view, this also includes a situation in which the employee's employer employs the health professional, and HIV-testing is available to employees as part of a wellness programme. See Dupper and Garbers at C1-77.
The Code further provides that such testing may only take place with informed consent and pre- and post-test counselling (as defined by the Department of Health's National Policy on Testing for HIV), and with strict procedures relating to the confidentiality of an employee's HIV-status.\textsuperscript{66} In essence, this means that in South Africa, an employee who gives informed consent to HIV-testing waives the protection of section 7(2) of the EEA. The High Court has described the requirements for informed consent to HIV-testing as follows:

Speaking generally, it is axiomatic that there can only be consent if the person appreciates and understands what the object and purpose of the test is, what an HIV positive result entails and what the probability of AIDS occurring thereafter is. Evidence was led in this case on the need for informed consent before the HIV test is performed. Members of the medical profession and others who have studied and worked with people who have tested positive and with AIDS sufferers have developed a norm or recommended minimum requirements necessary for informed consent in respect of a person who may undergo such a blood test. Because of the devastation which a positive result entails, the norm so developed contains as a requirement counselling both pre- and post-testing, the latter in the event of a positive result. These requirements have become almost universal in the Republic of South Africa.\textsuperscript{67}

The Department of Health's National Policy on Testing for HIV defines 'informed consent' to mean that the individual concerned has been provided with information, he or she has understood it and based on this he or she agrees to undergo the HIV-test. In the words of the policy paper, this 'implies that the individual understands what the test is, what the object and purpose of the test is, why it is necessary and the benefits, risks, alternatives and possible social implications of the outcome.'\textsuperscript{68} Further, the pre-test counselling provided for should involve a confidential dialogue with a suitably qualified person, for example a doctor, nurse, pharmacist, social worker, psychologist or trained HIV-counsellor in which, amongst other things, the nature and purpose of the test, the meaning of both a positive and negative result, safer sex and strategies to reduce risk can be discussed. All of this is to enable the individual to make an informed decision about whether to take the test or not. As regards post-test counselling, this should involve one or more sessions in which the individual is given the opportunity to discuss and properly understand the results. If the results are negative, the individual should be informed about various strategies for risk reduction and also about the possibility of infection dur-

\textsuperscript{66} See clause 7.1.5(b).
\textsuperscript{67} C v Minister of Correctional Services 1996 (4) SA 292 (T) at 301B-D.
\textsuperscript{68} Draft National Policy on Testing for HIV, issued in terms of the National Policy for Health Act, Act No. 116 of 1990.
ing the 'window period'. If, on the other hand, the results are positive, the individual should be told of the possibility of follow-up supportive counselling and medical care, what his or her responsibilities are towards other people, including possible sexual partners, and what implications the positive result may have on the individual and his or her family.

Court authorisation is, as I earlier mentioned, not required for anonymous testing undertaken for epidemiological purposes or to determine the prevalence of HIV/AIDS amongst the workforce for planning purposes, for example, in developing training and awareness programmes, formulating an HIV-policy, etcetera. The Code of Good Practice also states that such testing may occur in the workplace provided it is undertaken in accordance with established ethical and legal principles regarding such research.\textsuperscript{69} The Labour Court has recently confirmed this.\textsuperscript{70} To avoid possible circumvention of this rule regarding privacy, the Code further makes explicit that testing is not to be considered anonymous if there is a reasonable possibility that a person’s HIV-status can be deduced from the results.

As a final precaution, the Code expressly requires full confidentiality regarding information on the result of an HIV-test and, consequently, any health service that conducts testing must ensure that the results are not disclosed without the consent of the employee concerned.\textsuperscript{71} Also, if an employee chooses to voluntarily disclose his or her HIV-status to the employer or to other employees, this information, according to the Code, may not be disclosed to others without the employee’s express written consent. Where consent cannot be given in writing, other steps must be taken to ensure that the employee truly wants to disclose his or her status.\textsuperscript{72} In the case of an illiterate person, this presumably means that the employer takes down a statement to which the particular employee can then attach his or her thumbprint in the presence of witnesses.

An HIV-test done in contravention of section 7(2) is not a criminal offence. However, it is unlawful and an employee or trade union may refer a dispute to the Commission for

\textsuperscript{69} Clause 7.1.8  
\textsuperscript{70} \textit{PFG Building Glass (Pty) Ltd v CEPPAWU \& others [2003] 5 BLR 475 (LC)}  
\textsuperscript{71} The one exception in this regard is if an emergency situation necessitates the testing of a blood sample and the individual refuses to give consent or is unable to do so. This will be discussed in more detail in section 4.3 below.  
\textsuperscript{72} Clause 7.2.2
Conciliation, Mediation and Arbitration (CCMA) and, if the dispute remains unresolved, to the Labour Court for adjudication.\textsuperscript{73} An employee who has given informed consent to the test would of course have no basis for lodging a dispute, unless the employee could show that the consent had been improperly obtained, confidentiality had been breached, or that other improprieties had taken place.\textsuperscript{74} In these and other cases, the Labour Court has been granted broad powers under the EEA, including the power to award compensation and damages.\textsuperscript{75} Again we see an example of a legislative safeguard of the right to privacy and confidentiality.

Turning now to how these questions have been dealt with in the mining industry, I mentioned earlier that unauthorised HIV-testing has in the past been routinely practiced there.\textsuperscript{76} To ensure that this no longer takes place, the Code of Good Practice defines 'HIV-testing' broadly not only to include non-invasive procedures (i.e. the taking of a smear of saliva) and invasive procedures (i.e. drawing of blood), but also 'written or verbal questions inquiring about previous HIV-tests; questions related to the assessment of "risk behaviour" (for example questions regarding sexual practices, the number of sexual partners or sexual orientation); and any other indirect methods designed to ascertain an employee's or job applicant's HIV-status'.\textsuperscript{77} This is particularly important for illiterate persons who in this respect are especially vulnerable to discriminatory practices, including that of unauthorized HIV-testing.\textsuperscript{78} The relatively low rate of literacy in the mining industry is thus yet another factor that makes the rights of mineworkers to privacy especially vulnerable.

Having said that, recent evidence suggests that the mining industry has come to realize that pre-employment testing to determine the HIV-status of employees is counterproductive and that such practices, whether overt or surreptitious, will not ensure that workplaces are kept immune from the epidemic. There is a growing realization that voluntary counselling and testing (VCT) is a better means to prevent new infections and this has meant that employers now actively encourage their employees to utilize VCT services to

\textsuperscript{73} See section 10 EEA
\textsuperscript{74} See Ockert Dupper and Christoph Garbers 'Employment Discrimination' in Clive Thompson and Paul Benjamin \textit{South African Labour Law Vol 1} (Juta 2002) CC 1-77 - CC 1-78
\textsuperscript{75} Section 50 EEA
\textsuperscript{76} See section 4.1, above
\textsuperscript{77} See Code of Good Practice Glossary of terms
\textsuperscript{78} See Ross Jennings, Jowie Mulaudzi, David Everatt, Marlise Richter and Mark Heywood \textit{Discrimination and HIV/AIDS} (October 2002), p.20
determine their HIV-status. In an environment where people with HIV/AIDS still are stigmatised and where the vast majority remain unaware that they are infected, this is a particularly important development. Studies show that, in general, few employees make use of the VCT services provided by the mines, fearing that the information could be used against them and that they may as a consequence be retrenched and, as the case may be, repatriated. Indeed, there is ground for their fear. In 1986 when the mining companies conducted their first HIV-surveys, workers from Malawi were banned from working on South African mines. There has also been a number of documented instances where hospital workers in hospitals that are under the control of mining houses have leaked the results of HIV-tests, further undermining confidence in their VCT programme. As a result, companies have had to take additional measures to ensure confidentiality, for example, using numbers instead of names in their medical files.

In closing this part, I want to draw attention to a recent development that has brought the entire issue of HIV testing in the mining industry to the fore again, and as a consequence, many of the legal, ethical and policy considerations that I have thus far discussed. The issue involves the question of how to classify the death of a worker who dies as a result of an injury sustained while on duty. In October 2000, Mulunga Cossa, a worker at Rustenburg Platinum Mine, died in hospital a month after sustaining knee injuries in an accident in the mine's Turffontein shaft. The Chief Inspector of Mines ruled that Cossa's death was a fatality arising from the injuries sustained in the mineshaft, and did not result from his HIV-positive status. As a result, a levy of R60 000 was imposed on the mine - a ruling that the mining company has challenged in the Pretoria High Court. The case has been postponed until January 2004 in order to allow the Tripartite Committee on HIV/AIDS in the Mining Industry an opportunity to try to resolve the issue of how deaths should be classified.

However, the matter goes beyond the issue of classification. Against the background of the ruling by the Chief Inspector of Mines, the mining company argues that in order to

79 See Declaration of Intent: Mining - HIV/AIDS Summit 2003, p. 3
80 See Andrew Maykuth 'For HIV-positive South Africans, a chance to work and live', The Philadelphia Inquirer, July 29, 2001, page A 1. Currently, it is estimated that 10-15% of all employees in the mining industry make use of VCT services. See Chamber of Mines Fact Sheet on the Mining Industry and HIV/AIDS p.3
81 See end of section 2
prevent serious impairment, disability or death occurring as the result of non-life-threatening injuries sustained while on duty (as happened in the Cossa case), to protect other employees, and to be able to place HIV-positive employees in less hazardous jobs, they must be allowed to test employees for HIV. As one mine official argues:

I am appealing to the state to give management permission to test all employees for AIDS. At present we are sending sick people underground on a daily basis. They place themselves and people who assist them after injury at great risk. If we test them, we can treat them and assist them to live longer and make their lives more bearable.  

The mining company is thus adamant that the issue involved is not financial, but a principled one. Only if the HIV-status of workers is known, the company argues, can it assist them and provide anti-retroviral therapy: 'We could, through the various interventions, prolong their lives. We don’t have to shy away from the workers who are infected with the disease, but we have a responsibility as a company to help prolong their lives. But we can only do that when, and if, we know their status with regard to HIV/AIDS.'

The National Union of Mineworkers, while supporting VCT programmes on mines, strenuously opposes this idea of compulsory testing. Whether the Tripartite Committee on HIV/AIDS will accept the recommendation of the employers that they should be allowed to test existing and potential underground employees in the interest of safety, remains to be seen. However, such a recommendation would not settle the issue. As I made clear earlier, testing for HIV at the insistence of the employer requires Labour Court approval in terms of section 7(2) of the EEA. And the burden is on the employer to convince the Court that the testing can be justified on the basis of, among other things, medical facts or the inherent requirements of the job.

Despite the explicit statements of the representatives of the mining company concerned, it is not entirely clear what the true reasons are that underpin the desire for testing in this

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82 See Andrew Maykuth 'For HIV-positive South Africans, a chance to work and live', The Philadelphia Inquirer, July 29, 2001, page A1
83 J F S Ungerer, Rustenburg Platinum Mines official, in papers filed before the Pretoria High Court, as quoted in Bonny Schoonakker, 'Death may cost mines millions', Sunday Times, 25 May 2003, p.22
84 The financial aspect of the issue has to do with whether the death of HIV-positive miners should be included in the accident statistics of a mine. These statistics are used to determine a mine’s safety risk, which in turn results in a specially calculated levy being imposed on the mine. If a fatality like that of Mr Cossa is excluded from the statistics (i.e. if judged to be due to a disease and not due to a work injury), the risk assessment of the mine will be lower and so will the levy imposed on the mine. See Khopotso Bodibe and Nawaal Deane 'HIV testing of miners under fire' Mail and Guardian, 7 July 2003
85 Mike Mtakati, spokesperson for Anglo-Platinum, quoted in Khopotso Bodibe and Nawaal Deane 'HIV testing of miners under fire' Mail and Guardian, 7 July 2003
86 Telephone interview with Dr Lettie la Grange, Anglo-Platinum’s chief medical officer, 21 July 2003
instance. In case risk of occupational transmission is given as the reason (i.e. medical facts), then the application before the Labour Court is bound to fail. For in evaluating the risk, the Court will evaluate not only the magnitude of the risk, but also its probability. Despite the ultimately fatal consequences that result from transmission, the risk of transmission in the mining sector is in fact negligible. The situation of mineworkers underground can certainly not be equated with the situation of health workers who perform invasive surgery. In the latter case, the risk of transmission is real and significant. In the case of mining operations, the minimal risk can be adequately dealt with through compliance with the provisions of the Mine Health and Safety Act and Regulations on Hazardous Biological Agents. In my view, it seems as if the impetus for compulsory testing is based not so much on medical reasons (i.e. risk of transmission) as on a growing frustration on the part of employers with the low take-up rate of VCT services among employees. Even though the provision of anti-retroviral therapy has already had a positive effect on the number of employees who make use of VCT services, the stigma around HIV/AIDS still prevents significant numbers of mineworkers from participating. For employers, the effect of the lukewarm reception of VCT has serious consequences as they increasingly lose valuable experienced employees to illness and death, often (as was the case with Mulunga Cossa) due to non life-threatening injuries.

However, in my view, compulsory testing (even if for acceptable or justifiable reasons) is not the appropriate response. There are instead two other, more effective, ways for the industry to proceed. First, the Occupational Diseases in Mines and Works Act, 78 of 1973, requires that all persons performing risk work are in possession of a certificate of fitness, and that they undergo medical examinations at regular intervals. When properly conducted, these examinations can ensure that a worker is fit enough to perform work underground. Naturally, this must not be used to test either directly or indirectly for HIV, but only to objectively determine the fitness of employees to perform risk work. In fact, one of the reasons advanced by the inspector of mines in the Cossa-case for ruling his death work-related, was that Mr Cossa had been considered fit to work underground.

87 Khopotso Bodibe and Nawaal Deane 'HIV testing of miners under fire' Mail and Guardian, 7 July 2003
89 See 4.3 below
90 Claire Keeton 'Mines' AIDS program saves money and lives' Sunday Times, 19 January 2003
91 Section 15
by the mine.\textsuperscript{92} Secondly, companies should strive to create an environment in which employees are able to participate in confidential and voluntary counselling and testing (VCT) without fear of stigmatisation and discrimination. A shift is already taking place in those companies where anti-retroviral therapy has been provided, with many VCT units experiencing a surge in the number of employees making use of the service. The fear of compulsory testing would put a stop to this trend, and further hamper the efforts of the mining industry to effectively manage the epidemic.\textsuperscript{93}

### 4.3 Healthy work environment

One of the ten key principles of the ILO Code of practice on HIV/AIDS and the world of work is that the work environment should, as far as possible, be healthy and safe for all concerned parties. The duty that is placed on employers includes the duty to provide information and education on HIV transmission, and appropriate first aid provisions in the event of an accident. In addition, employers should adapt work to suit the capabilities of workers in light of their physical and mental health.\textsuperscript{94} Similar principles are expressed in the South African Code of Good Practice on key aspects of HIV/AIDS and employment. More particularly, it addresses three aspects, each of which will be discussed in more detail below. First, it places a duty on employers to maintain a healthy and safe work environment. Second, it prescribes the action that an employer must take in the event of occupational exposure.\textsuperscript{95} And finally, it sets out the steps that an employer should follow in assisting employees with compensation claims.\textsuperscript{96}

#### Maintenance of a healthy and safe environment

The first of these aspects is given content by the Mine Health and Safety Act, 29 of 1996, that, amongst other things, places a duty on every employer to ensure safety and to maintain a healthy and safe mine environment \textit{as far as is reasonably practicable}. The phrase 'as far
as is reasonably practicable', which otherwise could give rise to interpretive difficulties, is given an explicit definition in the Act. Practicability is to be measured with regard to (i) the severity and scope of the hazard or risk concerned, (ii) the state of knowledge reasonably available concerning that hazard, (iii) the availability and suitability of means to remove or mitigate the hazard or risk, and (iv) the costs and benefits related to that. It is apparent, given these criteria, that the presence of HIV in the workplace in this respect places negligible additional burdens on employers in the mining industry. Routes of transmission of the virus are well known and this information is readily available. Also, since HIV can only be transmitted through contaminated body fluids (blood, semen, vaginal secretions and breast milk), the risk of transmission at the mines is low and the necessary precautions could be put into effect with only minor costs. In terms of the regulations for Hazardous Biological Agents, these include hand washing after touching blood, body fluid, secretions, excretions and contaminated items; wearing gloves when working with these items; wearing a mask and eye protection or a face shield during procedures that are likely to generate splashes or sprays of blood or body fluid, secretions and excretions; wearing protective clothing; and disinfecting patient-care equipment, linen and the environment. Although these precautions are in practice most important for those who work with health care at the mines, some of the precautions (such as the washing of hands after exposure to blood and body fluids), apply more widely and should be brought to the attention of all employees, especially employees involved in rescue operations underground.

Action in respect of an occupational accident

It must be noted that, as discussed in 4.2 above, one of the most serious issues facing the mining industry in the context of HIV/AIDS is the loss of employees due to minor injuries. A typical example would be that of a mineworker who sustains a deep laceration in his thigh during work. Normally, one would expect the injury to result in an absence of ten days from work, medical follow-up on two occasions, leaving the employee with no permanent disability. However, because of the poor immunity of a worker who has contracted HIV/AIDS, the injury could result in gangrene in the affected leg, which in turn

97 Section 102
98 GN R 1390, GG 22956, 27 December 2001
99 B.1.1 - B.1.7
100 Agreement between AngloGold Limited and five trade unions (2002), paragraph 5.3 (available at http://www.anglogold.com)
could lead to amputation, hospitalisation for more than two hundred days, permanent
disability and, as a consequence, for the employer, the loss of skilled and experienced la-
bour power.\textsuperscript{101}

It is clear that those infected with the virus are more susceptible to so-called opportunis-
tic infections. To this comes a heightened sensitivity to heat stress environments and
chronic illnesses that 'contribute to weight loss, fatigue, lowered awareness, dementia,
judgmental errors and depression' which, in the mines, inevitably compromise the health
and safety of the individual as well as that of fellow employees.\textsuperscript{102} In addition, there are
those who claim that in light of the fact that no cure is available, fatalistic behaviour on
the part of an infected employee is possible, especially in cases of severe depression.\textsuperscript{103}
Thus, although the risk of a miner actually contracting the virus remains low, these fac-
tors do contribute to an increased probability of occupational injuries in the mining in-
dustry.

In the event of an injury occurring in the workplace, the Code of Good Practice provides
that employers must have policies in place to manage occupational exposure to HIV,
which includes access to post exposure prophylaxis (PEP).\textsuperscript{104} In South Africa, the provi-
sion of PEP following occupational exposure has been supported by the National De-
partment of Health, and is currently standard practice. In this regard, the Department's
guidelines for the management of occupational exposure to HIV are instructive.\textsuperscript{105} In
case of exposure to body fluids, the affected area should be cleaned immediately with an
antiseptic agent and water, and mucus membrane and eye exposures should be rinsed
and flushed extensively with water. Also, once the HIV-status of the source patient has
been established, the guidelines provide recommendations for the administration of PEP.
PEP should be initiated promptly (preferably within 1-2 hours after the exposure), and
most experts recommend that PEP be administered within 24 hours after exposure, after
which time there will be no benefit.\textsuperscript{106}

\textsuperscript{101} Arthur Begley 'AIDS and Worker's Compensation in the Mining Industry' \textit{Occupational Health S.A}
May/June 2000, p.20
\textsuperscript{102} MAC La Grange 'HIV/AIDS in the South African Mining Industry - Health and Safety Implications',
p.5 (unpublished paper on file with the author)
\textsuperscript{103} 'HIV/AIDS in the South African Mining Industry - Health and Safety Implications', p.5
\textsuperscript{104} Clause 8(iv)
\textsuperscript{105} Department of Health \textit{Management of Occupational Exposure to the Human Immunodeficiency Virus (HIV)}
(1999)

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Here a highly important question arises. What are the conditions under which the HIV status of the exposure source (in this case, the injured employee) may be determined? Again, according to the guidelines, if there is no record of the HIV status of the employee, then the employee must be informed that blood needs to be obtained for the purposes of testing for HIV, and informed consent must be given for the testing to take place. This must also be accompanied by pre- and post-test counselling. However, should the employee refuse consent after having been informed that the result may be disclosed to the exposed co-employee concerned, or if the employee is unable to give consent, testing may be conducted without informed consent. This emergency situation thus provides the third exception to the general rule that informed consent is necessary for HIV testing to be conducted.

In connection with these issues, it is important to emphasise the role of Wellness Programmes in the mining industry. As earlier mentioned, in section 4.2, companies in South Africa has come to actively endorse these for the stated reason that they want 'to keep HIV-negative patients negative and to get HIV-positive patients into the Wellness Programme.' Also, beginning this year (2003), some mining companies provide infected employees (and in the case of De Beers, also spouses and life partners) with highly active anti-retroviral therapy (HAART) as part of their comprehensive Wellness Programmes. However, there are unfortunately a number of factors (some unique to the mining environment) that continue to hamper the effectiveness of these Wellness Programmes. These range from widespread misconceptions of the disease to mistrust of the motives behind the programmes themselves to a lack of commitment to staying in these programmes.

106 Management of Occupational Exposure to the Human Immunodeficiency Virus (HIV), paragraph 3.4
107 Management of Occupational Exposure to the Human Immunodeficiency Virus (HIV), paragraph 2.1
108 See Department of Health Draft National Policy on Testing for HIV, paragraph 3(b)
109 As we have seen, the other two exceptions are (i) when testing takes place as part of unlinked and anonymous testing for epidemiological purposes and (ii) where statutory provision or legal authorisation for testing exists (for example, if the Labour Court has approved an application for testing in terms of section 7(2) of the EEA). See part 4.2
111 See Joint Announcement by De Beers and the National Union of Mineworkers, 6 June 2003 (http://www.debeersgroup.com)
112 Examples mainly relate to modes of transmission such as the general belief that the virus can be passed on by mosquitoes and through food.
113 Many employees believe that the condoms dispensed are themselves contaminated with AIDS or are frightened to give blood for testing because they believe that the blood will be sold. See Andrew Maykuth
It is the last mentioned phenomenon that may be the most crucial to address, especially in those cases where anti-retroviral therapy is provided, since these drugs require a rigorous schedule to administer, and lapses can reduce the effectiveness and lead to the development of drug-resistant strains.\textsuperscript{115} As Brian Brink, Anglo American's medical director notes: 'You can't just throw drugs at the problem and create a super-resistant strain. That would be a disaster, an unprecedented disaster.'\textsuperscript{116} The challenge is therefore not only to administer the treatment correctly, but also to ensure that the patient keeps to the strict treatment regime. An additional challenge is to what extent the treatment regimen can be sustained once the employee is dismissed due to medical incapacity, retires (whether on the basis of age or ill-health), or is retrenched. In this respect, the approach of De Beers is unique in the industry. In addition to providing treatment, care and support at medical facilities on the mines, De Beers has extended these services through a network of participating medical practitioners beyond their own medical facilities. These medical practitioners are in turn required to ensure that the treatment given is sustainable and administered according to international best practice.\textsuperscript{117} This extended network of participating doctors enables the company not only to continue treatment for those employees who have left employment due to retirement, retrenchment or ill-health, but also to extend treatment to the spouses and life partners of employees.\textsuperscript{118} The De Beers programme came into operation on 1 July 2003 and will run for a two-year trial period.

\textsuperscript{114} For example, it is not unusual for half of the patients in these programmes to regularly miss their appointments, while others drop out to seek alternative treatment from traditional healers. See Andrew Maykuth 'For HIV-positive South Africans, a chance to work and live', \textit{The Philadelphia Inquirer}, July 29, 2001, page A 1. This is in part why there is recognition in the mining industry that 'traditional healers have an important role to play in the comprehensive response to HIV/AIDS.' See \textit{Declaration of Intent: Mining HIV/AIDS Summit 2003}, p. 2.

\textsuperscript{115} Some triple anti retroviral drug therapies involve taking 18 pills a day in a particular sequence, and adherence to the prescribed drug regimens is crucial for long-term success. Missing a single dose of medication 'may allow drug concentration in blood and tissues to drop below that needed for full HIV suppression'. This decrease 'allows HIV replication to occur in the optimum environment for selection of drug resistant mutant strains'. Tony Barnett and Alan Whiteside \textit{AIDS in the Twenty-First Century: Disease and Globalization} (Palgrave Macmillan 2002), pp 44-45.


\textsuperscript{117} See De Beers \textit{The De Beers Treatment Programme}, p.1 (www.debeersgroup.com)

\textsuperscript{118} De Beer's treatment of spouses and life partners, especially those who live in the rural areas, could have a marked impact on the number of AIDS orphans in South Africa. (South Africa is expected to have two million AIDS orphans by 2010.) At the time of writing, Anglo American was also considering the possibility of treating the families of workers in rural areas. The De Beers experience may therefore prove to be instructive to the industry as a whole.
Duty to assist employees with compensation claims

Mirroring the view expressed in the ILO code of practice, the South African code establishes that an employee may be compensated if he or she becomes infected with HIV as a result of an occupational accident. It also places a duty on employers to assist with the application for benefits. This includes giving information to the affected employee on the procedures that need to be followed, and providing help with the collection of information that will allow the employee to establish the link between the injury on duty and the HIV-infection.

Two pieces of legislation regulate the issue of compensation in South Africa - one general and one specific to the mining industry. The general law, the Compensation for Occupational Injuries and Diseases Act (COIDA), 130 of 1993, governs the reporting of all injuries and occupational diseases, excluding miners with occupational lung disease. HIV-infection acquired as a result of an occupational injury is thus one for which compensation can be claimed under COIDA. The process is however quite complex. For the purposes of compensation, the employee must prove a link between the injury on duty and the HIV-infection, a link that in practice can be very difficult to establish. It is true, as pointed out above, that there is an obligation upon the employer (in terms of the Code) to assist the employee with this task. But the law places the onus squarely on the employee. Schedule 3 of COIDA lists 28 occupational diseases together with a list of work that could potentially involve the handling of or exposure to certain listed substances. If an employee contracts any of the listed diseases and was employed in a listed work, it is presumed, until the contrary is proven, that the disease was contracted in the course of employment. However, HIV-infection is not one of the diseases listed, which means that the employee has to establish that the infection arose out of and in the course of employment. For this reason, it becomes very important to have information about the HIV status of the employee lodging a compensation claim as well as that of the source employee, i.e. the one that is claimed to have transmitted the virus.

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119 See ILO code of practice, 8.5(b) and Clause 9(1) and 9(2) of the SA code
120 Clause 9(i) and 9(ii)
121 Miners with lung disease acquired as a result of occupational exposure are governed by the Occupational Diseases in Mines and Works Act, 78 of 1973.
Having said that, it should be pointed out that the compensation commissioner must judge every claim on its own merits, and thus take the surrounding circumstances of the injury into consideration. This means that while information about the HIV-status of the source employee will strengthen the claim of the employee concerned, it is not absolutely necessary for a claim to be successful. Should the status of the source employee not be available, it rests on the employer to demonstrate that every effort was made to assess the HIV-status of the source employee, and that this permission was refused. Note that we are here dealing with a non-emergency situation, in other words where the employee only becomes aware some time after the incident that he or she is infected. In such a case, the employer is not allowed to test the source employee for HIV without informed consent. Instead, the employer must provide other relevant clinical information on the source employee that will assist the employee with his or her claim. Finally, the employee applying for compensation has to demonstrate an HIV-negative status at the time of the injury. In this respect, a sero-conversion within three months of the injury is considered by the Compensation Commission to be reasonable evidence that this came about as a result of the injury. This third aspect of the right to a healthy work environment thus provides an employee infected with HIV as a result of occupational exposure some support in applying for financial compensation.

4.4 Continuation of the employment relationship

The ILO code provides that HIV infection is not a cause for termination of employment, and that persons with HIV-related illnesses should be able to work for as long as they are medically fit in available and appropriate work. The same two principles, namely pro-

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122 See Department of Health Management of Occupational Exposure to the Human Immunodeficiency Virus (HIV) (1999), Appendix 2, p.7
123 Management of Occupational Exposure to the Human Immunodeficiency Virus (HIV), p.7
124 COIDA provides in section 65(4) that employees have 12 months 'from the commencement of th[e] disease' to bring it to the attention of the employer or the compensation commissioner.
125 As pointed out earlier, testing without informed consent can only take place in a situation in which the source employee refuses to be tested (or is unable to do so) and the administration of post exposure prophylaxis (PEP) can still be effectively administered, i.e. within 24 hours of exposure.
126 For example, clinical signs indicating possible HIV infection such as TB infection, signs of immune deficiency such as oral thrush and / or oral hairy cell leukoplakia on the tongue, Kaposi sarcoma, recurrent infectious conditions such as diarrhoeal diseases, pneumonia, meningitis, and unexplained weight loss. See Management of Occupational Exposure to the Human Immunodeficiency Virus (HIV), pp.4 and 7.
127 Sero-conversion means the moment a person’s HIV status converts or changes from being HIV negative to HIV positive. It usually occurs four to eight weeks after an individual has been infected with the HIV virus (http://www.afroaidinfo.org).
128 Management of Occupational Exposure to the Human Immunodeficiency Virus (HIV), p.7
129 Paragraph 4.8
tection from dismissal on the basis of HIV-status and accommodation of those suffering from HIV-related illnesses for as long as is reasonably possible, are also enshrined in the South African Code of Good Practice.\textsuperscript{130} The Labour Relations Act (LRA) gives specific meaning to the first of these principles by prohibiting dismissal based on a discriminatory reason, designating this as \textit{automatically} unfair.\textsuperscript{131} Although HIV-status is not explicitly mentioned, the non-exhaustive nature of the list and, as earlier mentioned, the recognition of HIV-status as a protected ground by the Constitutional Court\textsuperscript{132} means that the dismissal of a worker solely on the basis of his or her HIV-status will attract the strongest censure from the law.\textsuperscript{133}

The LRA also gives expression to the second principle in the provisions regarding dismissal for incapacity due to ill health.\textsuperscript{134} As stated in the Act, an employer must allow an employee suffering from HIV-related illnesses to work for as long as it is medically possible (all the while taking steps to accommodate the employee should the virus begin to take its toll) before terminating his or her service. The Code of Good Practice on Dismissal gives further guidance in this matter, by the provision that the employer must embark on an extensive investigation regarding the extent to which an employee is able to perform the work, the extent to which his or her work circumstances or duties might be adapted to accommodate the illness or disability, and the availability of suitable alternative work.\textsuperscript{135} In the course of the investigation, the employer must follow a fair procedure and allow the employee to state his or her case and to be assisted by a trade union representative or co-employee.\textsuperscript{136}

Companies in the mining industry have themselves, in their various workplace policies and agreements, come to endorse these in the context of the HIV epidemic. The principle that no employee may be dismissed on the basis of HIV-status is, for example, expressly documented.\textsuperscript{137} In addition, they acknowledge that employees must be allowed 'to pursue their work activities as long as they are physically and mentally able to meet ac-

\textsuperscript{130} Clause 11
\textsuperscript{131} Section 187(1)(f)
\textsuperscript{132} \textit{Hoffman v South African Airways} (2000) 21 ILJ 2357 (CC)
\textsuperscript{133} An automatically unfair dismissal entitles an applicant to a maximum of 24-months instead of the usual 12-months compensation. See section 194(3) LRA
\textsuperscript{134} Section 188(1)(a)(i) and the Code of Good Practice: Dismissal (Schedule 8), Item 10
\textsuperscript{135} Item 11
\textsuperscript{136} Item 10(2)
\textsuperscript{137} See, for example, Goldfields-agreement, paragraph 10.1; Goldfields HIV-policy, paragraph 10.1; AngloGold agreement, paragraph 3.3
ceptable performance standards and as long as their continued employment does not pose a safety or health hazard to themselves or others.' Further, should the employee be too ill to perform his or her current work, specific guidelines and procedures regarding incapacity must be followed. The Gold Fields Limited policy contains a particularly interesting and innovative provision. It states that in the event that an employee suffering from HIV/AIDS is terminated on the basis of ill health, the mine concerned 'will endeavour to recruit a family member as replacement [...] if a suitable vacancy exists, and provided such family member meets the requirements of the vacancy.' Whether the individual mines actually follow through on this undertaking is not clear. However, the preference given to family members at least indicates recognition of the potential negative impact that the loss of income can have on a family unit, and represents an attempt to alleviate this in some manner. One can only hope that this will be followed by other companies in the mining industry.

5. Conclusion

It is estimated that 5 million South Africans are HIV-positive and that approximately 1700 people in South Africa become infected every day, representing one out of every 10 infections worldwide. South Africa thus has the largest infected population in the world, as well as the fastest rate of new infections. This can be explained as a result of a combination of poverty, illiteracy, migrant labour, commercial sex work and disruptions to family and communal life that increase the individual's risk of HIV infection. Because the majority of those who die of AIDS are adults in their productive prime, namely between 20 and 49-years of age, it is obvious that the workplace will not be able to escape the effects of the AIDS epidemic. These include a reduced supply of labour, the loss of skilled and experienced workers, increased pressure on women to earn an income as well as care for the sick, reduced productivity, absenteeism and early retirement, and a

138 De Beers Joint HIV/AIDS Workplace Policy, paragraph 8.3.1
139 De Beers Joint HIV/AIDS Workplace Policy, paragraph 8.3.3; Goldfields agreement, paragraph 10.2; AngloGold agreement, paragraph 3.4
140 Policy, paragraph 11.3; Agreement, paragraph 11.2
negative impact on employee benefits. As an example, many South African companies are losing 3% of their employees to AIDS each year.\textsuperscript{145}

Despite these alarming facts, employers and employee organisations for a long time were slow to recognise the potential impact of AIDS on the labour market and on industrial relations.\textsuperscript{146} Unions, on the one hand, concentrated haphazardly on policy development. Employers, on the other hand, mainly responded by seeking to minimize the impact of AIDS through strategies such as pre-employment HIV testing and unilateral adjustments to employee benefits.\textsuperscript{147} Job applicants and employees who had contracted HIV were refused employment, promotion or were simply dismissed regardless of their capacity for work.

What I hope to have shown in this paper is that things are beginning to change. Legislation, codes, policies and agreements have been established that can serve as models for other industries in South Africa and for governments and industries in other countries in creating a set of best practices in the area of HIV/AIDS and the world of work.

\textsuperscript{145} Heywood and Hassan 845.
\textsuperscript{146} Heywood and Hassan 846.
\textsuperscript{147} Heywood and Hassan 846.