Privacy, Surveillance and HIV/AIDS in the Workplace. A South African Case Study“
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Interview with Ms. Phumla MBONISWA, NUM HIV/AIDS Officer, 13.11.2007

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I. NUM and HIV/AIDS

1. What are the recent NUM activities on HIV/AIDS?
2. What is the NUM‘ evaluation of the HIV/AIDS policy of Anglo American, Eskom, BHP Billiton?

II. Confidentiality

1. In the view of trade unions, are employers interested in identifiable HIV/AIDS data?
2. How trade unions define unauthorised disclosure of HIV/AIDS status?
3. Does fear of weak confidentiality safeguards may play the role in a weak uptake of VCT and treatment in the workplace or are there other important factors?
4. Is there a ground for trade union’s concern for HIV/AIDS identifiable data treatment in the workplace? (example with the nurse)

III. Stigma

1. In the view of trade unions, what is more important, the rights of the infected or non-infected workers?
2. Are HIV/AIDS positive workers more afraid of discrimination from the part of employers or co-workers?

As NUM we encourage workers to get tested. We think it is crucial for adressing the epidemic that everyone monitors his/her HIV status. However, in the workplace the problem of testing gets a different dynamics. HIV/AIDS status is too closely connected to the threat of loosing a job, loosing a job in the moment when it is the most urgently needed by a worker.

The problem of how closely HIV/AIDS is linked to a threat of loosing a job is to a great extend about confidentiality of HIV/AIDS status. Currently, many companies outsource VCT in the workplace and employ commercial laboratories to perform testing and gather data. In our view, though, it is not possible to be assured about confidentiality of

individual HIV data of workers as we deal here with a commercial relationship between the company and a laboratory. It is rather possible that if the employer would demand more individualized data on who is HIV positive, he could get it. That is why workers do not have an absolute trust even in an outsourced VCT programs and the uptake is not high enough.

With Anglo American we were involved in negotiations on providing treatment for workers. The agreement was signed. However, the company did not agree to entitle both workers and members of their families to treatment options provided by occupational clinics. We are currently battling with Anglo American for extended workplace programs as it is not possible to succesfully treat workers if members of their families are left untreated . Also, in Anglo American the outsourced workers are not covered by the treatment programme. We think that excluding outosourced workers from HIV/AIDS corporate shemes will create huge problems with efficiency of workplace HIV/AIDS initiatives, as replacing regular workers with outsourcing is a growing problem in South Africa and elswhere.

In relation to policy on HIV/AIDS of Anglo American, which is often described in the media as an example of good practice, we, as NUM, have policy reasons for criticizing it. First of all, Anglo American policy, although it covers both testing and treatment, and although is unquestionalbly one of the most ethically influenced corporate policies in South Africa, in our view has been still too much influenced by economic aspects of the policy, too much oriented on cost benefit analysis. Other elements, which are important for encouraging workers to take in these workplace policies – like councelling, training, voluntary testing – were not a priority. It can be said that the policy was driven more by public relations concerns than the concern about workers.

Evaluation of NUM
Even though big employers currently try to manage HIV/AIDS in the workplace (they implement widely advertised HIV/AIDS programs, frequently commercialized and outsourced to professional, expensive companies) on the workplace level we still see a scenario in which HIV positive workers are found not fit to work because of their HIV status, contrary to the fact that they are ususally fit to work for a long time. This is the main concern of HIV positive workers, that if they disclose their status they will be dismissed. Frequently, they suffer from stress and it is proven that stress might affect viral system. That is why NUM encourages workers to get tested but we advice to do it outside the company in order to protect confidentiality of their HIV status against the employer.

There is also the problem of medical examination in case of finding of unfitness to perform work because of HIV/AIDS. According to the procedure, if the occupational doctor suspects that the worker is no longer fit to work he/she decides about temporarily removing the worker from the workplace for a recovery. In case of temporary unfitness to work the employer should come up with recommendation for further employment of the worker concerned, since being HIV positive usually means being fit for work, even if with slight organizational modifications (like changed time or kind of work). Even people

with AIDS, after starting ARV treatment, improve dramatically. Unfortunately, the recent trend is that the employers avoid making recommendations for further employment of HIV positive workers, even if they are required to do so by law, in order to get rid of the workers who are already HIV positive. In consequence, people loose work and income.

Anglo American, BHP Billiton and Eskom, especially on the local level, are not exceptions.

In BHP Billiton we have an agreement on HIV/AIDS policy signed. That is good. However, we do not like this agreement. The problem is that this BHP Billiton has not decided to cover dependants of HIV positive workers with testing and treatment possibilities. In our view, such policy will never succeed, nor socially, neither medically. Also, as long as confidentiality clause is not appropriate, we will advise workers to get tested outside the workplace. This is the case of BHP Billiton.

We do have our critical remarks about the HIV/AIDS policy of Anglo American but we agree that the company makes a significant effort to address the issue and tries to adopt a rights oriented approach. Their problem is implementation of a good, centrally planned policy on a decentralized level, where local managers might not be that committed to secure rights of HIVpositive workers. One can say that the head is good but the belly is not.

When it comes to Eskom, we still have not managed to get the employer to sign the agreement on HIV/AIDS policy with us. The company has its workplace HIV/AIDS policy but it seems to overlook the issue of rigths and ethics and is mainly economically oriented. As to confidentiality of HIV testing the same critique apply as in case of BHP Biliton.

Another problem is when HIV/AIDS meets TB and workers may be misdiagnosed, especially in the mining industry. Sometimes doctors who are employed by companies do not have expertise in separating occupational and non-occupational TB. HIV/AIDS and TB may be then misdiagnosed which has significant consequences for compensation expenses. It is very difficult for trade unions to prove that a worker got silicosis – a mining occupational disease, not TB. If such worker is HIV positive the assuption will be that TB has been acquired as an HIV opportunistic disease, not as an occupational disease and such worker will not get compensation.

When it comes to VCT it is important to stress the crucial role of employers. By implementing HIV/AIDS the employers can significantly improve state of knowledge on the disease, promote safe behaviour like using condoms, fight stigmatization of HIV positive workers. HIV/AIDS in South Africa is indeed a disease that requires changing minds. Employers, especially big ones that heavily rely on migrant work, have not only the opportunity but also the duty to react.

We as NUM want to lead in negotiating HIV/AIDS policy in the workplace. Having said all the critical remarks about Anglo American, Eskom, BHP Billiton we want to stress

that these are big employers which at least try to address the problem how to organize the work of their HIV positive and negative employees. In many smaller companies it is still too difficult to convince the employer about the necessity to implement HIV/AIDS policy of non-discrimination, testing and treatment. Currently, our main challenges are: get smaller companies to negotiate and implement workplace HIV/AIDS policy, get those who have already developed a basic HIV/AIDS programme to extend it to workers‘ dependants, come to consensus how to manage VCT in the way that will secure confidentiality of HIV status of workers.

In relation to stigma, in our view, although there are numerous examples of workplace based discrimination from the part of co-workers – in practice the co-workers are the ones who carry the burden of HIV/AIDS together with the positive collegue. These are the ones who will take a part of his/her work when the positive worker feels tired, they will carry the burden of their positive collegue increased absenteeism. In our view HIV positive workers are not afraid of stigma that much, they are more afraid of loosing jobs. Again, we encourage them to get tested outside the workplace in order to be in control of information on their HIV/AIDS status.