
GLOBAL
PROGRAMME
ON **AIDS**



REPORT OF THE
CONSULTATION ON
AIDS AND THE WORKPLACE

GENEVA
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INTRODUCTION

Infection with the human immunodeficiency virus (HIV) and the acquired immunodeficiency syndrome (AIDS) presents a global problem, its social, cultural, economic, political, ethical, and legal aspects being multiple, its impact profound. The workplace plays a major role in the lives of people. Today, there are an estimated 2.3 thousand million economically active persons in the world. Consideration of the infection in relation to the workplace is therefore crucial in dealing effectively with the problems of HIV/AIDS at the local, national, and international level.

To examine this issue, a three-day consultation (27-29 June 1988) was convened in Geneva by the World Health Organization (WHO) in association with the International Labour Office (ILO). Thirty-six participants from 18 countries attended the consultation including representatives of government, trade unions, business, and the public health, medical, legal, and health education professions. A list of the participants is given in Annex 3.

Dr J. Cohen, representing the Director General of WHO, welcomed the participants and outlined the three themes of the consultation, risk factors associated with HIV infection in the workplace, responses by business and workers to HIV/AIDS, and the use of the workplace for health education activities.

The first two days of the meeting were chaired by Dr J. Wallin (Sweden), the last day by Dr R. Mullan (USA). Ms C. Levine (USA), Mr M. Raymond (Scotland), and Ms E. Rubin (Australia) acted as rapporteurs for the consultation. Two working groups were established to draft a consensus statement and a statement on health education and promotion strategies at the workplace.

The consultation was concerned with workers employed in the great majority of occupations, where there is no occupationally related risk of acquiring or transmitting HIV infection.

RISK FACTORS ASSOCIATED WITH HIV INFECTION IN THE WORKPLACE

Dr J. Mann, Director, WHO Global Programme on AIDS (GPA), described the work of the Programme and emphasized the importance of the consultation in the overall strategy. Noting that the consultation is on AIDS and the workplace, not in the workplace, he said that it is necessary to go beyond information and education and create a link between a supportive social environment, educational messages, and the health and social services. AIDS is both a danger and an opportunity, providing the impetus to deal with longstanding problems such as intravenous drug use and the relation between health and the workplace. It is an unprecedented disease in that it is clearly recognized as a worldwide problem at the very time it is occurring. The consultation is concerned with the vast majority of workers that are not at risk through their occupation or their occupational setting.

Mr G. Kliesch, Director, Working Conditions and Environment Department, ILO, noted the need for cooperation among the United Nations agencies and the potential impact on the relation between employers and workers if discrimination continues in relation to AIDS. He also noted the impact of AIDS on social security programmes and pension plans, and the need for more responsible reporting by the media on the disease.

Dr J. Chin, Chief, Surveillance, Forecasting and Impact Assessment Unit, GPA, reviewed the global statistics on AIDS, pointing out that almost every country has been or will be affected. The natural history of the disease involves a long latency period between infection and the onset of symptoms, with an increasing trend towards the development of AIDS after a period of years in those infected with HIV.

Reviewing the evidence on transmission, he emphasized the different risks of infection of different routes, transfusion of HIV-contaminated blood being the most likely to transmit HIV, perinatal transmission next, and sexual intercourse (by far the most common route) less risky for a single episode, the likelihood of transmission varying with the presence of risk factors possibly including other sexually transmitted diseases. Intravenous drug abuse is risky because of repeated exposure to HIV-contaminated needles, syringes, or other injection equipment. Other modes of transmission have not been documented. In health care settings, less than 1% of needle-stick exposures to blood of persons with HIV infection have resulted in infection of the health worker. The transmission risk from normal school, social, community, and employment contact is considered to be non-existent.

Dr R. Mullan, National Institute for Occupational Safety and Health, Centers for Disease Control, USA, reviewed the specific risks of HIV infection at the workplace. Apart from health care workers and first-response personnel (e.g., firefighters, emergency medical response personnel, law enforcement officials), whose risk is low but real, only personal service workers whose job duties entail close personal contact with their clients and the use of potential or intentional skin-piercing instruments run a theoretical risk. Such occupations include acupuncturists and tattooists, where skin penetration is to be expected, and cosmetologists and barbers, where unintentional skin penetration is possible. The theoretical risks in these occupations can be minimized or eliminated by following recommended guidelines for protection from infectious diseases.

Several questions were asked concerning the unintentional exposure to needles or syringes contaminated by intravenous drug users of people not engaged in law enforcement activities (e.g., postal workers or plumbers who accidentally come upon such a needle in the course of their work). A similar question was raised concerning postal and other transport workers exposed to damaged and leaking packages of biological specimens. This kind of occurrence was considered to be uncommon, with an unquantifiably low risk of transmission.

A clarification was requested regarding the survival of HIV outside the human body.

Questions were also raised about the adequacy of first-aid training and procedures to deal with workplace accidents, since they are foreseeable and theoretically a source of HIV transmission.

RESPONSES BY BUSINESS AND WORKERS TO HIV/AIDS

Mr A. Gladstone, Director, Industrial Relations and Labour, Administration Department, ILO, described the policy issues facing governments, business, and labour organizations.

Dr G. Haughie, Director, Health and Safety, IBM, USA, described IBM's policy, which was formulated in 1985 and approved by management. It stresses respect for the individual and the treatment of employees with AIDS in a manner similar to those suffering from other serious illnesses in terms of confidentiality, access to benefits, and accommodation to work. The company does not test applicants or employees for HIV. Since 1987 there has been a strategic plan with three components:

- (1) assistance to employees and their families;
- (2) education programmes; and
- (3) support of external programmes to combat AIDS (e.g., research grants).

IBM does not notify co-workers if an employee has AIDS. If an employee requests a transfer because of concern about an HIV-infected co-worker, the request is treated like all other requests for transfer for personal reasons. IBM employees have shown interest in educational programmes, such as a home video on AIDS. IBM is concerned about its employees and is in a suitable position to educate them. Such a proactive approach makes good business sense and presents a reasoned approach to public policy issues and costs.

Ms E. Rubin, Australian Council of Trade Unions (ACTU), said that ACTU based its response to AIDS on accepted trade union principles:

- (1) workers have a right to expect a safe and healthy workplace;
- (2) workers have a right to know of hazards, which must be kept to a minimum; and
- (3) improvements in health and safety can be achieved by collective action.

The ACTU policy recognizes the risk of discrimination against workers with AIDS or those perceived to be at high risk, such as homosexuals and persons with haemophilia. It stresses the importance of occupational health and safety guidelines, clear and accurate information, and the protection of union members.

Guidelines for specific occupations provide for adequate training, protective attire where appropriate, revision of first-aid kits and procedures, confidentiality, the provision of health care and services, protection of employee rights and benefits, no discrimination on basis of sexual orientation or handicap, and no compulsory screening. If screening is done it must be voluntary and with informed consent. Employees have no obligation to inform employers of their HIV status.

Mr R. Earwicker, Trades Union Congress (TUC), United Kingdom of Great Britain and Northern Ireland, said that the TUC's concern with AIDS focuses on human rights, not just on health and safety. In a first stage, the TUC thought of the HIV/AIDS problem as one affecting only special categories such as laboratory workers. In a second stage, it faced the problems of workers who care for persons with HIV/AIDS, this including prison officers, social service workers, health care workers, and ambulance workers. The TUC developed procedures and guidelines for those situations. In a third stage, the TUC is faced with more general aspects of industrial relations and the difficult issues of discrimination and ignorance.

The TUC has to guide unions and make representations to government. This includes promoting:

- (1) improved awareness of health education;
- (2) proper health and safety arrangements, including the continuing problem of implementation;
- (3) adequate public resources, e.g., the ability of the National Health Service to respond to the need to deliver health care where it is needed (Central London, where most AIDS cases are located, is in general losing population and therefore its health resources have diminished);
- (4) treatment and advice;
- (5) avoidance of discrimination.

The TUC is opposed to pre-employment and employment screening and is committed to preserving confidentiality. It is important to have joint employer-trade union declarations on all the relevant issues. The TUC is opposed to the dismissal of HIV-infected employees, even when the pressure to remove a worker comes from a union member.

Ms J. Williams, United States Department of Labor, referred to publications of the United States General Accounting Office, Office of Management and Budget, and other agencies. Their overriding theme is that employees with AIDS should be treated like employees with any other disease. In the United States there is a wide measure of

agreement between employees and unions on the basic approach, but there are two problems: (1) the pace varies between large and small companies; and (2) antidiscrimination cannot be achieved by information alone but must involve a change of attitude.

Ms M. Day, Manitoba Government Employees Association, Canada, described the provisional policy of the Canadian Labour Congress (CLC). The key points are:

1. Protection is needed for members perceived to belong to high-risk groups.
2. AIDS is only one of a range of communicable diseases.
3. AIDS is a serious threat to health.
4. Education is more effective than legislation in controlling AIDS.
5. There is a need for clear and accurate information jointly communicated by unions and employers.
6. There is a need for clear guidelines on safety precautions and for adequate training and practices.
7. The confidentiality of workers must be protected.
8. Protocols for the provision of services must be developed jointly.
9. Compulsory testing must be opposed.
10. All testing must be voluntary with informed consent and counselling must be available.

In Canada, initiatives for health and safety education and policy development come from labour. The Canadian Labour Congress has lobbied extensively for increased government funding for education. Human rights remain high on its agenda.

Dr W.J. Urbatus, Ciba-Geigy, Switzerland, described the policy of this multinational chemical and pharmaceutical company. There is no justification for ostracizing people with this disease, much less for isolating them. The company's policy is based on the following principles:

1. No testing is carried out at present for job candidates or existing employees.
2. Employees with HIV receive counselling and, as long as they agree to reassignment, are placed in jobs with no risk of infection to them.
3. Persons requesting an HIV antibody test are referred to hospitals or other health care facilities; the company does not pay for the test.
4. Blood tests required for visas for certain countries are paid for by the company.

A company-wide AIDS task force includes one of the Ciba-Geigy directors-general. The company provides education through its publications. Travellers abroad are given syringes to prevent HIV transmission in health care settings where sterile needles and syringes may not be available.

In the general discussion it was noted that WHO policy prohibits holding meetings, courses, or seminars in any country that requires HIV certificates from prospective participants.

Dr P. Westerholm, Swedish Labour Ministry Action Group on HIV/AIDS, reviewed AIDS policy development in relation to the Swedish labour market. The trade unions play an important role in political leadership in the Nordic countries; the rate of membership is high, 90-95% of employees in Finland and Sweden being organized in trade unions. When the first AIDS cases appeared in Sweden and public awareness of the risks developed, the trade unions regarded the problem as a public health issue and as such best dealt with by the health authorities and the competent government authorities. It was also considered that the information material produced by the health authorities and the extensive media coverage of the issues involved provided sufficient information. It very soon became clear, however, that the information disseminated by the health authorities did not reach the workplaces.

At first the unions believed that the mass media had provided enough information. They then realized that much of the information was confusing and that there was a fair amount of confusion and anxiety. Cases of discrimination were reported and there was an increasing demand for trade union information. Special areas of concern were the risks for certain types of workers, the risk of discrimination, and the social impact at the workplaces. The unions, reappraising the situation, recognized that laws and negotiated agreements are not enough and that a change in public attitudes is needed. The workplace was considered to provide a strategic platform for bringing about such a change. The action envisaged was to be taken by the unions alone, by the unions jointly with employers, and by both in cooperation with the health authorities and government agencies.

The Swedish Labour Ministry Action Group on HIV/AIDS, a collaborative group composed of representatives of employers organizations and trade unions from the private and public sectors and the health authorities, has produced a nine-point consensus statement on HIV risks and the workplace. The Swedish Federation of Employers has produced two information brochures on AIDS. Trade unions have produced booklets on bloodborne infections, with emphasis on HIV/AIDS, to be used as a basis for designing local action programmes. The trade unions oppose compulsory testing and emphasize the confidential nature of all health information.

There are, however, some problems. First, health education must go beyond the promotion of condoms and deal with basic factors in social relations, the developing of tolerance and understanding for minorities. Secondly, programmes have to be preventive, that is, be in place before problems arise. They also have to take into consideration the situation of small as well as of large employers. Finally, there is the question of who will do the work. Professionals and lay people must carry out health education, and all the available resources must be marshalled and new and resourceful partners found for collaboration at the local level.

Dr M.A.L. Hassan, Chief, Arab International Centre for Fighting AIDS, Egypt, reported that as yet there is no HIV/AIDS problem in Egypt. A seroprevalence survey of 10 000 Egyptians considered to be at high risk revealed no HIV positives. The First International Arab Conference on AIDS, held on 3-5 March 1988 and attended by over 2 000 delegates, made over 20 recommendations that involve the holding of further scientific conferences and seminars and the use of various educational techniques in the mass media. A series of control measures were also proposed, including the mandatory HIV testing of high-risk groups coming from foreign countries, severe penalties for drug sellers, the exemption of pregnant nurses from caring for AIDS patients, premarital testing, and the exemption of all nurses from caring for AIDS patients if they are not provided with protective equipment. An AIDS information centre was also proposed.

Ms C. Levine, Citizens' Commission on AIDS for New York City and Northern New Jersey, USA, presented the Commission's ten principles for the workplace. The Commission is a private, independent group of business, labour, and non-profit agency leaders that was created by 17 foundations to stimulate leadership in the private sector. It focused first on the workplace because the corporate response to AIDS in the United States has been slow, because the workplace is an under-utilized forum for AIDS education, and because much of the discrimination against people with HIV/AIDS has centred around employment. The ten principles stress non-discriminatory policies, education for all, joint leadership by management and labour at the highest level, communication of policies to employees in clear and accurate language, no routine compulsory pre-employment or employment screening for workers, and adequate training and equipment in those workplaces where there may be a risk. So far over 50 major corporations, unions, and non-profit agencies have publicly endorsed the principles, thus creating a consensus on a basic approach that reflects sound epidemiological data, prudent business practice, and a humane and compassionate attitude to individuals.

USE OF THE WORKPLACE FOR HEALTH EDUCATION ON AIDS

There was much discussion about whether nongovernmental organizations should be included in the partnership of government, employees, and employers concerned with AIDS issues in the workplace. Appropriate nongovernmental organizations were felt to be important for the development of AIDS policy and education.

Screening was an issue that gave rise to much discussion. The demands of insurance and superannuation agreements make statements about screening difficult. Pre-employment testing issues are complicated by the demands of information for insurance purposes.

It was emphasized that, while people with AIDS should be treated in the same way as other workers, AIDS involves ethical and social issues that require reassessment of policy and practices.

The extent to which employers should be responsible for providing education and information was discussed. It would be of value if authoritative private agencies working in partnership with employers had access to the workplace to provide counselling and information.

Participants were particularly concerned about the privacy and confidentiality of all medical records and the distinction between the two concepts. Discrimination and stigmatization were considered to be key issues in workplace attitudes towards AIDS.

Non-discrimination in relation to workplace benefits was also considered central to the well-being of people with HIV. The practice in some quarters of dismissal and denial of benefits to people with HIV was referred to. HIV issues must be considered in the context of the prevailing economic climate and patterns of employment in different countries.

Policy development and policy implementation are dynamic processes, both interrelated.

A constant theme of the discussion was the opportunities presented by the AIDS crisis for re-examining existing health and social practices and policies more generally.

Dr Raymond, Scottish Health Education Group, outlined the situation in Europe. He placed the development of AIDS education within the context of health promotion and stressed collaboration, evaluation, appropriateness, and the links between policy and education.

Dr Bunker, Director, Center for Health Promotion, George Mason University, USA, presented a similar overview of the extensive experience in North America. Several studies have shown that only a small percentage of United States companies have provided AIDS education and developed an AIDS policy. Workers' attitudes and behaviour show a high level of anxiety about working with HIV-infected persons. The United States Presidential Commission on the Human Immunodeficiency Virus Epidemic concluded in June 1988 that workplace education is a major tool in combating AIDS and HIV but that important barriers still remain. Task force initiatives provide a model for developing educational material and supporting the implementation of AIDS education programmes, the goal of which is to reduce fear and hysteria and prevent the spread of AIDS.

Packages and strategies produced by companies, unions, and nongovernmental agencies were reviewed. Participants then viewed a videotape recording produced by the Bay Area Task Force on AIDS in the United States. This is a good illustration of the type of material that can be used for the discussion of AIDS-related issues in the workplace.

THE CONSENSUS STATEMENT

A draft consensus statement developed by the working group was revised following consultation with participants and reintroduced for discussion. The discussion emphasized the need to protect workers perceived to be infected by HIV/AIDS against discrimination by co-workers, employers, clients, and unions.

With minor amendments, the statement was endorsed by all the participants (Annex 1).

The Chairman then introduced the draft statement on health promotion and health education strategies for HIV/AIDS in the workplace. As the draft was a strategy paper rather than a consensus statement, he asked participants to focus on the range of issues covered and their usefulness rather than on a precise terminology.

Participants discussed the draft (Annex 2) and the need to link it with the objectives of the consensus statement, in particular to promote a climate of mutual understanding in the workplace.

Clarification was sought on the skills required to assist individuals to change their risk behaviour and on whether such skills depend on an understanding of the issue. The need to facilitate understanding of AIDS as a social problem and to encourage participation in programmes both at local and at national level was stressed.

On the question whether participation in such programmes should be voluntary or obligatory concern was expressed by some participants lest voluntary programmes reach only those who are already taking positive steps to reduce their risk behaviour, and that in itself may lead to discrimination. Other participants argued that the wishes of the individual should be respected; voluntary participation is likely to result in increased commitment to the programme.

It was argued that to restrict education and training initiatives to working hours is unduly restrictive and ignores the competing production demands on managers. Participants agreed that a variety of education and training initiatives are required and that action may or may not take place during working time. There was, however, general agreement that provision of information within working hours would enhance the effect of the programme. The need for the commitment of and cooperation between management and unions was stressed.

The question of flexibility in relation to AIDS education and training was discussed. In some cases such programmes could be integrated into other programmes; in others they would not be integrated but be simply complementary to other programmes. Programmes need to be of a continuing nature, too, rather than single isolated events. Nor should AIDS education and training displace other work-related health and safety education or general occupational health and safety training.

It was noted that any AIDS education programme should be developed on the basis of reliable sources to ensure that the information provided is accurate. This is particularly important because secondhand and thirdhand material is often cited and is likely to be taken out of context.

The need to recognize differences between developed and developing countries was discussed. Many developing countries suffer from lack of resources and have competing priorities that hinder the development of AIDS programmes. It was pointed out that WHO provides material to national AIDS committees in over 160 countries, material that is technically accurate and could be adapted to local requirements and workplace conditions.

RECOMMENDATIONS

The following recommendations were made to WHO and ILO:

1. WHO and ILO should ensure wide distribution of the report of the consultation and the consensus statement.
2. WHO should intensify its efforts to ensure that discrimination and stigmatization do not occur, based, for example, on ignorance regarding the etiology, geographical origins, or modes of transmission of HIV.
3. WHO, in collaboration with ILO, should survey current legislation, jurisprudence, and practice concerning discrimination in the workplace in relation to HIV/AIDS. The survey would provide valuable information on current practices, to which governments could refer before developing their own policies. It would also provide a more solid factual background for the study of non-discrimination issues in the workplace.
4. WHO and ILO should further consider the special concerns and needs of seafarers regarding HIV/AIDS.
5. WHO and ILO should consider evaluation of the chemical or microbiological hazards to HIV-infected persons in the workplace.
6. WHO should develop first-aid guidelines to ensure the minimal risk of and the optimal hygienic precautions against infectious diseases and include consideration of occupational first-aid officers. This recommendation is an example of how AIDS can be used to address broader workplace concerns.
7. WHO, in conjunction with ILO, should consider the provision of technical support to other organizations, the dissemination of educational material, and the integration of AIDS into the agenda of other international conferences. Accordingly, WHO and ILO should consider:
 - (a) the provision of technical support, including technical assistance, consultation, and training;
 - (b) the development of guidelines, manuals, and other materials on HIV/AIDS and the workplace;
 - (c) means of ensuring that HIV/AIDS issues are discussed at appropriate international and national meetings;
 - (d) the holding of an international consultation on HIV/AIDS and the workplace, possibly in association with the Fifth International AIDS Conference to be held in June 1989 in Montreal, Canada;
 - (e) the establishment of a clearinghouse for materials and information on policies. While the ILO International Occupational Safety and Health Information Centre (CIS) has links with over 60 countries, there is as yet only a small bridge between CIS and AIDS information. The clearinghouse might be expanded to include a register of researchers, projects, and conferences, and its value would be enhanced if evaluation of the entries could be undertaken. Emphasis should be placed on cooperation between industrialized and underdeveloped countries.
8. WHO and ILO should help ensure that national AIDS committees establish links with those working on HIV/AIDS workplace issues.

CONSENSUS STATEMENT

I. General statement

Infection with the human immunodeficiency virus (HIV) and the acquired immunodeficiency syndrome (AIDS) represent an urgent worldwide problem with broad social, cultural, economic, political, ethical and legal dimensions and impact.

National and international AIDS prevention and control efforts have called upon the entire range of health and social services. In this process, in many countries, HIV/AIDS prevention and control problems and efforts have highlighted the weaknesses, inequities and imbalances in existing health and social systems. Therefore, in combatting AIDS, an opportunity exists to re-examine and evaluate existing systems as well as assumptions and relationships.

Today there are 2.3 billion economically active people in the world. The workplace plays a central role in the lives of people everywhere. A consideration of HIV/AIDS and the workplace will strengthen the capacity to deal effectively with the problem of HIV/AIDS at the local, national and international levels.

In addition, concern about the spread of HIV/AIDS provides an opportunity to re-examine the workplace environment. It provides workers, employers and their organizations, and where appropriate, governmental agencies and other organizations, with an opportunity to create an atmosphere conducive to caring for and promoting the health of all workers. This may involve a range of issues and concerns, not only individual behaviour, but also addresses matters of collective responsibility. It provides an opportunity to re-examine working relationships in a way that promotes human rights and dignity, ensures freedom from discrimination and stigmatization, and improves working practices and procedures.

II. Introduction

Epidemiological studies from throughout the world have demonstrated that the human immunodeficiency virus (HIV) is transmitted in only 3 ways:

- (a) through sexual intercourse (including semen donation);
- (b) through blood (principally blood transfusions and non-sterile injection equipment; also includes organ or tissue transplant);
- (c) from infected mother to infant (perinatal transmission).

There is no evidence to suggest that HIV transmission involves insects, food, water, sneezing, coughing, toilets, urine, swimming pools, sweat, tears, shared eating and drinking utensils or other items such as protective clothing or telephones. There is no evidence to suggest that HIV can be transmitted by casual, person-to-person contact in any setting.

HIV infection and AIDS (HIV/AIDS) are global problems. At any point in time, the majority of HIV-infected persons are healthy; over time, they may develop AIDS or other HIV-related conditions or they may remain healthy. It is estimated that approximately 90% of the 5-10 million HIV-infected persons worldwide are in the economically productive

Annex 1

age-group. Therefore, it is natural that questions are asked about the implications of HIV/AIDS for the workplace.

In the vast majority of occupations and occupational settings, work does not involve a risk of acquiring or transmitting HIV between workers, from worker to client, or from client to worker. This document deals with workers who are employed in these occupations. Another consultation to be organized by the WHO Global Programme on AIDS will consider those occupations or occupational situations, such as health workers, in which a recognized risk of acquiring or transmitting HIV may occur.

The purpose of this document is to provide guidance for those considering issues raised by HIV/AIDS and the workplace. Such consideration may involve review of existing health policies or development of new ones. This document focuses upon the basic principles and core components of policies regarding HIV/AIDS and the workplace.

By addressing the issues raised by HIV/AIDS and the workplace, workers, employers and governments will be able to contribute actively to local, national and international efforts to prevent and control AIDS, in accordance with the WHO's Global AIDS Strategy.

III. Policy principles

Protection of the human rights and dignity of HIV-infected persons, including persons with AIDS, is essential to the prevention and control of HIV/AIDS. Workers with HIV infection who are healthy should be treated the same as any other worker. Workers with HIV-related illness, including AIDS, should be treated the same as any other worker with an illness.

Most people with HIV/AIDS want to continue working, which enhances their physical and mental well-being and they should be entitled to do so. They should be enabled to contribute their creativity and productivity in a supportive occupational setting.

The World Health Assembly resolution (WHA41.24) entitled, "Avoidance of discrimination in relation to HIV-infected people and people with AIDS" urges Member States:

"....(1) to foster a spirit of understanding and compassion for HIV-infected people and people with AIDS...;

(2) to protect the human rights and dignity of HIV-infected people and people with AIDS...and to avoid discriminatory action against, and stigmatization of them in the provision of services, employment and travel;

(3) to ensure the confidentiality of HIV testing and to promote the availability of confidential counseling and other support services..."

The approach taken to HIV/AIDS and the workplace must take into account the existing social and legal context, as well as national health policies and the Global AIDS Strategy.

IV. Policy development and implementation

Consistent policies and procedures should be developed at national and enterprise levels through consultations between workers, employers and their organizations, and where appropriate, governmental agencies and other organizations. It is recommended that such policies be developed and implemented before HIV-related questions arise in the workplace.

Annex 1

Policy development and implementation is a dynamic process, not a static event. Therefore, HIV/AIDS workplace policies should be:

- (a) communicated to all concerned;
- (b) continually reviewed in the light of epidemiological and other scientific information;
- (c) monitored for their successful implementation;
- (d) evaluated for their effectiveness.

V. Policy components

A. Persons applying for employment: Pre-employment HIV/AIDS screening as part of the assessment of fitness to work is unnecessary and should not be required. Screening of this kind refers to direct methods (HIV testing) or indirect methods (assessment of risk behaviours) or to questions about HIV tests already taken. Pre-employment HIV/AIDS screening for insurance or other purposes raises serious concerns about discrimination and merits close and further scrutiny.

B. Persons in employment:

1. HIV/AIDS screening: HIV/AIDS screening, whether direct (HIV testing), indirect (assessment of risk behaviours) or asking questions about tests already taken, should not be required.

2. Confidentiality: Confidentiality regarding all medical information, including HIV/AIDS status, must be maintained.

3. Informing the employer: There should be no obligation on the employee to inform the employer regarding his or her HIV/AIDS status.

4. Protection of employee: Persons in the workplace affected by, or perceived to be affected by HIV/AIDS, must be protected from stigmatization and discrimination by co-workers, unions, employers or clients. Information and education are essential to maintain the climate of mutual understanding necessary to ensure this protection.

5. Access to services for employees: Employees and their families should have access to information and educational programmes on HIV/AIDS, as well as to relevant counselling and appropriate referral.

6. Benefits: HIV-infected employees should not be discriminated against including access to and receipt of benefits from statutory social security programmes and occupationally related schemes.

7. Reasonable changes in working arrangements: HIV infection by itself is not associated with any limitation in fitness to work. If fitness to work is impaired by HIV-related illness, reasonable alternative working arrangements should be made.

8. Continuation of employment relationship: HIV infection is not a cause for termination of employment. As with many other illnesses, persons with HIV-related illnesses should be able to work as long as medically fit for available, appropriate work.

9. First aid: In any situation requiring first aid in the workplace, precautions need to be taken to reduce the risk of transmitting blood-borne infections, including hepatitis B. These standard precautions will be equally effective against HIV transmission.

HEALTH PROMOTION STRATEGIES FOR HIV/AIDS IN THE WORKPLACE

I. Introduction

In the vast majority of occupations or occupational settings there is no risk of acquiring or transmitting HIV. However, the workplace can play a major role in health education, and it does so in many countries. As it is the primary means of persuading individuals to modify risk behaviour and of minimizing fear and prejudice based on ignorance, it is important to use the workplace for education.

The following guidelines for health promotion and health education strategies for HIV/AIDS in the workplace are designed in accordance with the policy principles and policy implementation of the consensus statement (Annex 1). As with policy considerations, educational strategies must be based on active collaboration between workers, employers, their organizations and, where appropriate, government agencies and other organizations.

As the workplace is a part of society, workplace health promotion for HIV/AIDS should be seen within the context of health promotion activities at the community, national, and global level.

II. Aims and objectives of workplace AIDS education and information programmes

The aims of workplace AIDS education and information programmes are:

- * to minimize fear and anxiety concerning HIV/AIDS
- * to help prevent the spread of HIV infection
- * to promote a sensitive and responsible attitude towards HIV-infected persons
- * to keep HIV-infected persons and people with AIDS informed about their rights.

Programme objectives must be realistic. They will therefore vary, for example, between countries and between workplaces since legislation, organizational structures, and national practices differ especially in relation to small and medium-sized enterprises. The objectives of workplace AIDS health programmes are:

- * to communicate accurate up-to-date, information on HIV infection to all personnel and their families
- * to promote accurate and trustworthy personal HIV risk assessment
- * to promote skills that will assist individuals to change their attitudes and behaviour
- * to promote the health of HIV-infected people and people with AIDS within the workplace
- * to ensure that workplace AIDS education programmes are incorporated into general workplace health programmes

Annex 2

- * to ensure that workplace AIDS education programmes are integrated with or complementary to other community AIDS programmes.

III. Target groups

The workplace comprises a variety of groups of people. They comprise persons of different gender who, in addition to being either employees or employers, come from different cultural, geographical, educational, social, and religious backgrounds.

At the broadest level, all personnel within a workplace must be involved in AIDS education and information programmes, but specific programmes may be required for specific target groups. For example, employees in occupations that involve long periods of isolation from family and normal social contacts should receive specific educational programmes.

IV. Programme development

Among the characteristics of an effective workplace AIDS education and information programme are:

- * a managerial commitment to ongoing training and AIDS education at the workplace, which will require training for managers on AIDS and AIDS-related issues
- * involvement of the target personnel in programme development
- * employment of a variety of educational and communication techniques
- * utilization of small interactive group techniques where possible
- * positive and competent programme leadership
- * material and educational techniques in the programme that are appropriate to the target group
- * recognition that an effective programme requires appropriate and ongoing resource allocation
- * access to counselling and support services for employers, employees and those involved in carrying out the training and educational programme.

V. Programme implementation

The manner in which the programme is introduced is as important as the design of the programme.

An action plan for programme implementation should be established by the collaboration effort of employers and employees.

Several features will promote the success of the programme. They include:

- * continuing consultation with all the relevant groups during its implementation
- * the allocation of time within working hours for the programme

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- * recognition that, while an AIDS education programme may be a new initiative, it should not replace existing occupational health and safety programmes; where integration would be beneficial to the AIDS programme and the existing occupational health programme, it should take place.

VI. Evaluation of workplace AIDS education and information programme

As part of the development of an AIDS education and information programme, mechanisms should be developed to monitor its implementation and improve its effectiveness. This evaluation should determine whether the aims and objectives of the programme are being accomplished.

VII. Programme support facilities

An AIDS education programme requires a variety of support facilities to maximize its effectiveness, including:

- * contact with a reliable source to ensure that the information provided is accurate and up to date
- * development of a network to enable information to be exchanged with other workplace-based education programmes
- * access to clearinghouse facilities, including information and advice on relevant workplace AIDS education programmes
- * where appropriate, the use of government, community, and other resources
- * research, in particular, on educational methods and their effectiveness and on relevant lifestyle issues
- * provision of an environment that makes "the healthier choices the easier ones".

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