



Submission to the Department of Labour on the Draft Circular Instruction regarding compensation for occupationally acquired HIV¹

Introduction

The Department of Labour is commended for taking the initiative in compiling an Instruction to clarify various issues around compensation for occupationally acquired HIV.

Our experience has been that many employees who are at risk of contracting HIV are unaware of the procedures and requirements for claiming compensation for occupationally acquired HIV. It is therefore important that any Circular on occupationally acquired HIV deal with issues as comprehensively as possible to eliminate any uncertainty. We strongly suggest that this Circular be accompanied by a rigorous public education campaign aimed at informing employees at risk of contracting HIV at the workplace about their rights in respect of compensation for occupationally acquired HIV.

Our key recommendations are:

- That the Department considers the use of two PCR tests instead of laboratory tests at various stages to determine whether HIV infection was as a result of an occupational incident/accident. This will greatly simplify procedures and will give the Commissioner a much more definite and early conclusion about whether an HIV infection was occupationally acquired.²
- That the requirement for a base-line test at before 72 hours, be extended to 10 days.
- That the Department revisit the need for testing of source patients in light of the accuracy of determining occupationally acquired HIV through the use of PCR testing. This will eliminate the rights violations that have accompanied testing of source patients.
- That the Circular broadly spells out the treatment available in cases of occupationally acquired HIV. This will greatly assist employees and their health providers and would prevent any inconsistency in the

¹ Circular Instruction No. 183, Government Notice No. 1349, Government Gazette, Vol 473 No 27003, 19 November 2004

² Our submission recommends the use of PCR tests but, in the alternative, also comments on some of the shortfalls of current provisions on testing in the Circular.

decisions of the Compensation Commissioner regarding medical aid claims.

- That more emphasis be placed on the duties of employers in relation to this issue. We suggest that the Department compile a pamphlet for employers elaborating on their various duties under current policies and legislation relating to limiting the risk of HIV exposure at the workplace, providing post-exposure prophylaxis in cases of exposure to HIV and actively encouraging employees to test for HIV and assisting them in claiming compensation in cases of occupationally acquired HIV.

This submission comments on each of the sections of the Draft Circular. Where necessary we have suggested that some of the issues covered in the principal Act³ be repeated or cross referenced in the Circular to facilitate clarity and to assist employees who might not always be in a position to read the Circular and Act in conjunction.

Definition (section 1)

1. It would be useful if some of the technical terms used in the Circular are defined in this section (e.g “laboratory test” and “treating doctor”) and if some terms are explained in more detail:
 - a. “medical aid” – as per section 1(xxii) of the principal Act with specific inclusion of treatment applicable to HIV/AIDS, including antiretroviral treatment and laboratory tests (e.g. CD4 count and viral load testing).
 - b. “post-exposure prophylaxis” – antiretroviral medicines taken within 72 hours of an exposure to HIV to prevent reduce the risk of infection with HIV.
 - c. “seroconversion” – the time at which a person’s antibody status changes from negative to positive. A seroconversion illness sometimes occur at this stage.
 - d. “window period” – this is the period between HIV infection and seroconversion (when the body makes antibodies against the HIV infection).
2. We submit that the definition of an “occupationally acquired HIV infection” should be limited to “an infection contracted as a result of exposure to an HIV infected source in the workplace.” Should this not be accepted, the second part of the definition should be reworded as follows: “ordinarily resulting in progressive weakening of the immune system of an individual that typically leads to AIDS in the absence of appropriate treatment.”

³ Compensation for Occupational Injuries and Diseases Act 130 of 1993 as amended.

Diagnosis (section 2)

3. The following aspects in this section should be clarified:

- a. Section 2(c) provides that the employee must be tested for HIV, through a laboratory test, within 72 hours. The time period indicated is presumably to ensure that the employee, if he or she tests HIV negative, can benefit from post-exposure prophylaxis (PEP). Four key concerns arise from this provision:
 - i. Will the Compensation Commissioner consider claims where a rapid HIV test was performed because no other test option was available to the employee at the time of the incident? We submit that the Compensation Commissioner should allow claims where a rapid test was conducted within 72 hours, provided that it was confirmed by a laboratory test as soon as possible thereafter. Rapid tests are sufficiently accurate these days that this should definitely be allowed.
 - ii. Will the Compensation Commission consider claims where the employee was unable to be tested within 72 hours and has an HIV test within a reasonable time thereafter but prior to the period from which seroconversion from such incident is likely to take place? In this respect, it is submitted that the employer should inform employees of the importance of reporting occupational accidents/incidents and should take responsibility for recommending and where necessary assisting an employee to go for a base-line HIV test prior to the expiration of 72 hours in order for the employee to also benefit from PEP. It is further submitted that the need for an HIV test within 72 hours for the purpose of obtaining PEP, and the requirement that an HIV test be conducted as soon as possible after the occupational exposure, should be delinked. This would mean that, in cases where the employee was unable to be tested for HIV within 72 hours, the employee would still be able to test thereafter without damaging his or her claim for compensation. We suggest that the cut-off time for a base-line HIV test should be 10 days after the occupational incident/accident.
 - iii. At the moment, the Department of Health's Guidelines on the Management of Occupational Exposure to HIV (1999)⁴ provides for the provision of PEP and applies to all personnel working in health care settings whose activities involve contact with patients or who handle blood products and body fluids. Nevertheless, there may be instances where, for any of a variety of reasons, the employee did not get tested for

⁴ Cross-reference to these Guidelines in the Circular is important since the guidelines explain aspects around PEP and the risks associated with exposure in more detail.

HIV in time to receive PEP or where PEP was not available to or accepted by the employee. It should be emphasised that an employee's claim should not be affected by his or her failure to take PEP to reduce the risk of HIV infection from an exposure.

- iv. Many employees, particularly casual workers and cleaners, are not familiar with their rights to PEP and compensation and the procedures they need to follow. There should be an obligation on employers to inform all employees of this and as well as all other occupational health and safety issues at the time of appointment or orientation.⁵ Although this is explained in the principal Act, it is important that it is emphasised in the context of this Circular.
 - v. It is submitted that employees are more likely to seek HIV testing and compensation after an accident if they are convinced of the confidentiality of their test results. This principle is contained in section 5.2(d) but should be emphasised. An environment which eliminates fears can be achieved if employers also adhere to the various other aspects of the Code of Good Practice on Key Aspects of HIV/AIDS and Employment.
- b. Section 2(d) provides that, as far as reasonably practicable, it must be confirmed that the source was HIV infected. The following submissions are made in this regard:
- i. Testing of source patients often occur in settings where the source person's rights are not respected. Source persons are often coerced or pressured into having HIV tests or tested without their consent.
 - ii. It should also be noted that, except in hospital settings after needlestick injuries, it may generally be difficult to determine who the source person is. This is often the case where cleaners sustain injuries.
 - iii. We accordingly submit that source person testing constitutes an unnecessary invasion of the privacy and bodily integrity of the source. The insistence on the testing of a source person in effect places a more onerous duty on some employees to prove their claims than on others.

⁵ For example, where a casual cleaner is transferred from kitchen duty to working in wards and sustains a needlestick injury, she would not otherwise be aware of the necessary procedures to be followed or the urgency of getting tested for HIV and taking PEP. Failure by the employer to assist and provide the necessary information could substantially affect her claim for compensation at a later stage.

- iv. We further submit that, where there is an identifiable source person, and for the purpose of putting an employee at ease, a source person may be approached for an HIV test. All the requirements regarding informed consent apply and, in addition, the source person should be adequately counselled on the purpose of the test, the maintenance of confidentiality and on whether or not he or she would want the test results. The source person's right to refuse testing should be explained and should he or she refuse testing, no additional pressure should be placed on him or her. Section 2(d) and 5.2(c) should be read in conjunction. We submit that the testing of existing blood samples of a source person should also only be done with the informed consent of the source person.
- v. It would be extremely useful to both employers and employees if the Compensation Commissioner could, perhaps in a Schedule to the Circular, set out examples of what it considers "reasonably practicable". The Department should also consider incorporating some of the steps and guidelines on testing of a source person identified by the Canadian HIV/AIDS Legal Network⁶:
- "A trained health care worker who was not involved in the exposure and is not providing care to the source patient or exposed worker, should approach the source person. The source person may regard the trained professional with more trust, especially if the professional's approach is sensitive and considerate.
 - The approach should be in a setting that affords privacy and protects confidentiality.
 - The person making the approach should be non-judgmental, non-abusive, skilful, knowledgeable, and informative. The person should recognize the needs of the source person, and include the source person in decision-making. The person should be able to answer specific questions, provide an opportunity for the source person to disclose concerns, and help alleviate anxiety around testing.
 - The source person should have the right to refuse to be informed of the results of the test.
 - The recording of the result should be made in a way that does not disclose the identity of the source person, encouraging him or her to come forward to be tested.

⁶ De Bruyn, T (2002) Occupational exposure to HIV and forced HIV testing: Questions and Answers. Canadian HIV/AIDS Legal Network.

- Regulations, policies, and protocols should set out in specific terms who will have information about the source person, the test, and the result of the test, and what information they will have. Regulations, policies, and protocols should also set out in specific terms the requirements of confidentiality on the part of persons receiving information, and stipulate penalties for any breaches of confidentiality. Although such provisions may, practically speaking, be of little value to the source person in the event of a breach, they nevertheless establish a basis for recourse against anyone breaching confidentiality.
 - Provision may be made to destroy any record of the results of the test, so that the source person may be assured that the results may not be used in any future considerations with regard to employment, insurance, disability, etc.”
- vi. If there is a negative base-line test shortly after the accident and seroconversion takes place later, testing the source person should really not be necessary in order to prove that the HIV infection was occupationally acquired.
- vii. Does the Compensation Commissioner require an affidavit from the employer recording efforts made to determine the HIV status of the source? If so, this requirement should be specifically noted in the instruction.
- viii. The possibility should be acknowledged that the source person was, at the time of testing, in the window period and accordingly tested HIV negative. Unfortunately it is often impossible to track source persons for further follow up tests. Provision should be made for an employee to make out a case of occupationally acquired HIV, despite an initial HIV negative test result from a source person. This would be possible where, for instance, an employee’s doctor can trace the course of his or her HIV infection and any seroconversion illnesses to determine the likely time of infection. A doctor’s report should be sufficient for this purpose.⁷
- c. Section 2(e) requires a confirmatory laboratory blood test confirming seroconversion, at 6 and/or 12 weeks or 6 months after the date of the accident. This raises four key concerns:
- i. It is not clear whether the Compensation Commissioner requires an employee to go for HIV testing at 6 and/or 12 and 6 months, or whether the Compensation Commissioner

⁷ This problem can be resolved if the initial test of the source person was a PCR test.

simply requires that the employee tests HIV positive at some point in time within the first 6 months after the incident.

- ii. We submit that this section should explain the rationale behind the testing in the Circular to ensure compliance therewith. There would be a need for 5 HIV tests: a base-line test within 10 days after the occupational incident/accident, a second test to ensure that the employee was not in the window period of an earlier HIV infection, a test at 3 months (12 weeks), a test at 6 months, and a possible test at 1 year.⁸ Such tests are important to assist in determining the likelihood of occupationally acquired HIV, especially in cases where the source patient's HIV status is unknown. It is important to note that these 5 tests would be unnecessary if employers offered an employee the option of a PCR test. This would mean that an employee gets a baseline test (ideally also a PCR test to deal with the problem of the employee possibly being in the window period of an earlier infection) and then one PCR test thereafter. Although a PCR test is more expensive than HIV antibody tests, it is submitted that the direct and indirect costs associated with frequent HIV antibody tests necessitates the use of PCR tests.
- iii. Since Hepatitis B and C can be acquired at the workplace in the same manner as HIV, it would make sense to specifically link guidelines relating to occupationally acquired HIV with those relating to occupationally acquired Hepatitis. Employees should be informed that needlestick injuries, for instance, pose a risk in relation to other illnesses as well, and that tests should be done for these.

Impairment (section 3) & Benefits (section 4)

4. HIV is a progressive disease and the rate at which a person living with HIV's immune system deteriorates, depends on a wide variety of factors. Medicines to prevent or treat opportunistic infections would have to be taken on an ongoing basis and after a person's immune system has been severely affected by HIV (usually measured by a CD4 count) antiretroviral treatment will have to be continued for life. A person living with HIV can become ill, causing temporary total disablement, at any time, and can thereafter recover and continue with a normal life.

⁸ We would submit that there is a chance, albeit statistically small, that seroconversion from the occupational exposure occurs after 6 months. Where an employee has not tested positive at 6 months, it could be recommended that he or she have a further test at 12 months. This will make provision for employees who contracted HIV from an occupational incident but who have not yet seroconverted at 6 months after the incident. Once it is accepted that provision should be made for the possibility of seroconversion after 6 months, section 4's introduction which provides for the lapse of benefits where no seroconversion after 6 months from the date of the incident, should be changed to 12 months. This possibility will be eliminated should our suggestion of PCR testing be accepted instead.

5. In this context, the rationale in section 4(a) behind limiting payment for temporary total or partial disablement to 24 months is unclear. Does this limitation refer to each opportunistic infection or illness causing temporary total or partial disablement, or does it mean that in total an employee with occupationally acquired HIV can only claim temporary total or partial disablement for 24 months?
6. Does section 4(b) mean that an employee would be entitled to 15% permanent disablement benefits, presumably paid in a lumpsum, upon confirmation of occupationally acquired HIV? What is the rationale behind setting compensation at 15%?
7. From what point would an employee be entitled to 100% permanent disablement benefits? Two scenarios should be considered in this respect:
 - a. Where an employee is on antiretroviral treatment and never reaches the stage of AIDS?
 - b. Where an employee reached the stage of AIDS, received 100% permanent disablement benefits, went on antiretrovirals, and then recovered.
8. Does the Department intend to issue further instructions, in terms of section 4(b) to indicate how permanent disablement as a result of HIV/AIDS related conditions will be assessed?
9. No mention is made of benefits payable to dependants after the death of the employee. Although this is provided for in the principal Act, it is important that this be included in this Circular and that public education be conducted to ensure that dependants are aware of their rights.
10. It is submitted that the Circular should emphasise that employees are entitled to additional compensation from the Compensation Fund in cases where they acquired HIV due to the employer's negligence in providing protective equipment as provided in the principal Act.
11. Section 4(c) is unclear. For the section to make any sense, the terms "medical aid", "reasonable treatment", "definitive diagnosis" and "necessary treatment" would have to be clarified.
12. We recommend that the Circular sets out broadly examples of the forms of treatment which would be covered. In this respect we recommend that the Commission consults the wording in the Medical Schemes Act's provision on Prescribed Minimum Benefits without limiting the treatment, management and care for which employees may claim.⁹

⁹ See the Amendment of Annexure A of the General Regulations made in terms of the Medical Schemes Act 131 of 1998 (Government Gazette No 27055, Government Notice No R1410, 3 December 2004): Treatment includes:

- HIV voluntary counselling and testing

13. It is not clear to what extent the Compensation Commissioner would pay for medical expenses such as counselling or nutritional supplements where medically indicated, or where treatment was sought from traditional or complementary health practitioners? Section 4(c) provides for any “necessary treatment” “provided by any healthcare provider.” It should be noted that, in terms of the new Traditional Health Practitioners’ Bill 66 of 2003 (soon to be enacted), traditional healers fall under the definition of health care providers.
14. In terms of the National Health Act 61 of 2003, persons receiving compensation for compensable occupational injuries and diseases are not able to access free primary health care services. It is therefore important that the Compensation Commissioner has a relationship with the Department of Health which will ensure that such persons are not forced to pay upfront for medical services or have to wait long for reimbursement from the Compensation Fund. Although many private doctors, once aware that a claim has been accepted, will submit claims directly to the Compensation Commissioner, there have been cases where the Compensation Commissioner delays payment and legal measures are sought against a patient.

Reporting (section 5)

15. Where an obligation rests on an employer to submit any report timeously, the employee should not be penalised or barred from compensation simply because this report is a few days late.
16. It would be useful if the Circular emphasised the obligation on employers to ensure that all employees are aware of the need to report incidents/accidents immediately to the employer.
17. It is not clear for which period monthly progress reports have to be submitted. If an employee is on antiretroviral treatment for a number of years, would it require monthly reports for the duration of the treatment prior to an assessment of 100% permanent disablement?
18. It should be specified in the Circular when each report should be submitted and by whom.

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- Co-trimoxazole as preventive therapy for TB
 - Diagnosis and treatment of sexually transmitted infections
 - Pain management in palliative care
 - Treatment of opportunistic infections
 - Prevention of mother to child transmission of HIV
 - Post exposure prophylaxis following occupational exposure
 - Medical management and medication, including the provision of antiretroviral therapy, and ongoing monitoring for medicine effectiveness and safety, to the extent provided for in the national guidelines applicable in the public sector (The national guidelines are set out in the Operational Plan for Comprehensive HIV and AIDS care, management and treatment for South Africa, and the National Antiretroviral Treatment Guidelines).

Claim processing (section 6)

19. For the benefit of employees, it is submitted that a section should be added on objection processes available to employees should their claim be rejected or medical treatment refused even though already covered in the principal Act.
20. The Circular should confirm that the 12 month time limit within which a claim can be lodged, applies from the date of diagnosis of HIV and not from the date of the occupational incident.