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ABOUT THE AUTHOR

Since completing my Ph.d. thesis on utopian thought, my research has been focused on human rights and clinical bioethics due to my involvement since 2001 with the Research Ethics Committee of the University Hospital of Getafe. The establishment of the Chair "Disability, Chronic Illness and Accessibility to Rights" at the University of Alcalá, later transformed into a Research Group that includes a Legal Clinic, has allowed me to develop a research line focused on the rights of people with chronic illness or disability, particularly HIV. Between 2005 and 2006, I led a research project on the information provided to cancer patients treated in public hospitals in the Madrid region. From 2008 to 2014, I coordinated a dissemination and transfer research platform within the project "The Time of Rights," part of the Consolider – Ingenio 2010 program. I have participated in over 30 research projects or research contracts on disability, chronic illness, HIV and human rights. I have also led large teams during my tenure as Director of the Master's Program in Fundamental Rights at the "Bartolomé de las Casas" Institute for Human Rights at the Carlos III University (2005–2011). From 2017 to 2019, I lead a research project under the National R&D&I Plan funded by the Ministry of Science, Universities, and Innovation on access to rights for people with chronic illness or disability. In 2013, I received a Salvador de Madariaga Fellowship to join Professor Richard Ashcroft at Queen Mary College (London) from June 1, 2013, to January 15, 2014. In July 2019, I conducted a research stay at the Centre for Health Law, Science and Policy at the University of Birmingham to study with Professor Jean McHale the effects of Brexit on access to antiretroviral treatment in Spain and the UK. In 2021, a four-year collaboration agreement was signed between the Ministry of Health, CESIDA, and the University of Alcalá, in which I serve as the IP for the University to develop actions and content related to the Social Pact for Non-Discrimination and Equal Treatment Associated with HIV. This agreement is resigned until 2029.

ABOUT DECADE RESEARCH GROUP

The research group "Disability, Chronic Illness and Accessibility to Rights" (DECADE-UAH by its Spanish acronym) is focused on the study of the legal system as a factor in the cause, distribution and prevention of disease and injury. This research group is the home of the UAH Legal Clinic, which, since the 2012-2013 academic year, has answered more than 2.700 queries sent by people with HIV, by people at risk of infection or by people who work or live with them. This allows it to be a privileged observation point to know which institutional practices, legal norms, internal protocols or social behaviours generate a limitation of rights or some kind of discrimination towards people living with HIV in Spain.

INTRODUCTION: THE HIV AT WORK

The report *HIV/AIDS Surveillance in Europe 2024 (2023 Data)*, jointly published by the European Centre for Disease Prevention and Control (ECDC) and the WHO Regional Office for Europe, presents data on HIV/AIDS for the year 2023 in the WHO European Region and the EU/EEA. Among the key findings we can read that in 2023, 112.883 new HIV diagnoses were reported across 47 countries in the WHO European Region, including 24.731 in EU/EEA countries. The overall rate in the Region was 12,7 diagnoses per 100.000 population. In the EU/EEA, the rate was lower at 5,3 per 100.000. Compared to 2022, the Region experienced a 2,4% increase in HIV diagnoses, though the numbers are still below pre-COVID-19 levels. There is a growing concern about undiagnosed HIV infections, particularly in the Eastern part of the Region. The modes of transmission varied significantly by region: heterosexual contact was predominant in the East, while sex between men remained the most common in the EU/EEA. Migrants made up a significant portion of new diagnoses, particularly in the EU/EEA and the Western subregion. More than half (52.4%) of new diagnoses were made at a late stage (CD4 < 350/mm3), and AIDS diagnoses have continued to decline, with 7.878 cases reported in 2023, a 50% decrease from 2014.

These findings have a significant impact on the working conditions of the persons living with HIV. In the report *Global HIV Discrimination in the World of Work*, produced by the International Labour Organization (ILO) in partnership with Gallup, HIV-related stigma and discrimination in the workplace are explored. Among the key findings we can read that HIV-related stigma and discrimination remain widespread in the world of work despite progress in treatment and awareness. In this sense, about 38,4% of respondents expressed reluctance or opposition to people living with HIV working directly with others. Acceptance levels vary by region, with highest support in Eastern and Southern Africa (89,9%) and lowest in Asia and the Pacific (40,6%). Education plays a critical role: individuals with tertiary education are far more likely to support inclusive employment. Misconceptions about HIV transmission persist; for example, many believe HIV can be transmitted through kissing or sharing a bathroom. More accurate knowledge correlates with greater acceptance of people living with HIV in the workplace. And a majority (59,6%) of respondents support mandatory HIV testing before employment, though support is lower among those with better knowledge of transmission.

This report recommends the elimination of mandatory HIV testing and reform discriminatory laws; promotion of inclusive workplace policies and expand educational efforts on HIV transmission; increase of collaboration with people living with HIV to develop effective, rights-based programs; investment in access to justice and protective legal services; and integration of HIV issues into occupational safety, health, and wellness programs.

In several reports, UNAIDS identifies discrimination in the workplace as a significant barrier to the effective response to HIV and the protection of human rights. This organization emphasizes that stigma and discrimination increase the risk of acquiring HIV, limit access to employment, and contribute to violence and marginalization, particularly among key populations and vulnerable groups.

In several studies promoted by UNAIDS, it is seen that discrimination due to HIV status leads to job loss in more than 50% of cases in several countries, and that a significant percentage of people living with HIV report being denied health services or forced to undergo medical procedures against their will. UNAIDS advocates for the complete elimination of discrimination and stigmatization against workers living with HIV, including those seeking employment, regardless of their real or perceived HIV status or their belonging to populations considered at higher risk. In this sense, the response to HIV in the workplace must be based on the recognition of human rights, fundamental freedoms, and gender equality for all workers and job seekers. HIV should be recognized and treated as a workplace issue, and this perspective should be integrated into national and international responses. UNAIDS opposes mandatory HIV testing as a condition for employment and defends the confidentiality of the HIV status of workers. Disclosure should only occur with the informed consent of the person concerned. The organization urges the adoption of internal policies and practices that guarantee equal treatment, prevent harassment, and ensure that people living with HIV have the same opportunities for hiring, promotion, and remuneration as other employees. In special, UNAIDS highlights that LGBTI people and other key populations face higher rates of workplace violence and discrimination in employment and education, exacerbating their vulnerability and exclusion. UNAIDS's position is clear: eliminating discrimination in the workplace is essential to protect the rights of people living with HIV, ensure their access to employment and health services, and achieve the goal of ending AIDS as a public health threat by 2030.

According to ILO and UNAIDS, HIV stigma and discrimination continue to be a barrier to employment and workplace equality. Addressing misinformation, boosting education, and enacting inclusive policies are vital to combatting discrimination and achieving global health and employment goals.

In order to secure the civil, political, and social rights and freedoms of people living with HIV or at risk of infection, the grounds or reasons (Part II, art. 20; Part V, art. E) for which a person cannot be discriminated against in the workplace should be expanded in the European Social Chater to expressly include **serological status**.

Serological status is a distinct reason from both disease and disability because people with HIV, thanks to advances in antiretroviral treatments, are not sick and can perform work regularly, and their ability to perform basic daily activities is not affected[1]. A person with a positive result for an infectious agent or pathogenic microorganism may neither be ill nor have a physical, sensory, intellectual, or mental deficiency. Differentiated treatment due to serological status is mainly due to the knowledge or attribution to a person of a health data such as the presence or absence in blood serum of detectable antibodies against a specific antigen. Antibodies are a type of protein, called immunoglobulins, produced by the immune system to fight the presence of pathogenic substances like viruses in the body. Serological status allows knowing if a person has been exposed to a virus or other infectious organism.

The inclusion of this specific ground is because people with HIV constitute both a "group" and an "oppressed group". They are a collective of people with their own identity that determines how the people who comprise it interpret both interpersonal relationships and themselves. Their identity goes beyond being homosexual, an injecting drug user, or having a particular gender identity. They have a specific affinity with each other that is the result of a particular sense of history[2].

On the other hand, they constitute an "oppressed group" because, in the case of people with HIV, we can find, firstly, *exploitation*, which is the transfer of the results of one group's labor for the benefit of another. Secondly, we can find the *marginalization* of people with HIV because they have been expelled from participation in social life, subjecting them to material deprivation[3]. This marginalization occurs because in the early years of the epidemic, infections and virus transmission were predominantly among very young people

[1] RAMIRO AVILÉS, MA., *La discriminación por razón del estado serológico: el caso del VIH*, Aranzadi, 2023.

[2] YOUNG, IM., "Polity and group difference: A critique of the ideal of universal citizenship", *Ethics*, 99:2 (1989), p. 259.

[3] YOUNG, IM., *Justice and the politics of difference*. Princeton University Press, 1990, p. 53.

who could not complete their academic training, which has often hindered their access to or permanence in the labor market[4]. Similarly, people with HIV in the workplace must hide their health status due to the risk of not being hired, being fired, or suffering from mobbing[5]. Thirdly, people with HIV have been *excluded from participation* in the decision-making process about their living conditions and actions[6]. Fourthly, people with HIV suffer *cultural imperialism* because they experience how dominant meanings in a society make them invisible while generating stereotypes and labelling them as "the others". This cultural imperialism "implies the universalization of the experience and culture of a dominant group, and its establishment as a norm (...) the dominant cultural products of society, that is, those most widely disseminated, express the experience, values, goals, and achievements of these groups"[7]. This means that it is the dominant group that constructs the narrative around HIV, which is none other than that of illness and death[8] and aversion to the bodies of people with the infection or who may be at real or figurative risk of infection. Finally, people with HIV live with the *fear of experiencing random, unprovoked attacks* that affect both their physical integrity and their property, for no other reason than to cause harm, humiliate, or, in the most extreme case, kill[9].

Discrimination based on serological status occurs when a person, due to having obtained a positive result for an infectious agent or pathogenic microorganism in a serological analysis[10], is treated "less favourably than others in an analogous or comparable situation" (direct discrimination); or when that person with a positive result, "an apparently neutral provision, criterion, or practice causes or may cause (...) a particular disadvantage compared to others" (indirect discrimination); or when a person, due to their relationship with the one who obtained a positive result, is treated less favourably (discrimination by association). Similarly, discrimination due to serological status could occur when the less favourable treatment or disadvantage "is based on an incorrect assessment of the person's characteristics" (discrimination by error). Serological status could also lead to multiple discrimination and structural discrimination, as it converges, for example, with sexual orientation or identity, age, or sex. Multiple discrimination occurs "when a person is discriminated against simultaneously or consecutively for two or more reasons provided

[4] OLIVA, J., "Labour participation of people living with HIV/AIDS in Spain", *Health Economics*, 19 (2010), pp. 491-500.

[5] PEREIRA, A., "HIV/Aids and discrimination in the workplace: The cook and the surgeon living with HIV", *European Journal of Health Law*, 17 (2010), pp. 139-147.

[6] YOUNG, IM., *Justice and the politics of difference*, op.cit., p. 56.

[7] YOUNG, IM., *Justice and the politics of difference*, op.cit., p. 59.

[8] CATALAN, J. et al., "The changing narratives of death, dying, and HIV in the United Kingdom", *Qualitative Health Research*, 30:10 (2020), pp.1561-1571.

[9] YOUNG, IM., *Justice and the politics of difference*, op.cit., p. 61.

[10] Sometimes serological testing is not performed because the health data is obtained from a test that does not involve obtaining a blood sample but is known from a non-blood sample or secretion. In any case, positive reactivity in the non-blood sample or secretion, which often needs to be confirmed in blood, leads to the same discriminatory result.

for in this law," while structural discrimination occurs "when various causes provided for in this law concur or interact, generating a specific form of discrimination".

A positive result can mean that the person is infected or has been infected, hence discrimination due to serological status can occur whether the infection is active or has already been overcome. In some cases, the positive result cannot be reversed; in others, it can. In the case of HIV, when a positive result is confirmed, there is no possibility of expelling the virus from the body because the virus's genetic material, through the process of reverse transcriptase, integrates into the DNA of the infected person's cells, thus facilitating its replication; in other cases, such as the SARS-CoV-2 virus causing coronavirus disease (COVID-19) or the Ebola virus, the person can overcome the infection and will have antibodies that can be detected with specific tests. In both the case of HIV and SARS-CoV-2 or Ebola, cases of discrimination have been documented towards infected people, towards people who have overcome the infection[11], towards people who were related to them for work or family reasons[12], or towards people who were mistakenly attributed the infection[13].

In the case of HIV, people with the infection may, firstly, not be sick if they have an adequate level of defences or CD4 lymphocytes, and secondly, they may not have a physical, sensory, intellectual, or mental deficiency that prevents them from performing basic daily activities. Scientific response has managed to develop a series of antiretroviral treatments with which people with HIV have a life expectancy comparable to that of the general population[14]. And despite not having a visible illness or disability, they are discriminated against due to their serological status in many areas of life, especially in the workplace. The personal health data, real or fictitious, about serological status is the direct cause of the discriminatory treatment that people living with this virus in their body, people who are related to them, or people to whom the infection is erroneously attributed, face daily. Discrimination due to serological status is sophisticated because differentiated treatment no longer occurs due to physical appearance, the expression of political ideas, or the manifestation of a religious creed, but rather due to the obtaining or attribution of results from a chemical and biochemical study. As with 'genetic predisposition,' technology is required to discriminate. A very specific medical test is needed. From the moment real or fictitious seropositivity is known, a negative social value judgment is produced, a reproach is generated, leading to prejudices and stereotypes towards people with HIV that

[11] BAI, P., et al., "An assessment of Ebola-related stigma and its association with informal healthcare utilisation among Ebola survivors in Sierra Leone: a cross-sectional study", *BMC Public Health*. 20:182 (2020), https://doi.org/10.1186/s12889-020-8279-7

[12] MCKAY, D., et al., "Attacks against health-care personnel must stop, especially as the world fights COVID-19", *Lancet*, 395 (2020), pp. 1743-1745.

[13] VORONIN, Y., et al., "HIV vaccine-induced sero-reactivity: a challenge for trial participants, researchers, and physicians", *Vaccine*, 33:10 (2015), pp. 1243-1249.

[14] GUELER, A., et al., (2017). "Life expectancy in HIV-positive persons in Switzerland: matched with general population", *Aids*, 31:3 (2017), pp. 427-436.

result in social stigma and discrimination. This greatly hinders the normalization of HIV testing, as once the result is obtained, the person with HIV is included in an oppressed group because their body ceases to be normative.

People with HIV, those to whom the infection is attributed, or people who are related to them are assigned a label of dangerousness (that of 'infecting' third parties) that justifies the limitation of their rights and differentiated treatment. Thus, this type of discrimination implies considering that the real or fictitious serological status of a person with respect to HIV constitutes a threat to the health and safety of third parties, further assuming that any person living with HIV is necessarily a public health risk. It is generally assumed that living with HIV necessarily poses a risk of transmission, and it is not considered necessary to demonstrate the existence of an individualized and significant risk. This implies assigning a label loaded with a deep moral judgment, which constitutes an especially serious problem for people belonging to oppressed, minority groups without influence in society. Hence, many cases of HIV discrimination are class exclusions, meaning that all people living with HIV are treated unjustifiably differently, without making any distinction, simply because they have been labelled as 'seropositive'. They cannot be excluded from any profession, not even in the healthcare field performing invasive procedures, considering advances in antiretroviral treatment and prevention measures. People with HIV cannot be subjected to employment access or maintenance tests that are not suitable, necessary, and proportionate. Therefore, no differences in treatment other than those derived from the serological status itself, objective limitations for the exercise of certain activities, or those required for public health reasons may be protected.

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