



Partnership on HIV and Mobility in Southern Africa
(PHAMSA)



IOM International Organization for Migration
OIM Organisation Internationale pur les Migrations
OIM Organización Internacional para las Migraciones



regional guidelines

on HIV and AIDS for the
Construction Sector
in the SADC Region

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CONSTRUCTION



foreword

The International Organization for Migration (IOM) Regional Office for Southern Africa is pleased to launch the Regional Guidelines on HIV and AIDS in the Construction Sector in the Southern African Development Community (SADC) Region. These guidelines are developed as part of IOM's regional Partnership on HIV and Mobility in Southern Africa (PHAMSA)¹. PHAMSA is a regional project that aims to reduce the HIV vulnerability of migrant and mobile populations by developing partnerships with stakeholders in the SADC region. By developing these guidelines, IOM has contributed to one of the key intervention areas of the SADC HIV and AIDS Business Plan, which states that "policies on HIV and AIDS for migrant/mobile populations and displaced populations should be developed and harmonised"².

In the process of developing these Regional Guidelines on HIV and AIDS in the Construction Sector in the SADC Region, IOM drew together stakeholders from the SADC Secretariat, SADC governments, trade unions, employer and employee organizations, NGOs, research institutions, donors and international organizations in the region. We are confident therefore that this broad participation has contributed extensively to making these guidelines comprehensive. It is our hope that policy makers and stakeholders will actively use the guidelines in the construction sector to develop policies and programmes that will reduce the HIV vulnerability of its workers.

We would like to acknowledge and thank participants in the development of these guidelines. Finally, we would like to acknowledge the financial support of the European Union (EU) Regional Funds, which was channelled through the SADC HIV and AIDS unit.

Hans-Petter Boe

IOM Regional Representative for Southern Africa



table of contents

foreword	1
list of abbreviations	3
introduction	4
section 1	
Why are workers in the construction sector in the SADC region vulnerable to HIV?	5
Structural factors of HIV vulnerability	6
Environmental factors of HIV vulnerability	6
Individual factors of HIV vulnerability	7
section 2	
Agenda for action	8
Coordination, collaboration, dialogue and technical resource	9
Policy Development and Implementation	9
Social impact analysis	10
Rural development and local community development	10
Health and safety	10
Employment practices	11
Living conditions	11
Gender	11
Migrants' Rights	12
section 3	
Suggestions for further research	13
conclusion	13
appendix 1: International and Regional Treaties and Declarations	14
appendix 2: IOM's response to HIV and AIDS	15
end notes	15



list of abbreviations

AIDS	Acquired Immune Deficiency Syndrome
AU	African Union
BIFSA	Building Industry Federation of South Africa
CBOs	Community-Based Organisations
CIRBR	Construction Industry Retirement Benefit Fund
CSWs	Commercial Sex Workers
GDP	Gross Domestic Product
HIV	Human Immuno-deficiency Virus
IDPs	Internally Displaced Persons
ILO	International Labour Organization
IOM	International Organization for Migration
KAP	Knowledge Attitudes and Practices
MDGs	Millennium Development Goals
MOU	Memorandum of Understanding
NEPAD	New Partnership for Africa's Development
NGOs	Non Governmental Organisation
OHCHR	Office of the United Nations High Commissioner for Human Rights
OHS	Occupational Health and Safety
PHAMSA	Partnership on HIV and Mobility in Southern Africa
PLWHA	People Living With HIV and AIDS
SADC	Southern African Development Community
SATUCC	Southern Africa Trade Union Coordination Council
SIA	Social Impact Analysis
STIs	Sexually Transmitted Infections
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
ZAR	South African rand



introduction

The severity of the HIV epidemic in Southern Africa cannot be overstated. Southern Africa is the worst affected region with most countries experiencing adult HIV-prevalence rates of between 14 and 33 percent.³ The reason why the epidemic is particularly virulent in Southern Africa is still unclear. A number of different factors have been advanced to explain the epidemiology of HIV and AIDS in Southern Africa. These include poverty and economic marginalisation; different strains of HIV; high rates of sexually transmitted infections (STIs) and opportunistic infections; the absence of male circumcision; and the role of core transmission groups, such as commercial sex workers.

However, perhaps the key factor explaining the rapid spread of HIV over the last decade is population mobility. Population mobility contributes to the unique patterns of sexual networking in Southern Africa, including high levels of concurrent sexual partners which is a particularly relevant issue in this region.⁴ The links between population mobility and HIV are related to the conditions and structure of the migration process. Migrants often face poverty; discrimination and exploitation; alienation and a sense of anonymity; limited access to social, education and health services; separation from families and partners; and separation from the sociocultural norms that guide behaviour in stable communities.⁵

For example, the system of “circular migration”, which exists to this day in many countries of Southern Africa, increases the vulnerability of migrants to HIV infection and greatly facilitates the spread of STIs and infectious diseases such as Tuberculosis (TB).⁶ In Southern Africa, migrants and mobile populations, which include miners, truck drivers, military personnel, commercial farm workers, informal cross-border traders, and construction workers, often work and live in environments that are breeding grounds for unsafe sexual practices, including engaging in commercial or transactional sex, alcoholism and (sexual) violence. Furthermore, migrant workers are usually given limited duration contracts that oblige them to return home between contracts, exposing their families and communities to new diseases.

Given the high levels of migration, subsequent HIV vulnerability of its workers, and the paucity of existing

HIV interventions, IOM has identified the construction sector as one of the sectors to develop the Regional Guidelines on HIV and AIDS for.

OBJECTIVES OF THE REGIONAL GUIDELINES ON HIV AND AIDS FOR THE CONSTRUCTION SECTOR IN THE SADC REGION

The overall objective of these Guidelines is to reduce the number of new HIV infections and the impact of HIV and AIDS among all workers in the construction sector in the SADC region. Specifically, the Guidelines aim to:

1. Highlight and raise the awareness of stakeholders in the construction sector to the factors that increase HIV vulnerability among its workers;
2. Provide stakeholders in the construction sector with practical recommendations for action to address HIV vulnerability among their workers;
3. Provide stakeholders in the construction sector with tools to advocate for HIV and AIDS programmes and policies in the sector; and
4. Contribute to the development of regional/national policies on HIV and AIDS in the construction sector by policy makers making use of the recommendations from the Guidelines in regional/national HIV and AIDS strategic plans and policies.

The Guidelines were developed through a participatory process of field visits, interviews with key informants and a consultative regional workshop. In addition, a comprehensive literature review was undertaken. Based on the information collected and on the recommendations of the workshop, IOM drafted these Regional Guidelines on HIV and AIDS for the Construction Sector in the SADC Region.

Section 1 discusses the factors that make migrant workers in the construction sector vulnerable to HIV infection. Section 2, Agenda for Action, outlines the recommendations that need to be implemented by the different relevant stakeholders in the SADC region to reduce HIV vulnerability of construction workers.



section 1

Why are workers in the Construction Sector in the SA DC region vulnerable to HIV?

The construction sector in the SADC region is important both in terms of employment creation and its contribution to the economy. In 2002/2003, construction in the different SADC member states ranged from 2 to 16 percent of total gross domestic product (GDP), and employment in the construction sector ranged from 3 to over 10 percent of total employment.⁷ Considering that much of the actual employment through casual contracts and subcontracting may not be reflected in official employment statistics, employment creation is most likely underestimated.

The construction industry is to a large extent labour intensive and is characterized by high labour mobility. Once work on a construction site is completed, contract labourers move to a new project site or are laid off. This does not apply to the relatively small number of salaried, core, skilled workers and technical staff who are usually permanently employed by construction companies. Although temporary workers are mostly employed locally at a construction site, they have often migrated from elsewhere in search of employment after their contracts and projects ended.⁸ Hence, there is an inherent migratory nature to the construction sector, which means that the movement of labour, in terms of time and space, is relatively high compared to other industries. Labour recruitment practices in the construction sector in the SADC region have contributed to the process of “circular migration” whereby migrant workers return home once the job is completed and then return to job sites when new work is available.

Although few studies have looked specifically at HIV prevalence and/or vulnerability in the construction sector, high HIV-prevalence rates have been reported in and around construction sites. In Malawi, road construction has been linked to the spread of HIV,⁹ while in Lesotho, the Highland Water Project (Katse Dam) has led to an increase in STIs in the remote mountain areas.¹⁰ Some sources have indicated that the construction industry in South Africa has the third highest HIV incidence of the economic sectors in the country, after the mining and transport sectors.¹¹

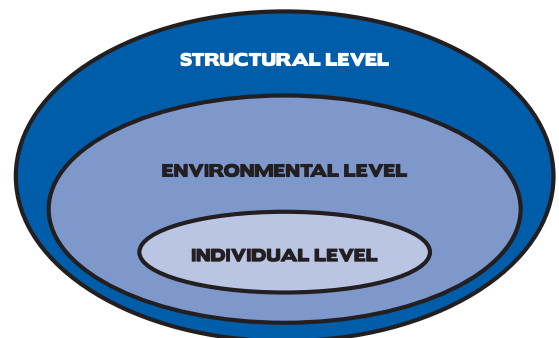
DIFFERENT LEVELS OF HIV CAUSALITY: THE INDIVIDUAL, ENVIRONMENTAL AND STRUCTURAL LEVELS

Existing HIV and AIDS interventions in the construction

sector primarily focus on increasing awareness, education, prevention, and voluntary counselling and testing (VCT) at construction sites. The fact that most responses are aimed at individual behaviour change is because most people view the risky sexual practices of construction workers and their health-seeking behaviour as the main cause of the increased HIV prevalence in the sector. However, this approach does not take into account the fact that the individual behaviour of construction workers is a function of the environment and the circumstances in which they find themselves.

In these Guidelines, we identify and analyse the structural and environmental factors that may increase HIV vulnerability for construction workers.¹² In the context of migration and HIV, while the structural factors motivate people to migrate in search of work on construction sites, it is primarily the socio-economic environment in which they find themselves that is conducive to the spread of HIV. A change in environment is often associated with changes in social norms and values, which in turn affect individual (sexual) behaviour. Thus, the three levels are all interrelated; one level creating the context within which the other level may persist.

The diagram below illustrates the interrelationship among the three levels of HIV causality: the structural level impacts on the environmental level, which in turn impacts on the individual level.



The factors that exacerbate HIV vulnerability of migrant construction workers are presented below, according to these three different levels: structural, environmental and individual. It must be stressed that

internal migrants often face the same challenges as cross-border foreign migrants, as they are also thrust in alien environments, separated from their families for long periods of time, and may be subjected to poor and dangerous working and living conditions.

STRUCTURAL FACTORS OF HIV VULNERABILITY

Many of the underlying factors sustaining the migration of construction workers, such as unbalanced distribution of resources, unemployment in rural areas, socio-economic instability and political unrest, are determinants of the increased risk of HIV infection. Therefore, national and regional responses to reduce HIV vulnerability in the construction sector should also be cognizant of these root causes of migration.

Some other structural factors increasing HIV vulnerability for workers, their families and the communities surrounding construction sites include limited policy development on HIV in the construction sector, limited development and implementation of labour rights frameworks, and gender inequality and gender dynamics around construction sites.

Regional and national policies on HIV and the construction industry

There are limited regional and national policies in the construction industry in general. For example, there is no regional SADC protocol on the construction sector like there are SADC protocols for other sectors, such as mining, transport and tourism.¹³ Such a regional SADC protocol on the construction sector could include minimum standards of labour practices, and address health and HIV issues as well. Also, there are limited initiatives on policy development from departments/ministries of public works in SADC to address HIV in the construction sector.

Labour rights frameworks

SADC has given some attention to the regional harmonization of domestic labour laws but the extent to which this has resulted in direct discussions and policy development on labour migration between countries is limited. Furthermore, there is limited ratification and implementation of applicable international conventions on migration among SADC member states, such as the *UN International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (2003)*, and the *ILO Convention No. 97 on Migration for Employment (1949)*.

Immigration laws

There are generally two different types of foreign migrant worker in the construction sector for whom different immigration laws apply. One category is comprised of skilled, managerial, or technical staff that are usually under full-time contracts with large construction companies. These workers are sent to foreign construction sites with work visas obtained by their companies. The second category is made up of unskilled or semi-skilled contract workers who may migrate from one site to another, undocumented, in search of work.

Most SADC member states do not make provision for foreign unskilled or semi-skilled construction workers to obtain valid work permits and therefore many are forced to work undocumented. Undocumented workers are usually apprehensive of any contact with immigration departments due to fear of deportation. Because of their lack of legal status, many workers do not access health, and/or HIV and AIDS services, which may result in untreated STIs and workers not knowing their HIV status.

Gender inequalities

The economic and social gender inequalities between men and women have perpetuated the dominance of men over women in Southern Africa. In general, women have limited access to social and economic resources. Consequently, the majority of women are poor, economically dependent on men and have limited decision-making powers. Women from impoverished communities surrounding construction sites may engage in transactional sex with construction workers. Also, spouses or partners of migrant construction workers are often powerless to negotiate safe sex due to this gender inequality. As a result of these dynamics, women are more vulnerable to contracting HIV. This partly explains the relatively higher HIV-infection rates amongst women than men in the SADC region.

ENVIRONMENTAL FACTORS OF HIV VULNERABILITY

Environmental factors that increase HIV vulnerability for construction workers are primarily the direct socio-economic living and working conditions. These are often characterized by the nomadic “on-site” lifestyle near isolated and often impoverished communities, limited access to healthcare services, paucity of HIV and AIDS interventions, and the nature of employment contracts.

Nature of work and “on-site” lifestyle

Construction workers lead a nomadic “on-site” lifestyle in remote areas – living away from families and support systems in temporary accommodation with few recreational facilities for long stretches of time. The following factors are commonly found on or near construction sites, and create an environment that could increase risky sexual behaviour:

- **Dangerous working conditions:** Construction is one of the most dangerous lines of work, with a proportionately high number of job-related accidents and diseases. In South Africa alone, according to the Federated Employers’ Mutual Assurance Company Ltd (FEM), approximately 25 500 accidents are reported per annum at a total direct cost (compensation) of approximately ZAR 200 million. In terms of fatalities, the industry ranks third after mining and transport, with a total of 74 deaths recorded on site in 2003.¹⁴ Faced daily with difficult and dangerous working conditions and risk of physical injury, construction workers tend to be preoccupied with other immediate challenges and may regard HIV infection as a distant risk.
- **Boredom and loneliness:** There is limited availability of recreational activities such as sports or entertainment at or around construction sites. While workers are distanced from traditional norms, culture and support systems that regulate behaviour in stable communities, the feelings of boredom, loneliness, and isolation can result in a disregard for health among construction workers. In addition, the proximity and availability of commercial sex workers may fill the workers’ (temporary) emotional and sexual needs.
- **Lack of social cohesion at construction sites:** The social exclusion that migrants often feel in their new environment and the lack of community cohesiveness may lead to risky sexual behaviour among workers and members of the surrounding community. The social structures and norms in these environments may create feelings of anonymity, which could result in workers taking less accountability and responsibility. These feelings could also be due to shifting social norms and lack of community sanction for errant individual behaviour.

Construction sites often located near isolated and impoverished communities

Construction sites are often located in or near underdeveloped areas with high levels of poverty. In such environments, some members of the local community, especially poor women, may engage in transactional and commercial sex with construction workers who have disposable income. Furthermore, in conditions of loneliness and isolation, sexual intimacy with sex workers may come to symbolize a form of emotional intimacy that could be lacking in other areas of their lives.¹⁵

Limited access to healthcare services and lack of HIV and AIDS interventions

In general, construction workers lack access to healthcare services because these services are either not available or accessible near the construction sites. Even in areas where healthcare services do exist in the local communities, undocumented migrant workers may be reluctant to seek these services for fear of harassment or deportation.

Furthermore, there is a lack of HIV and AIDS interventions in the construction sector due to limited understanding by government departments and management of construction companies of HIV-vulnerability factors in the sector, and the lack of commitment from the management of construction companies to HIV and AIDS programmes both at “headquarters” level and on or near construction sites. In addition, logistical difficulties may be encountered in implementing interventions due to the geographical remoteness of construction sites, constantly changing and complex configuration of activities on construction sites, and rapid turnover of employees owing to the extensive use of limited duration contracts.¹⁶

Types of employment contract

Increasingly, there is a trend towards subcontracting in the construction sector in Southern Africa. The tendency towards labour-only subcontracting on construction sites increases the HIV vulnerability of construction workers in two ways: ¹⁷

Firstly, these subcontracted employment contracts indemnify the general contractor from various responsibilities towards workers’ safety and health and often lack the provision of health benefits for workers. Also, the subcontracted companies might feel less inclined to provide access to prevention and care programmes, condoms, and STI treatment as this might increase their costs and make them less competitive.

Secondly, the abundance of subcontracting schemes on construction sites may increase the complexity in developing effective HIV and AIDS strategies and interventions. This is because targeting the full spectrum of those employed on a construction project becomes difficult when workers have different types of contract, contract duration, remuneration, entitlement, and benefit.

INDIVIDUAL FACTORS OF HIV VULNERABILITY

The individual factors of HIV vulnerability describe how individuals act on a particular issue in a particular situation or environment. Examples that increase the HIV vulnerability of construction workers include the following:

Low HIV and AIDS knowledge and risk perception

In general, knowledge about HIV and AIDS is low amongst construction workers; many believe in myths, and have misconceptions about how HIV is transmitted. This shapes the individual's perception of the risk of contracting HIV, and therefore the individual's sexual behaviour. Low perceptions of risk may result in low or incorrect condom use.¹⁸

Reluctance to access health care services

In particular, if a migrant construction worker is undocumented, he may be reluctant to access public services, including healthcare services, out of fear

of being deported. Workers may also be reluctant to get tested for STIs or HIV for fear of stigma and discrimination and losing their jobs if their employer finds out their HIV status.

Stereotypical notions of gender

As previously mentioned, economic and social gender inequalities between men and women are pervasive in Southern Africa, and constitute a structural factor that aggravates HIV vulnerability. In the traditionally male-dominated construction sector, stereotypical notions of gender, including submissive roles for women and strong, masculine roles for men, may exacerbate risk-taking sexual behaviour for both men and women, and create an environment conducive to discrimination and sexual harassment towards female co-workers and members of the communities near construction sites.

Given the vulnerability to HIV infection of construction workers in the SADC region, which are outlined in Section 2, specific recommendations for action are presented below. The recommendations are targeted at specific stakeholders, including the SADC Secretariat, SADC member states, the client, employers, trade unions, NGOs, CBOs and other service providers.

As the regional political coordinating body, the **SADC Secretariat ("SADC")** has an important role to play in ensuring that the structural and environmental factors



section 2

Agenda for Action

that increase vulnerability to HIV for construction workers are properly addressed. Also, **governments of SADC Member States** – be they national, provincial, district or local municipality authorities - have an important role to play to reduce the impact of HIV and AIDS among workers in the construction sector, as they are the primary providers of health and other services for its citizens, as well as for the foreign migrants living and working within its borders.

Next, some of the most important stakeholders in addressing HIV and AIDS in the construction sector are the clients and the employers. **The client** in a construction project is the investor, and also the owner of the project, who enters into a contract with a general contractor, who in turn might subcontract specific tasks to numerous subcontractors. Clients

may be national or local governments, private sector companies, international financial institutions such as the World Bank, or development agencies such as bilateral donor agencies.

The prevalence of subcontracting, especially the tendency toward labour-only subcontracting, not only lessens the likelihood of health benefits provision for the temporary workers on site, but also increases the complexity of developing effective interventions, including HIV and AIDS interventions, targeting the full spectrum of those employed on a construction project. In this regard, the role of the client in a construction project is critical, in that they hold the ultimate authority to enforce specific interventions and minimum standards on health and safety on site.

Employers may include all types of company engaged in

the business of construction - from the general contractor who, under contract with the client, oversees the overall project, to the various subcontractors who actually employ workers on the ground. The employers are key players in

overseeing the actual implementation of interventions on the ground.

Lastly, **trade unions** may provide critical interventions in advocacy, awareness raising and education.

RECOMMENDATIONS	STAKEHOLDERS
COORDINATION, COLLABORATION, DIALOGUE AND TECHNICAL RESOURCE	
<p>Strengthen the coordination and collaboration on social issues related to the construction sector among SADC member states: Since construction workers interact with communities of host, receiving and transit countries, there is a need to address issues regionally. SADC should act as the coordinating body for the different initiatives, and facilitate research, policy and programme development at national and regional levels focusing on migrant construction workers. SADC should also facilitate sharing of experiences regionally, as well as provide a platform for effective and ongoing consultation and social dialogue between various stakeholders within SADC.</p>	<p>SADC Secretariat Governments of SADC member states</p>
<p>Establish a construction resource group: SADC should assist in the establishment of a regional resource group that could provide technical expertise, as needed, on ways to integrate HIV issues in the construction sector.</p>	<p>SADC</p>
<p>Establish a focal point on migration: A focal point for migration should be established at the SADC Secretariat, focusing on issues related to labour migration, preferably located within the Social and Human Development Unit. The role of the focal point should focus on increased bilateral and multilateral arrangements that pertain to the management and regulation of cross-border migration.</p>	<p>SADC</p>
POLICY DEVELOPMENT AND IMPLEMENTATION	
<p>Initiate policy development for the construction industry: SADC and its member states should develop regional policies and encourage bilateral policies that focus on the construction industry, particularly highlighting the issue of migrant labour in the sector. This should include the development of immigration policies that make it easier for unskilled and semi-skilled workers to obtain work permits and visas to work on various construction sites in the different SADC countries, as well as simplification of rules and procedures for sending remittances across borders.</p> <p>SADC should also consider the development of a new protocol for the construction industry, which would create an enabling environment at the regional level for the movement of migrant construction workers. Such a protocol should include minimum occupational health and safety (OHS) standards as well as provisions for reducing the HIV vulnerability of construction workers. SADC</p>	<p>Governments of SADC member states</p>
<p>Facilitate easier movement of persons in the SADC region: Current efforts at economic regional integration within SADC aim to enhance regional economic development, as expounded in the SADC Trade Protocol, "... to enhance the economic development, diversification and industrialization of the Region".¹⁹ However, while it facilitates the movement of goods and capital, the Trade Protocol ignores the movement of labour, which is likely to move within and across national boundaries as it follows capital. Thus, SADC should facilitate easier movement of labour in the region.</p>	<p>SADC Governments of SADC member states</p>
<p>Actively advocate for the implementation of the SADC Protocol on Health:²⁰ According to the SADC Protocol on Health, policies should be harmonized ensuring access to treatment for various diseases, including HIV and AIDS and STIs, for all people in the SADC region, regardless of their country of origin or legal status.</p>	<p>SADC Governments of SADC member states</p>
<p>Ratify international human rights treaties: National governments should ratify relevant international conventions on migrants' human rights, especially the <i>UN International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (2003)</i> and the <i>ILO Convention No. 97 (Migration for Employment)</i>.</p>	<p>Governments of SADC member states</p>
<p>Include migration-related issues in the national AIDS response: National AIDS councils and ministries of health should advocate for the inclusion of policies and programmes for reducing the HIV vulnerability of migrant construction workers in national multisectoral AIDS response strategies. Also, national departments of public works should develop sector strategies and policies addressing HIV vulnerability in the construction sector.</p>	<p>Governments of SADC member states</p>
SOCIAL IMPACT ANALYSIS	
<p>Ensure inclusion of a Social Impact Analysis (SIA) in all new construction projects: A SIA would examine how a proposed construction development would affect the social dynamics of nearby communities in the short and long term. The SIA should assess the factors that increase disease around construction sites, including the spread of HIV. All clients, both public and private, should make such assessments compulsory for all major construction projects.</p>	<p>The Client</p>

RECOMMENDATIONS	STAKEHOLDERS
RURAL DEVELOPMENT AND LOCAL COMMUNITY DEVELOPMENT	
<p>Give priority to the development of rural areas to prevent excessive out-migration: SADC governments should focus more vigorously on rural development strategies within their national development plans. Adequate budgets should be allocated to develop and implement sustainable and gender-sensitive rural development programmes. For example, income generation, rural and community development, and job-creation projects should be promoted, particularly in migrant-sending areas. Also, governments should encourage private-sector investment in rural areas through, for example, the provision of tax incentives. This way, men do not have to migrate in search for work and can work near their families. Also, the levels of transactional and commercial sex would be reduced if there were alternative channels of income</p>	<p>Governments of SADC member states</p>
<p>Engage in dialogue with local communities and implement local community development schemes: The client and employers should engage actively with the local communities before and during the implementation of the construction project. This could include: 1) introducing the project to the local communities before commencement; 2) implementing development schemes and investments for local communities; 3) implementing education programmes on STIs for local community residents, including HIV, safe sex, and other reproductive health issues, targeting local commercial sex workers in particular; and 4) using local labour on projects if possible.</p>	<p>The Client Employers</p>
HEALTH AND SAFETY	
<p>Adhere to Occupational Health and Safety (OHS) standards: Governments should develop, strictly enforce and monitor adherence to a minimum of OHS standards in the construction sector in order to reduce the number of work-related accidents and transmission of STIs including HIV during construction projects.</p> <p>The Client and employers should promote, monitor and strictly enforce adherence to OHS standards and labour laws. Owing to the increasing use of subcontracting relationships, sub-contracted construction companies (the direct employers of the workers) often claim that they have limited liabilities and obligations towards workers. In order to address this issue, it is recommended that the client, as the owner of the construction project (and thus the employer), take responsibility for the basic safety and health of all workers on site. This includes actively promoting health and safety on site, regardless of the nature of the employment contract under which an individual worker is employed, and regardless of the possible existence of indemnity clauses.</p> <p>Trade unions should ensure that OHS standards are understood by workers and adhered to by employers. There should be a credible procedure in place for complaints to be addressed.</p>	<p>Governments of SADC member states</p> <p>The Client Employers</p> <p>Trade unions</p>
<p>Provide health services: Where such services exist, construction workers should be integrated into the health services provided by the surrounding community. This might involve the (temporary) strengthening of the capacity of these community services by the client or employers.</p> <p>In cases where local healthcare services do not exist, on-site health services should be provided. These services should be accessible for all construction workers, regardless of their contractual employment status or nationality, as well as to members of the local community. Services should include treatment for STIs and other opportunistic infections as well as VCT. In addition, employers should distribute HIV and AIDS education materials and condoms regularly. On-site services – accessible for construction workers during and after working hours - should be made a contractual requirement for every project, and be included as part of the budget.</p> <p>Trade unions should advocate/lobby with employers that comprehensive healthcare services, including free treatment of STIs, are available at construction sites with the highest standards of confidentiality respected and protected. Nearby NGOs, CBOs and other service providers could be contracted to provide this service.</p>	<p>The Client Employers</p> <p>Trade unions</p>
<p>Develop and implement HIV and AIDS workplace policies and programmes: Employers should develop and implement HIV and AIDS workplace policies that include peer education, and encourage confidential VCT on or near sites and support groups, amongst other things.</p> <p>Trade unions should more actively encourage the development of workplace HIV and AIDS policies and programmes. <i>The ILO Code of Practice on HIV/AIDS and the World of Work (2001)</i>²¹ should be considered as a useful tool to integrate HIV in the workplace.</p>	<p>Employers</p> <p>Trade unions</p>
<p>Review working hours and establish credible complaints procedures: In instances when deadlines are tight, construction workers tend to work long hours, which may increase the likelihood of accidents on site. Thus, working hours should be reviewed and minimum labour standards in this regard should be enforced. Further, a credible complaints procedure/mechanism accessible to all workers should be established.</p>	<p>The Client Employers</p>

RECOMMENDATIONS	STAKEHOLDERS
EMPLOYMENT PRACTICES	
Set and monitor employment practices in the construction sector: Although the economic rationale for subcontracting and/or labour-only subcontracting may be strong, the adverse impact of certain recruitment and employment practices on workers should be considered when subcontracting. Therefore, governments should enforce adherence to laws and standards by subcontractors.	Governments of SADC member states
Advocate for the use of local labour: In some SADC member states there are already requirements for certain public works projects to utilise local labour for a percentage of their unskilled and semi-skilled labour requirements. Governments should include this provision in all government issued construction projects and encourage the practice in private sector issued contracts.	Governments of SADC member states
Review employment mechanisms: As already indicated, there has been a move towards subcontracting, arguably in an effort to circumvent direct compliance with existing labour laws, to save costs and to have limited liability. Construction companies should be sensitized on their obligations as employers.	Employers
LIVING CONDITIONS	
Provide appropriate living conditions for workers: Employers should provide minimum standards for living conditions, including suitable accommodation and recreational facilities on or near sites. This should also include establishing and enforcing minimum quality standards for water, nutrition and sanitation. Companies working on large and long-term projects could build recreational facilities, which can be used by workers and members of the community during the project and after the project has been completed.	Employers
Promote social support for migrants: Strategies may include: allowing for more frequent visits home; providing suitable family accommodation (for long-term construction projects); simplifying the process of sending remittances; and providing for various support groups on site.	Employers
GENDER	
Actively advocate for inclusion of gender in policies and programmes: SADC should continue to focus on and increase awareness of gender to decrease gender stereotyping and discrimination in the region. The SADC Gender Unit along with relevant partners should continue to monitor the gender commitments of SADC member states under relevant international and regional treaties and advocate for the adoption of new and existing relevant international and regional human rights treaties.	SADC
Adopt and implement the SADC Code on the Equality of Women and the Reduction of Risk of HIV Infection: The proposed SADC Code on the Equality of Women and the Reduction of Risk of HIV Infection ²² should be finalised, adopted and implemented after the necessary input and consultation by member states. It is also recommended that HIV and AIDS be mainstreamed in the <i>SADC Declaration on Gender and Development (1997)</i> ²³ and that a SADC charter on gender be developed.	SADC
Ratify and implement human rights treaties on women's rights: For example, the 1979 UN Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), ²⁴ which all SADC member states have ratified, needs more vigorous implementation.	Governments of SADC member states
Provide public education on gender issues: Governments should continue to focus and increase awareness on gender issues so as to decrease gender stereotyping and discrimination. Governments should advocate for the mainstreaming of gender with all stakeholders in the construction sector, including employers, trade unions, schools, media, churches, and other civic organizations. It is important to include men in all gender interventions.	Governments of SADC member states
Promote safer sexual practices: Governments should put in place policies and programmes that make male and female condoms available and affordable at all times at different geographical locations, including remote construction sites.	Governments of SADC member states
Advocate for gender equality: Trade unions should ensure that gender issues are addressed on and around construction sites. Furthermore, they should monitor progress of SADC member states' commitments on gender. NGOs could provide gender education to government officials/leaders, businesses, trade unions, media, churches, youth organizations, schools, and other civic bodies. Gender training should raise awareness on gender issues by challenging and addressing traditional notions of "masculinity" and "femininity" in the Southern African context, especially in the interaction with poor communities and sexual and gender-based violence.	Trade unions

RECOMMENDATIONS	STAKEHOLDERS
MIGRANTS' RIGHTS	
<p>Protect migrants' right to health: Both human rights law and public health imperatives require that migrants' right to health be protected and promoted by governments and employers. Firstly, international human rights instruments explicitly recognise that human rights, including socio-economic rights and specific health-related rights, apply to all persons – migrants, refugees, and other non-nationals.²⁵ Secondly, policies and strategies in migrant receiving countries should acknowledge that HIV transmission (as with any infectious disease) is bi-directional. Failure by a host country to offer health services to migrants will impact negatively on the public health of that country.²⁶ Foreigners (legal or irregular) should therefore have access to health services, including STI treatment, VCT and HIV/AIDS prevention and care programmes, indiscriminately.</p>	<p>Governments of SADC member states The Client Employers</p>
<p>Engage in education and awareness programmes:</p> <p>Governments at national and local levels should undertake public education and information campaigns to reduce xenophobia and discrimination towards foreign migrants and develop and enforce national laws criminalizing expressions of xenophobia.</p> <p>Trade unions should advocate with governments and employers to increase their understanding of migration issues. Semi-skilled and unskilled migrant workers, especially if undocumented, will most likely not belong to trade unions. However, unions should be trained on migration issues, recognize this group of workers, and advocate for legal protection and minimum standards for them.</p> <p>Further, trade unions should provide education and awareness on women's rights, workers' rights, general human rights, and prevention of sexual exploitation. In particular, healthcare providers, shop stewards and workers should be educated on workers' labour and human rights with the aim of mitigating xenophobia and discriminatory practices towards migrant workers.</p>	<p>Governments of SADC member states Trade unions</p>

EXAMPLES OF EXISTING HIV AND AIDS ACTIVITIES IN THE CONSTRUCTION INDUSTRY

Although it is recognised that there are numerous HIV initiatives in the construction industry within the region, two specific examples of clients taking responsibility for the provision of HIV prevention, education and awareness campaigns on site are presented here. They are the HIV strategy of the Department of Public Works (DPW) of South Africa, and the HIV/AIDS specifications of the Construction Industry Development Board (CIDB) of South Africa.

In response to the potential impact of HIV and AIDS on the construction industry in South Africa, DPW has developed a strategy to mitigate the impact of the disease on the industry. As part of this strategy, the Department enforces the implementation of HIV/AIDS programmes in the construction work it commissions: contracts exceeding a certain amount of money are obliged to incorporate HIV and AIDS awareness programmes, and once contracts are granted, there are penalties for non-compliance. An HIV/AIDS Specification for Civil Contracts has been developed by DPW, which outlines the processes to be followed, including the requirements of the HIV/AIDS programmes, recommended practices, checklists and reporting.²⁷

Established by the South African Parliament in 2000,²⁸ CIDB is tasked with establishing a national register of contractors and projects, as well as best practice

contractor recognition and project assessment schemes. CIDB is aiming at a client-driven approach to HIV and AIDS interventions in the construction industry. Given the complexity and fragmentation of the industry, with many different role players from both the formal and informal sector, the role of the client as the ultimate employer of all construction workers is seen as the strongest link to achieving the desired intervention in the fight against HIV and AIDS. Since there is a tendency towards subcontracting on construction projects, the most effective entry point for interventions on HIV and AIDS is at project sites, by making it part of the "delivery" of a contract. Thus, contractors and projects should be registered, making them accountable for certain "best practices", not only in the area of HIV and AIDS prevention and care, but also in other aspects such as labour standards or environmental protection and sustainable development.²⁹

To this end, CIDB has developed a draft Specification for HIV/AIDS Awareness.³⁰ This specification serves as a guideline for the contractual requirements for HIV and AIDS awareness programmes. The specification has been designed to make the role of the client central to an HIV and AIDS strategy. This is achieved by making HIV/AIDS awareness on site an item that the contractor can price and be expected to deliver as part of the entire project.



section 3

Suggestions for further research

There is a general lack of information on the impact of HIV and AIDS on the construction sector, which makes it difficult to develop and monitor and evaluate policies and programmes adequately. Thus, it is recommended that research in the following areas be pursued to ensure the development of better policies and programmes on HIV and AIDS in the future:

- **Labour migration patterns and statistics in the construction sector:** To understand the target groups for interventions and their specific circumstances, more information is needed on the numbers and patterns of labour migration including: the direction, size, nature of migration; the routes and patterns of migration; and gender dynamics.
- **Impact assessment and analysis of HIV and AIDS on the construction industry:** Anecdotal evidence shows that HIV and AIDS are already negatively impacting on the construction sector through increased absenteeism, skills shortages,
- declining productivity and increasing costs. In order to inform better responses, public and private authorities involved in the industry should perform HIV impact studies. This can be done through (anonymous) HIV prevalence surveys, knowledge, attitudes and practices (KAP) surveys, and vulnerability assessments.
- **Impact of different employment contracts on HIV vulnerability of construction workers:** As mentioned, there is an increasing use of subcontractors and labour-only brokers in the construction industry. The possible negative side effects of this phenomenon include decreasing provision of health benefits to workers who are subcontracted and less effective HIV interventions on site. However, the full extent and nature of the impact of subcontracting on the health and well-being of construction workers needs to be fully explored and understood.



conclusion

The analysis and recommendations outlined above are a synthesis of the consultative process IOM undertook during 2004 and 2005 with relevant stakeholders in the construction sector in the SADC region. It is hoped and envisaged that these guidelines will contribute to reducing HIV infections and the impact of HIV and AIDS among workers in the construction sector in the SADC region by the increased awareness of key stakeholders in the construction sector of the factors that increase HIV vulnerability among construction workers. In addition, it is hoped that the Guidelines will be actively used by stakeholders to develop policies, programmes, and interventions and will be utilised as a tool to

advocate for HIV and AIDS programmes and policies in the sector. Lastly, it is hoped that the Guidelines may contribute to the development of regional/national policies on HIV and AIDS in the construction sector by policy makers making use of the recommendations in regional/national HIV and AIDS Strategic Plans and Policies.

In addition to these Regional Guidelines on HIV and AIDS in the Construction Sector in the SADC region, PHAMSA has developed regional guidelines on HIV and AIDS for the commercial agriculture and the informal cross border trade sectors. In the future, PHAMSA hopes to develop more regional guidelines for sectors that are characterized by high levels of mobility.



appendix1

International and regional treaties and declarations

There are a number of regional and international declarations and treaties that require countries to address the health needs of migrants, mobile workers, refugees and internally displaced persons (IDPs) that work and/or reside within their borders. Most countries of the SADC region have committed to and/or ratified these treaties and declarations. The most relevant regional and international

treaties and declarations are listed below. These provide a tool for advocating with SADC governments for policies and programmes that will reduce the vulnerability of migrants to various diseases, including HIV and AIDS.

First of all, it is important to place the HIV vulnerability of migrants and mobile populations in a human rights framework. All human

rights, including the right to health, apply to all people – including migrants, refugees and other non-nationals. The Office of the United Nations High Commissioner for Human Rights (OHCHR) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) have issued the International Guidelines on HIV/AIDS and Human Rights in order to assist states and other organizations in creating positive, rights-based responses that will be effective in reducing the transmission and impact of HIV and AIDS. The principle outlines of non-discrimination, equality and participation are particularly important in the case of groups affected by societal discrimination, such as migrants and refugees.³¹

GENERAL INTERNATIONAL AND REGIONAL TREATIES AND DECLARATIONS

The *International Covenant on Economic, Social and Cultural Rights (ICESCR)* recognizes the right of everyone to the enjoyment of the highest attainable standard of mental and physical health by all (article 12(1)).³² Article 12 (2) of the ICESCR states that steps to be taken by the states parties shall include those necessary for

- The improvement of all aspects of environmental and industrial hygiene
- The prevention, treatment and control of epidemic, endemic, occupational and other diseases.

In addition, the *Universal Declaration of Human Rights* (article 25) states that “everyone has the right to a standard of living adequate for the health and well being of himself and of his family, including food, clothing, housing and medical care and necessary social services”. This includes vulnerable groups such as migrants and mobile populations.³³

The *International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families*³⁵ (2003) provides a set of binding standards to address the treatment, welfare, and human rights of both documented and undocumented migrants, as well as the obligations and responsibilities of sending and receiving countries. It recognizes the right of all migrant workers and their families to emergency medical care (article 28) and the right of documented migrant workers and their families to equal treatment with nationals, and access to health services (articles 43 and 44).

Furthermore, it recognises the equality of migrant and state national workers with regard to safety, health and conditions of work (article 25), and urges state parties to ensure that working and living conditions of migrant workers and their families are in keeping with the standards of fitness, safety, health and principles of human dignity (article 70).

ILO Convention No. 97 on Migration for Employment (1949) requires “... appropriate medical services ... ensuring that migrants and members of their families enjoy adequate medical attention and good hygienic conditions at the time of departure, during the journey and on arrival in the territory of destination” (article 5). Further, the Convention requires that members “... undertake to apply, without discrimination in respect of nationality, race, religion or sex, to immigrants lawfully within its territory, treatment no less favourable than that which it applies to its own nationals in respect of ...” remuneration, membership of trade unions and enjoyment of the benefits of collective bargaining, accommodation, and social security (article 6).

In 2000, the General Assembly of the United Nations adopted the *UN Millennium Declaration* (GA Resolution 55/2),³⁶ which outlines the commitment of signatory countries to achieving the Millennium Development Goals (MDGs). The MDGs are used as benchmarks in social and economic planning at national, regional and international levels, and serve as a common policy framework for the entire UN system.³⁷ The UN Millennium Declaration also commits to taking “... measures to ensure respect for the protection of the human rights of migrants, migrant workers and their families, to eliminate the increasing acts of racism and xenophobia in many societies and to promote greater harmony and tolerance in all societies.”³⁸

The New Partnership for Africa's Development (NEPAD),³⁹ which was adopted in 2001, describes a number of objectives and actions that will improve the health of all Africans. For example, one of its objectives is “to strengthen programmes for containing communicable diseases” (paragraph 123), and it recommends actions

“to lead the campaign for increased international financial support for the struggle against HIV/AIDS and other communicable diseases” (paragraph 124). NEPAD also makes mention of the need “to reduce delays in cross-border movement of people, goods and services” and “recognises the need to harmonise border crossing and visa procedures” which will indirectly affect the HIV vulnerability of migrants and mobile populations (paragraphs 111-112).

Article 16 of the *African Charter on Human and People's Rights (1981)* states that “[e]very individual shall have the right to enjoy the best attainable state of physical and mental health,” and that State parties “... shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.”⁴⁰ Further, *The Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (2003)* recognises the equal rights of African women, including the right to healthcare, sexual and reproductive health and the right to be protected against STIs including HIV and AIDS.⁴¹

The SADC Charter of Fundamental Social Rights (2003), in article 2(c), urges member states to “promote labour policies, practices and measures, which facilitate labour mobility, remove distortions in labour markets and enhance industrial harmony and increase productivity in member states”.⁴²

INTERNATIONAL AND REGIONAL TREATIES AND DECLARATIONS ON HIV/AIDS

At the *United Nations General Assembly Special Session (UNGASS) on HIV/AIDS* in June 2001, 189 countries (including all SADC member states) adopted the Declaration of Commitment on HIV/AIDS. The meeting was a historic landmark, acknowledging the scope of the HIV/AIDS pandemic and setting out “global actions” to this “global crisis”. The Declaration established a number of goals for the achievement of specific quantified and time-bound targets on which progress all countries have to report on biannually.

Paragraph 50 of the Declaration acknowledges the needs of migrants and mobile populations as a vulnerable group that should be explicitly addressed:

... by 2005 member states should develop and begin to implement national regional and international strategies that facilitate access to HIV/AIDS prevention programmes for migrants and mobile workers involving the provision of information on health and social services.⁴³

In April 2001, the heads of state and government of the Organization of African Unity (OAU) signed the *Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases*⁴⁴ which declared AIDS a state of emergency on the African continent, and accorded the fight against HIV/AIDS the highest priority in national development plans. The declaration called on State parties to strengthen ongoing successful interventions and to develop new and more appropriate policies, practical strategies, effective implementation mechanisms and concrete monitoring structures at regional, national and continental levels.

In Article 11, the Declaration acknowledges the particular vulnerability of migrants and mobile populations to HIV infection:

We acknowledge that forced migrations due to war, conflicts, natural disasters and economic factors including unilateral sanctions imposed on some African countries, lead to an increased vulnerability and the spread of the disease. We note that special attention should be given to migrants, mobile populations, refugees and internally displaced persons in national and regional policies. We also note that special attention should be given to the problem of trafficking in human beings and its impact on HIV/AIDS.

The *SADC HIV and AIDS Business Plan: Strategic 5-Year Business Plan 2005-2009*⁴⁵ describes the regional priorities that have been identified by the SADC member states on HIV and AIDS. Output 1.4 of the Business Plan states, “... policies on HIV and AIDS for migrant/mobile populations and displaced populations should be developed and harmonised.” This output specifically looks at four target areas: 1) high transmission areas like cross-border sites and high traffic sites [...], 2) health issues for displaced and mobile populations including undocumented migrants, focusing on treatment continuity,

health services, and messages [...], 3) transit at border points, and 4) antiretroviral treatment for migrants and the equity in treatment access across countries.

In July 2003, all SADC countries signed the *SADC Declaration on HIV/AIDS*⁴⁶ in Maseru, Lesotho (commonly referred to as “The Maseru Declaration”). In this Declaration, the SADC countries state that halting and rolling back HIV infection constitutes a top priority on the SADC agenda, and an integral part of the regional programme of eradicating poverty. Although migrants or mobile populations are not specifically mentioned, article 3c of the Declaration makes reference to the needs of people living close to national borders: “Enhancing the regional initiatives to facilitate access to HIV/AIDS prevention treatment care and support for people living along our national border including sharing of best practices.”

The *SADC Protocol on Health (1999)* highlights the need to harmonise and coordinate policies on HIV/AIDS/STIs. The protocol states that

SADC member states “shall endeavour to provide high-risk and transborder populations with preventative and basic curative services for HIV/AIDS/STDs” (article 10(2)).⁴⁷

The *SADC Code on HIV/AIDS and Employment* was adopted by the SADC Council in May 1997 as one of the responses to the HIV/AIDS crisis in the region. The code covers twelve policy components, which provide guidelines for workplace programmes and policies that should be developed. The 8th policy component of the Code “risk management, first aid and compensation” makes reference to people on the move. It states, “[u]nder conditions where people move for work, government and organisations should lift restrictions to enable them to move with their families and dependents” (paragraph 8.3).

People who are in an occupation that requires routine travel in the course of their duties should be provided with the means to minimise the risk of infection including information, condoms and adequate accommodation (paragraph 8.4).



appendix 2

IOM's response to HIV and AIDS

The International Organization for Migration (IOM) is mandated to work with migrants, refugees, displaced persons and others in need of migration services or assistance.⁴⁸ For the purposes of IOM's work on HIV and AIDS, the term “migrants and mobile populations” refers broadly to people who move from one place to another temporarily, seasonally or permanently for a host of voluntary and/or involuntary reasons.⁴⁹ IOM's global policy on HIV/AIDS, which is described in IOM's position paper on HIV/AIDS and Migration,⁵⁰ focuses on three target areas: 1) advocacy and policy dialogue; 2) capacity building and mainstreaming; and 3) research and information dissemination.

IOM's response to HIV and AIDS targets migrants throughout all stages of their journey – before they leave, as they travel, in communities and countries where they stay and work, and after they return home. This often requires going beyond national approaches to develop regional and cross-regional approaches.

Cognizant of the increased vulnerability to HIV infection, IOM and the Joint United Nations Programme on HIV/AIDS (UNAIDS) signed a cooperation framework in 1999 to ensure that the needs of migrants and mobile populations are fully integrated into national and regional AIDS strategies and that these populations have access to adequate HIV/AIDS prevention as well as care and support.⁵¹

Furthermore, in October 2004 IOM signed a memorandum

of understanding (MOU) with SADC with the aim of developing and strengthening cooperation on matters of common concern regarding the growing regional challenges of migration: advancing understanding of migration issues; encouraging social and economic development through migration; and upholding the human dignity and wellbeing of migrants.⁵²

Given IOM's mandate to work on all issues related to migration, and the afore-mentioned agreements with international and regional partners, IOM identified the importance of addressing HIV and AIDS in the construction sector in the SADC region. Owing to its linkages with other sectors, economic growth-generating characteristics, and the fact that the sector is labour intensive, the construction sector is important for a country's development. However, despite the fact that there is increased realization within the sector of the potentially devastating impact of HIV, there have been limited interventions to date. Thus, it is with urgency that IOM and other stakeholders realized the importance of addressing the issue of HIV and AIDS in the construction sector. Recognising the high levels of labour migration in the construction industry within and across borders of the SADC region, and acknowledging the need for a regional approach, IOM facilitated the development of these Regional Guidelines on HIV and AIDS for the Construction Sector in the SADC Region.



end notes

- 1 For more information on PHAMSA, please visit <http://www.iom.org.za/PHAMSA.html>
- 2 SADC HIV and AIDS Business Plan: Strategic 5-Year Business Plan 2005-2009 (Output 1.4)
See: http://www.sadc.int/english/hiv_aids/key_documents/SADC%20HIV%20and%20AIDS%20Bus.pdf
- 3 UNAIDS (2006). “2006 Report on the global AIDS Epidemic”, http://www.unaids.org/en/HIV_data/2006GlobalReport/default.asp
- 4 Macdonald, D.S. (1996) Notes on the socio-economic and cultural factors influencing the transmission of HIV in Botswana, *Social Science and Medicine*, 42(9): 1325-33; Williams, B. & Campbell, C. (1998) “Understanding the epidemic of HIV in South Africa: Analysis of the antenatal clinic survey data”, *South African Medical Journal*, 88(3): 247-51; Barnett, T. & Whiteside, A. (2002) *AIDS in the twenty-first century*. New York: Palgrave.; Kalipeni, E., et al. (eds.) (2004) *HIV and AIDS in Africa*. Oxford: Blackwell.
- 5 IOM Position Paper on HIV/AIDS and Migration, 2002. <http://www.iom.org.za/Reports/PositionPaper.pdf>
- 6 Spaces of Vulnerability: Migration and HIV/AIDS in South Africa. Southern African Migration Project, Migration Policy Series No. 24. 2002. <http://www.queensu.ca/samp/>
- 7 Statistics are sourced from the Committee of Central Bank Governors in SADC, See <http://www.sadcbankers.org>.
- 8 Apart from some information regarding expatriate contractors working on foreign construction sites, there is little evidence available on the extent of cross-border migration in the construction sector. However, anecdotal evidence suggests that there is a significant number of unskilled labour crossing borders to work at construction sites. See Rogerson C M. 1999. *Building skills: Cross-border migrants and the South African construction industry*. The Southern African Migration Project (SAMP), Migration Policy Series No. 11. IDASA: Cape Town.
- 9 World Bank. (1994) *Considering HIV/AIDS in development assistance: A toolkit*. Chapter 3: A Sectoral Checklist, (a) infrastructure (transport). <http://www.worldbank.org/aids-econ/toolkit/infra.htm>
- 10 Colvin M., et al. (1998) Health and safety in the Lesotho Highlands dam and tunnel construction programme. *International Journal of Occupational and Environmental Health*, 4(4): 231-5.
- 11 Deputy Minister of Public Works Rev KM Zondi, 20 March 2003,

- speech at the launch of the HIV/AIDS Awareness campaign in Gugulethu, South Africa. See www.publicworks.gov.za/speeches/depmin/2003/20march2003.htm
- More recently, the Building Industry Federation of South Africa estimates (BIFSA) estimated that 22% of the construction industry's 600,000 workers have HIV/AIDS (see "Boost for Construction from 2005" in *Engineering News*, 15 February 2005, online edition. <http://www.engineeringnews.co.za/eng/sector/construction/>)
- 12 Adapted from Sweat M. & Denison J (1995). HIV Incidence in developing countries with structural and environmental interventions. *AIDS*, No. 9 (suppl. A): 251-257.
 - 13 http://www.sadc.int/index.php?action=a1001&page_id=protocols
 - 14 See CIDB best practice documents: Construction Procurement, Best Practice Guideline #D1: Subcontracting Arrangements, and Subcontract for Labour only Engineering and Subcontract for Labour only Engineering and Construction Works.
Also, the ILO estimates that each year approximately 60 000 fatal accidents occur on construction sites around the world. One in every six fatal accidents at work occurs on a construction site. (<http://www.ilo.org/public/english/bureau/inf/download/factsheets/pdf/wdshv.pdf>)
 - 15 Campbell, C. (1997) Migrancy, masculinity and HIV: the psychosocial context of HIV transmission on the South African mines gold mines. *Social Science and Medicine*, 45(2): 273-83,
 - 16 Dickinson, D. & Versteeg M. (2004) *HIV/AIDS in manufacturing and construction companies in Ekurhuleni*. Wits Business School, Johannesburg.
 - 17 Construction Industry Development Board (CIDB) of South Africa. 2004. Construction Procurement, Best Practice Guideline #D1: Subcontracting Arrangements. Edition 1 of CIDB document 1012. CIDB: Pretoria.
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 - 18 Construction Industry Development Board (CIDB) of South Africa. (2003). Specification for HIV/AIDS Awareness. Generic specification issued for public comment, June. CIDB: Pretoria.
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http://buildnet.csir.co.za/cdproc/3rd_proceedings.html
 - 19 <http://www.tralac.org/scripts/content.php?id=457>
 - 20 http://www.sadc.int/index.php?action=a1001&page_id=protocols_health
 - 21 http://www.ilo.org/public/english/protection/trav/aids/code/languages/hiv_a4_e.pdf
 - 22 The SADC Code on the Equality of Women and the Reduction of Risk of HIV Infection was written as a result of a resolution taken by members of the AIDS and Rights Alliance of Southern Africa (ARASA). ARASA was tasked with drawing up a code similar to the SADC Code on HIV and Employment, but focused specifically on gender-related issues within the AIDS epidemic. The first drafts were formulated at the Southern Africa AIDS Training Programme (SAT) / AIDS Consortium/AIDS Law Project Advocacy Training Workshop held in February 2003.
See <http://www.lac.org.na/alul/Pdf/fincode.doc>
 - 23 http://www.sardc.net/widsaa/sgm/1999/sgm_genderdec.html
 - 24 <http://www.unhchr.ch/html/menu3/b/21.htm>
 - 25 For example, the International Covenant on Economic, Social and Cultural Rights recognises the right of everyone to the enjoyment of the highest attainable standard of mental and physical health, which includes prevention, treatment and control of epidemic, endemic, occupational and other diseases, as well as the creation of conditions which would ensure access to all medical service and medical attention in the event of sickness (Article 12). Also, the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families provides a set of binding standards to address the treatment, welfare and human rights of both documented and undocumented migrants, as well as the obligations and responsibilities on the part of sending and receiving states.
 - 26 In some countries, legislation has been implemented in favour of universal access to care and treatment. For example, the law for contagious diseases in Germany requires that some infectious diseases, such as tuberculosis, be diagnosed and treated anonymously and free of charge at public health offices. See WHO (World Health Organization). 2003. International Migration, Health & Human Rights. WHO: Geneva.
 - 27 See <http://www.publicworks.gov.za>
 - 28 CIDB was established by Parliament as a statutory body, via Act No. 38 of 2000 (see <http://www.cidb.org.za/Resource/CIDBAct.pdf>).
 - 29 See also CIDB website <http://www.cidb.org.za>
 - 30 See <http://www.cidb.org.za/Resource/Specification.doc>
 - 31 HIV/AIDS and Human Rights: International Guidelines, UNHCR/UNAIDS, Geneva, 23-25 September 1996. See: <http://www.ohchr.org/english/issues/hiv/guidelines.htm>
 - 32 Article 12, ICESCR, UN General Assembly Resolution, 2200A-XXI. See: http://www.unhchr.ch/html/menu3/b/a_ceschr.htm
 - 33 <http://www.un.org/Overview/rights.html>
 - 34 http://www.unhchr.ch/html/menu3/b/m_mwctoc.htm
 - 35 <http://www.ilo.org/ilolex/cgi-lex/convde.pl?C097>
 - 36 <http://www.un.org/millennium/declaration/ares552e.pdf>
 - 37 For a full list of MDG goals, targets and indicators, go to http://unstats.un.org/unsd/mi/mi_goals.asp
 - 38 See UN Millennium Declaration, Section V: Human rights, democracy and good governance, Paragraph 25, Bullet point # 5.
 - 39 <http://www.nepad.org.ng/PDF/About%20Nepad/nepadEngversion.pdf>
 - 40 <http://www.africa-union.org>
 - 41 <http://www.africa-union.org>
 - 42 http://www.sadc.int/index.php?action=a1001&page_id=charters_social_rights
 - 43 <http://www.un.org/ga/aids/docs/ares262.pdf>
 - 44 http://www.un.org/ga/aids/pdf/abuja_declaration.pdf
 - 45 http://www.sadc.int/english/hiv_aids/key_documents/SADC%20HIV%20and%20AIDS%20Bus.pdf
 - 46 http://www.sadc.int/english/hiv_aids/key_documents/declaration.pdf
 - 47 http://www.sadc.int/index.php?action=a1001&page_id=protocols_health
 - 48 For more information on IOM please visit <http://www.iom.int>
 - 49 IOM Position Paper on HIV/AIDS and Migration, 2002
 - 50 <http://www.iom.int/DOCUMENTS/GOVERNING/EN/Mcinf252.pdf>
 - 51 In September 1999 IOM signed a co-operation framework with UNAIDS which was renewed in 2002. See http://www.iom.org.za/Reports/MOU_Unaids.pdf
 - 52 IOM and SADC. Memorandum of Understanding between the International Organization for Migration (IOM) and the Southern African Development Community (SADC), October 2004.

