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

Regional Assessment on HIV-Prevention Needs
of Migrants and Mobile Populations in Southern Africa

# **Construction** Sector Report

**IOM, February 2010**

# Table of Contents

**List of Abbreviations** . . . . . . 2

**1 Summary** . . . . . . 5

**2 HIV Vulnerability in the Construction Sector in Southern Africa** . . . . . . 6

2.1 The Construction Sector in Southern Africa . . . . . . 6

2.2 HIV Vulnerability among Construction Workers. . . . . . 7

**3 Policies Relevant to HIV in the Construction Sector in Southern Africa.** . . . . . . 9

**4 Assessment Findings** . . . . . . 10

**4.1 Sector-specific Vulnerabilities** . . . . . . 12

4.2 HIV-prevention Services and Programs . . . . . . 12

*4.2.1 Regional Programs and Services* . . . . . . *12*

*4.2.2 National Programs and Services* . . . . . . *12*

**5 Gaps, Challenges and Corresponding Recommendations** . . . . . . 16

**6 Localized, Detailed Mapping of Services** . . . . . . 19

**7 Migrant Stories** . . . . . . 21

**8 References** . . . . . . 23

**Annex 1: IOM Regional Guidelines on HIV and AIDS for the Construction Sector in the SADC Region** . . . . . . 26

## List of Abbreviations

| | |
|---|---|
| AIDS | Acquired Immunodeficiency Syndrome |
| ART | Antiretroviral Therapy |
| ARV | Antiretroviral |
| AU-NEPAD | African Union-New Partnership for Africa's Development |
| BCC | Behavior Change Communication |
| CBO | Community Based Organization |
| CDC | Center for Disease Control |
| CIDB | Construction Industry Development Board |
| CoH | Corridors of Hope |
| CoL | Change of Lifestyle |
| CRS | Catholic Relief Services |
| DRC | Democratic Republic of Congo |
| EGPAF | Elizabeth Glaser Pediatric AIDS Foundation |
| EU | European Union |
| FBO | Faith Based Organization |
| FGD | Focus-group discussion |
| FHI | Family Health International |
| GDP | Gross Domestic Product |
| GTZ | Deutsche Gesellschaft fur Technische Zusammenarbeit |
| HAMSET | HIV/AIDS, Malaria and Tuberculosis Control Project |
| HIV | Human Immunodeficiency Virus |
| HTC | HIV Testing and Counseling |
| ICBT | Informal Cross-border Trade |
| ICAP | International Center for AIDS Care and Treatment Programs |
| ICMM | International Council on Mining and Metals |

| | |
|---|---|
| ICSW | International Committee on Seafarer's Welfare |
| IEC | Information, Education, Communication |
| IFC | International Finance Corporation |
| ILO | International Labor Organization |
| IMHA | International Maritime Health Authority |
| INLS | National Institute to Fight HIV and AIDS (Angola) |
| IOM | International Organization for Migration |
| ISF | International Shipping Federation |
| ITWF | International Transport and Workers Federation |
| JHU | John Hopkins University |
| KII | Key Informant Interview |
| MARP | Most-at-risk population |
| MCP | Multiple and Concurrent Partners |
| MHSS | Ministry of Health and Social Sciences |
| MoH | Ministry of Health |
| MOHSW | Ministry of Health and Social Welfare |
| MOU | Memorandum of Understanding |
| NAAF | National HIV/AIDS Action Framework |
| NABCOA | Namibia Business Coalition on AIDS |
| NAC | National AIDS Commission |
| Nasoma | National Social Marketing Program |
| NBCRFI | National Bargaining Council for the Road Freight Industry |
| NGO | Non-governmental Organization |
| NSF | North Star Foundation |
| NSO | National Statistics Office |
| NSP | National Strategic Plan |
| OHEAP | Occupational Health Education and Awareness Program |

| | |
|---|---|
| **OSBP** | One Stop Border Post |
| **OVC** | Orphaned and Vulnerable Children |
| **PEP** | Post-exposure prophylaxis |
| **PHAMSA** | Partnership on HIV and Mobility in Southern Africa |
| **PMTCT** | Prevention of mother-to-child transmission |
| **PPP** | Public–private Partnership |
| **PSI** | Population Services International |
| **RSSC** | Royal Swazi Sugar Company |
| **SADC** | Southern Africa Development Community |
| **SCC** | Social Change Communication |
| **SMA** | Social Marketing Association |
| **SRH** | Sexual and Reproductive Health |
| **STI** | Sexually Transmitted Infections |
| **TB** | Tuberculosis |
| **UN** | United Nations |
| **UNAIDS** | Joint United Nations Program on HIV/AIDS |
| **USAID** | United States Agency for International Development |
| **USD** | United States Dollar |
| **VCT** | Voluntary Counseling and Testing |
| **WBCG** | Walvis Bay Corridor Group |
| **WBMPC** | Walvis Bay Multi-purpose Center |
| **ZBCA** | Zambian Business Coalition on AIDS |
| **ZHECT** | Zambia Health Education and Communication Trust |

# 1. Summary


This sector report forms part of a regional assessment commissioned by USAID entitled *Regional Assessment on HIV-prevention Needs of Migrants and Mobile Populations in Southern Africa*, which examines the migration patterns and the HIV vulnerabilities faced by migrants and mobile workers in the southern African region.

The assessment was conducted from August to September 2009 in the following countries: Angola, Mozambique and South Africa. This report investigates the specific challenges faced by mobile populations working in the construction sector in accessing HIV-prevention services. It identifies opportunities for programming and prioritizes key activities that should be pursued in the region so as to lessen the overall HIV vulnerabilities of migrants, mobile workers and the communities with which they interact.

In summary, the assessment makes the following specific recommendations:

**Policies and Regional Coordination**

- At the national level, all governments should sign, ratify and domesticate the UN International *Covenant on the Protection of Migrant Workers and their Families.*
- Implementation of the *World Health Assembly Resolution 61.17 on Migrants Health* should be promoted.
- Relevant national line departments or ministries should facilitate policies that address HIV prevention for the construction sector, and offer HIV-prevention services to both construction workers and the communities with whom they interact.
- Government should explore ways to extend legislation and better regulate workplace programs to ensure that all employers (large, medium and small-scale) provide access to HIV-prevention services to all employees, including casual workers.
- Government should enforce greater regulation and provide incentives for construction project clients to implement workplace policies and/or provide HIV services and programs on construction sites.

*Awareness Raising and Information Dissemination:*

- An evidence-based behavior and social change communication (BCC/SCC) strategy with appropriate communication messages and materials that are linguistically and culturally appropriate should be developed and implemented.

*Programs and Services:*

- In cases where local healthcare services do not exist or are difficult to access, on-site or mobile health services should be provided and made accessible for all construction workers, regardless of their contractual employment status or nationality, as well as to members of the local community. In addition, employers should distribute HIV and AIDS education materials and condoms regularly.
- The client, as the owner of the construction project (and thus the ultimate employer), should take responsibility for the basic health and safety of all workers on site. This includes provision of HIV-prevention services and programs, regardless of the nature of the employment contract under which an individual worker is employed.

- All new construction projects should conduct a Social Impact Assessment prior to commencement of the project to examine how a proposed construction development would affect the social dynamics of nearby communities in the short and long term. Such assessment should include the factors that increase disease around construction sites, including the spread of HIV.
- The client and employers should engage actively with the local communities before and during the implementation of the construction project, to implement education programs on STIs for local community residents, including HIV, safe sex and other reproductive health issues, targeting local commercial sex workers in particular.

*Research:*

- More research should be conducted on the various determinants of HIV among construction workers, and the sedentary population with whom they interact. Such research may assess the nature of sexual networks and the level of concurrent sexual partnerships that exist at construction sites.

*Others:*

- Governments should improve and expand statistical data collection on migration, disaggregated by age, sex and country of origin.
- Donors should strive to harmonize their funding strategies in the area of migration and HIV.

# 2. HIV Vulnerability in the Construction Sector in Southern Africa

## 2.1 The Construction Sector in Southern Africa

The construction sector in southern Africa has boomed over the years with large numbers of semi and unskilled workers gaining employment. For example, South Africa's construction industry has undergone dramatic growth since the early 2000s, when there were only some 520,000 workers employed in both formal and informal positions in the sector (CIDB, 2004). By mid-2009, the sector had more than doubled, employing over 1.1 million workers, or 8.3% of the country's workforce (Statistics South Africa, 2009). This was due to the fact that the industry has enjoyed double-digit growth since 2004 as a result of the Government's R416 billion (approximately USD 54 billion) infrastructure program and the R15 billion (approximately USD 1.95 billion) spent on preparations for the FIFA 2010 World Cup (SouthAfrica.info, June 1, 2007).

Another example is Angola, where the Government has prioritized the rehabilitation of the country's infrastructure in general and the road transport in particular. Since 2002, the Government has been undertaking several emergency programs to repair the principal roads, construct new bridges, rehabilitate the

oldest ones and connect key provinces to the main roads. This process has also included a huge effort in de-mining important roads.

The construction sector has a large number of semi-skilled and unskilled workers, who are primarily males between the ages of 18 and 35. Most construction projects are once-off projects, meaning that when the work is completed the workers move to a new project site or are laid off. Hence, there is an inherent migratory nature to construction, which means that the movement of labor, in terms of time and space, is relatively high compared to other industries. It also creates a process of circular migration whereby migrant workers return home once their job is completed, returning to job-sites only when new work is available.

While there is a growing tendency for construction companies to prioritize the use of locally available labor, there is still huge scope for foreign migrants to be employed in construction, especially through sub-contracting and labor brokering companies, on a casual basis. A recent shift towards informal employment in the sector and the increasing casualization of labor and use of sub-contractors has ensured that this is so (CIDB, 2004). Moreover, the likelihood is that such casual workers, if foreign, may be undocumented.

There are generally two different types of foreign migrant workers in the construction sector for whom different immigration laws apply. One category is comprised of skilled, managerial or technical staff that is 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 Southern African Development Community (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.

For example, many construction workers in South African cities come from neighboring countries such as Lesotho, Mozambique and Zimbabwe. Since South Africa's immigration regulations make it difficult to import workers legally from these countries, the construction companies tend to hire workers who are already in the country and who are often to be found congregating on street corners, seeking casual employment. In effect, this means that construction companies are major employers of undocumented or irregular migrants since many of these workers are undocumented (IOM/SAMP, 2005).

## 2.2 HIV Vulnerability among Construction Workers

In general construction workers lead a nomadic on-site lifestyle, sometimes in remote areas. Typically, they live in temporary accommodation away from families and support systems for long stretches of time, with few recreational facilities. They face difficult and dangerous working conditions, with risks of physical injuries, and thus they are preoccupied by immediate challenges of physical survival and financial need. Some workers in the construction sector in southern Africa come from as far away as China and elsewhere in South and South-East

Asia. Construction also has an impact on 'host communities', as a service industry develops around labor camps, which frequently involves sales of alcohol and transactional sex.

The *nature of work* of construction workers creates an environment that could increase risky sexual behavior. First, construction is one of the most dangerous lines of work, with a proportionately high number of job-related accidents and diseases. 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. Second, there is limited availability of recreational activities such as sports or entertainment at or around remote construction sites. While workers are distanced from traditional norms, culture and support systems that regulate behavior in stable communities, the feelings of boredom, loneliness and isolation can result in a disregard for health among construction workers. In addition, since construction sites are often located in or near underdeveloped areas with high levels of poverty, some members of the local community, especially poor women, may engage in transactional and commercial sex with construction workers who have disposable income.

In general, constructi**on 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.

Increasingly, there is a trend towards **subcontracting** in the construction sector in southern Africa. The tendency towards labor-only subcontracting on construction sites increases the HIV vulnerability of construction workers in two ways. 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 programs, 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.

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 behavior 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.

Lastly, in general, **knowledge** about HIV and STIs 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 behavior. Low perceptions of risk may result in low or incorrect condom use.

# 3. Policies Relevant to HIV in the Construction Sector in Southern Africa

In addition to the regional and national policies and legislation pertaining to migrant workers in general, mentioned in the Regional Report, this section reviews HIV policies for the construction sector in the countries of SADC. In all, not many SADC countries have specific policies addressing HIV in the construction sector.

***Angola:*** At the national level there are no specific policies addressing HIV in the construction sector. However, the Government is increasingly making private employers responsible for the health of their workers. The Decree No. 43/03 about HIV/AIDS, Employment and Professional Training (2003) makes employers responsible for HIV/AIDS activities and for the protection of the rights of employees living with HIV/AIDS. The Decree recommends that private companies educate employees as trainers and extension agents in order to organize periodic workshops and distribute condoms and informative materials about HIV/AIDS.

***South*** Africa: The Department of Public Works' HIV/AIDS Awareness Programme (2004) enforces the implementation of HIV/AIDS programs in the construction work it commissions: contracts exceeding a certain amount are obliged to incorporate HIV and AIDS awareness programs, and once contracts are granted, there are penalties for non-compliance. There is also the HIV/AIDS specification of the Construction Industry Development Board (CIDB) of South Africa (2003), which serves as a guideline for the contractual requirements for HIV and AIDS awareness programs. 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.

***Namibia:*** Workers in the construction sector employed by Government may benefit from the public sector workplace program, which is coordinated by the HIV unit in the office of the Prime Minister. There is no national construction-sector policy that may cover construction workers not employed by the Government.

***Malawi:*** The public-sector response to the AIDS epidemic in Malawi is guided by the National Public Service HIV/AIDS policy and the National HIV/AIDS workplace policy. There is no policy specifically targeting construction workers.

***Mozambique:*** The Government of Mozambique has undertaken action to promote HIV and AIDS workplace policies and programs by establishing the Unit for the Prevention and Fight against HIV/AIDS in the Workplace, comprised of the Ministry of Labour and representatives of the private sector and trade unions. There is no policy specifically targeting construction workers.

***Swaziland:*** The Ministry of Public Service and Information coordinates the public-sector response to the HIV and AIDS pandemic, with a workplace policy developed in 2004. There is no policy specifically targeting construction workers.

***Zambia:*** The National HIV/AIDS/STI/TB Policy (2005) provides a framework for specific sectoral responses to AIDS, including construction workers. However, there is no specific policy targeting construction workers at this point.

# 4. Assessment Findings

## 4.1 Sector-specific Vulnerabilities

Based on the field findings, the following factors make workers vulnerable to HIV in the commercial agriculture sector:

| | |
|---|---|
| ***Nomadic lifestyle*** | Construction workers typically live a nomadic and isolated lifestyle as they move from site to site. Many migrant construction workers are young, unmarried men whose job makes them too mobile to have the chance to form permanent relationships with women. This puts them at risk of HIV since they tend to form short-term relationships at each construction site or use commercial sex workers to fulfill their sexual needs. |
| ***Dangerous working conditions*** | Construction is one of the most dangerous lines of work, with a proportionately high number of job-related accidents and diseases. 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. |
| ***Availability of sex*** | Construction sites may be located in isolated areas near impoverished local communities. 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.<br><br>Even for workers looking for piecework jobs within urban areas, there are risks brought about by the social environment in the townships where they live. Many local women engage in sex work and transactional sex, and they are reported deliberately to target foreign men for their money. Informants explained that the dress, attitude and sexual forwardness of such women are very different to their experience of women back home (in this case Zimbabwe), where cultural norms do not allow such forwardness. Because sex is cheap and always available, informants said that they found it very difficult to refuse such easy advances (one-on-one interviews in Cape Town, September 2009). |
| ***Limited access to healthcare services*** | In general, construction workers lack access to healthcare services because these services are either not available or accessible near the construction sites. In general, 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. 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.<br><br>Even in areas where healthcare services do exist, migrant workers may be reluctant to seek these 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 mistreated by health workers or even 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. |

| | |
|---|---|
| ***Casual contracts and sub-contracting practices*** | Increasingly, there is a trend towards labor-only subcontracting on construction sites, which increases the HIV vulnerability of construction workers in two ways. 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 programs, condoms and STI treatment as this might increase their costs and make them less competitive.<br>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 benefits. |
| ***Gender inequality*** | 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 behavior 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. |
| ***Low and inconsistent condom use*** | Construction workers tend to be poorly educated, with low levels of HIV and STI knowledge and various misconceptions about the disease. Even where education and information is relatively available, there seem to be various misconceptions about condom use, as are reflected in Angolan vernacular expressions such as, 'meat with meat' and 'banana must not be eaten with skin' (one-on-one interviews, Luanda, September 2009). |

## 4.2 HIV-prevention Services and Programs

This section, while not a comprehensive list, mentions the most well-known programs and services that specifically target migrants and mobile populations and their families in the construction sector. Overall, there are very few HIV-prevention services and programs targeting construction workers.

### *4.2.1 Regional Programs and Services*

The assessment found only one regional program addressing HIV vulnerability in the construction sector in southern Africa.

***International Organization for Migration (IOM): Partnership on HIV and Mobility in Southern Africa (PHAMSA)***

In order to reduce the HIV incidence and impact of AIDS among migrant and mobile workers and their families in southern Africa, IOM has been implementing the regional PHAMSA program since 2004. PHAMSA targets six sectors with high levels of migrant and mobile workers (commercial agriculture, construction, cross-border trade, maritime, mining and transport) and has four main program components: (1) advocacy for policy development; (2) research and learning; (3) regional coordination and technical cooperation; and (4) pilot projects.

Specifically in the construction sector, PHAMSA has been active in advocacy activities such as the development of the 'Regional Guidelines on HIV and AIDS for the Construction Sector in the SADC Region' (see Annex 1 for details).

### *4.2.2 National Programs and Services*

The assessment reviewed the construction sector in three countries: Angola, Mozambique and South Africa. In general there are very few specific interventions targeting construction workers, with notable exceptions in Mozambique's Association of Entrepreneurs against AIDS (EcoSida) and Health and Development in the Workplace (SEDE) programs.

## *Angola*

### ***Government:***

As mentioned in section 2, the Angolan Government has prioritized the rehabilitation of the country's infrastructure in general and the road transport in particular since 2002. However, despite this big push for construction projects, there are no specific government interventions, and very few private or NGO interventions addressing the HIV vulnerability of construction workers.

### ***Private Sector:***

- The Business Committee against AIDS (CEC: Comité Empresarial de Combate ao HIV/AIDS), launched in 2006, mobilizes the business community in curbing the spread of HIV and the impact of AIDS. Some of the key objectives include channeling private-sector resources and capabilities toward HIV prevention for both private sector employees and their families and communities, and providing a forum for companies to share their HIV/AIDS-related experiences and materials. Among the companies participating in this initiative there is Odebrecht, the only company from the Construction sector, which at present is the leading member of the Committee.
- Odebrecht (one of the largest construction firms in Angola, originally Brazilian) has a comprehensive workplace HIV-prevention program, which includes information dissemination, education/peer-education, awareness, training, access to condoms, safe blood donation, meetings, public events, VCT, treatments of tuberculosis and other infections, management of STIs, vertical transmission prevention (from mother to child), prevention and care services, and support systems for people living with HIV/AIDS.
- Smaller companies may provide free condoms as their only prevention intervention.

### ***Non-governmental Organizations:***

- **Population Services International (PSI)** educates sex workers and truckers on STIs and HIV prevention using interpersonal communication and through mass-media campaigns. To reach these populations, PSI works together with trained activists from 12 local NGOs. They also make condoms available using social marketing approaches. This program is located at border zones, transport routes, ports and urban centers. Although these interventions do not specifically target construction workers, they are not excluded if they seek the services.
- **OXFAM-GB** has an HIV-prevention project in four Angolan provinces: Benguela, Huambo, Bié, Moxico and the capital Luanda. The project, financed by the European Union, targets the youth in general, informal traders, sex workers and truck drivers. Again, although not specifically targeting construction workers, neither will they be specifically excluded.

## Mozambique

### *Government:*

The Mozambique Bill of Rights provides for the right to health, but limits its application to citizens. However, as no personal identification documentation is required to access healthcare, foreigners, including undocumented labor migrants, can access the basic public health services without problems. It is important to note that the Mozambique health system is under immense pressure, as there is a chronic lack of doctors and nurses in the country, with only an estimated 500 doctors practicing medicine in the country (Key informant interview, Maputo, September 2009). This impacts negatively on the HIV-prevention services available, including dissemination of information. In fact, the field research revealed that the internal migrants interviewed had a much lower knowledge about HIV/AIDS than the foreign migrants interviewed.

### *Private Sector:*

- **The Association of Entrepreneurs against AIDS (EcoSida)** is a private-sector initiative with the mission to fight HIV in the workplace, reducing the incidence and prevalence of AIDS among workers and their dependents, involving employees in the fight against the disease. It was founded by 23 companies and business associations, and currently has more than 40 member businesses (including a private construction company based in Maputo, CETA). It provides programming and services in the workplace and the larger community. However, the private-sector response tends to be somewhat workplace specific and while migrant workers are eligible and quite often do receive company-sponsored HIV education and services, this can be incidental to their work status and not as a part of systematic effort or targeting. As such, mobile populations and labor migrants often escape the reach of generalized workplace HIV programming when they return to their home communities.
- In Tete, the government has made HIV awareness-raising programs and medical assistance to mining communities mandatory for the 250 companies with mining licenses operating in the province; this also applies to construction and other industries. As a result most large companies have extensive and comprehensive HIV-prevention programs available to all staff including: IEC campaigns, time off for HIV testing, referral and follow-up service with government health centers, STI treatment, treatment of opportunistic infections and ART.

### *Non-governmental Organizations:*

- **SEDE (Health and Development in the Workplace)** is a Mozambican non-profit initiative that provides awareness and education in HIV prevention to organizations of all sizes in both the public and private sector. In 2008, more than half of SEDE's private-sector requests for services came from construction and related industries with mobile workforces and a high percentage of casual laborers. SEDE provides an integrated set of prevention activities rather than focusing on one area of HIV prevention. It offers workplace situation analysis and assessment, development of HIV-workplace policies and support, HIV training for managers and peer educators, IEC activities, HIV counseling and testing, condom distribution, care and support, monitoring and evaluation.

## *South Africa*

### *Government:*

In South Africa, public healthcare by law is free to all citizens and non-citizens. However, it has been well documented that migrants face a range of challenges in accessing even basic healthcare. Allegations of discrimination and xenophobic attitudes by healthcare staff ranked as one of the leading barriers to healthcare reported by migrants interviewed by Human Rights Watch (2009: 55). Even though the law states that no identity documentation is required, migrants are often asked for their identity documentation before they can be seen by a medical officer (FGD, Durban, August 2009).

As mentioned in the policy section, the Department of Public Works' HIV/AIDS Awareness Programme (2004) enforces the implementation of HIV/AIDS programs in the construction work it commissions, and the HIV/AIDS specification of the Construction Industry Development Board (CIDB) of South Africa (2003) serves as a guideline for the contractual requirements for HIV and AIDS awareness programs.

### *Private Sector*

- Workplace HIV programs are increasingly being implemented by bigger construction firms, especially as all construction contracts from the government now stipulate that the contractor must have one in place. Many firms are using the HIV service provider **CareWorks**, which implements a holistic program, including training of peer educators, condom provision, IEC materials, stigma reduction, VCT and managing ART for those who test positive. The approach is working well, with 55–80% of employees reporting for VCT.
- However, as construction companies and CareWorks staff concede, only permanent employees are included in workplace programs although some casual workers might access condoms, IEC materials or VCT on occasions. CareWorks refers temporary or casual workers to appropriate government or NGO services if they test positive in tests carried out by them. Another shortcoming of workplace HIV programs is that they do not cover the families of workers. Also, many sub-contractor firms and labor brokers still do not provide their workers with any health-related benefits since they are overwhelmingly casual.

### *Non-governmental Organizations:*

- **Population Service International** (PSI) has an HIV/AIDS program in South Africa, through which it provides VCT services (both fixed and mobile) in South Africa's three largest cities – Johannesburg, Durban and Cape Town – as well as some border towns, and distributes condoms to vulnerable groups including migrants.
- **Medecins Sans Frontières** (MSF) clinics in Musina and Johannesburg, both fixed and mobile, provide diagnostic services, including rapid testing for HIV, syphilis and malaria, primarily to Zimbabwean migrants, some of whom may work in the construction sector. Additionally, the clinics supply general curative services, care and psychological support to victims of abuse, and a special counseling program for unaccompanied minors, offering emotional, educational and psychological support to children.
- In Cape Town, the **Refugee HIV Awareness & Management Project** provides HIV-education workshops and counseling to migrants and refugees but refers people to public health facilities for HIV testing.
- The **Sonke Gender Justice Network**, through its Refugee Health and Rights project, targets both refugees and migrants with gender sensitization programs, and focuses on facilitating access to health services in Johannesburg and Cape Town.
- Another service, which does not primarily target migrants but which is available to them along with local beneficiaries, is the mobile clinic called the **Tutu Tester**, of the **Desmond Tutu HIV Foundation**.

# 5. Gaps, Challenges and Corresponding Recommendations

The following table summarizes the gaps and challenges identified during the assessment, and makes corresponding recommendations for future activities.

| Gaps/Challenges | Recommendations |
|---|---|
| ***Policies and Regional Coordination*** | |
| Limited legal protection for migrant and mobile workers, especially undocumented and/or casual construction workers. | • At the national level, all governments should sign, ratify and domesticate the UN International Covenant on the Protection of Migrant Workers and their Families. This would afford migrant and mobile workers increased legal protection such as better living and working conditions and access to health.<br>• Implementation of the World Health Assembly Resolution 61.17 on Migrants Health should be promoted (see Section 8 of the Regional Assessment Report). |
| Limited national policies addressing HIV for construction workers. | • Relevant national line departments or ministries should facilitate policies that address HIV prevention for the construction sector, and offer HIV-prevention services to both construction workers and the communities with whom they interact. |
| Limited workplace policies, particularly among smaller sized companies. | • Government should explore ways to extend legislation and better regulate workplace programs to ensure that all employers (large, medium and small-scale) provide access to HIV-prevention services to all employees, including casual workers.<br>• Government should enforce greater regulation and provide incentives for construction project clients to implement workplace policies and/or provide HIV services and programs on construction sites. |

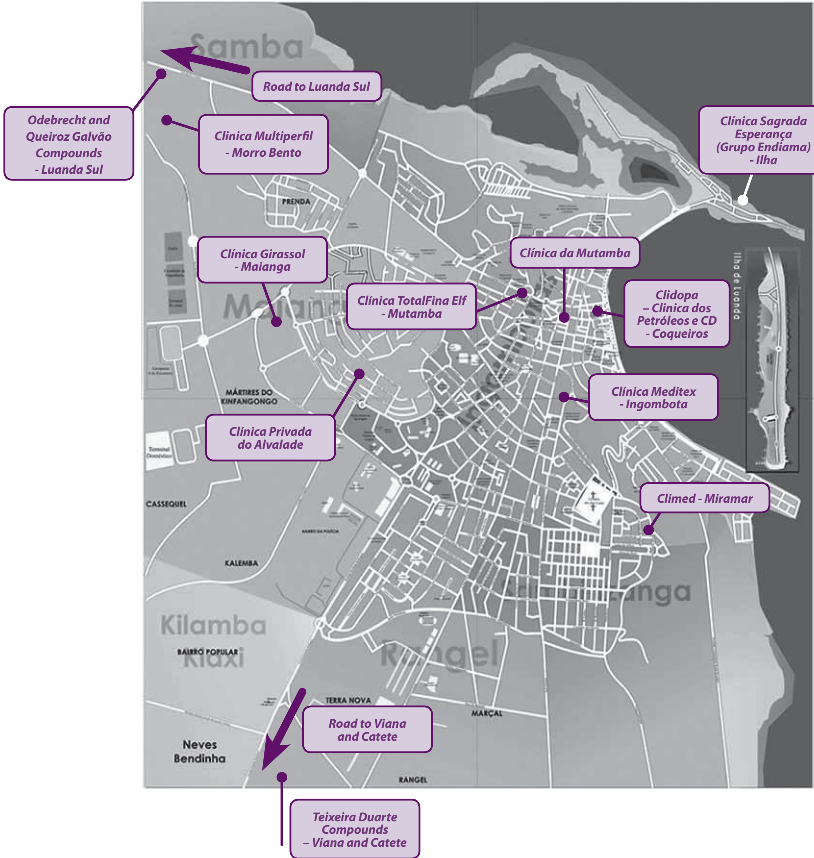
| ***Gaps/Challenges*** | ***Recommendations*** |
|---|---|
| ***Awareness Raising and Information Dissemination*** | |
| There is limited behavior and social change communication targeting construction workers, particularly those that are culturally and linguistically appropriate. | • An evidence-based behavior and social change communication (BCC/SCC) strategy with appropriate communication messages and materials that are linguistically and culturally appropriate should be developed and implemented. |
| ***Programs and Services*** | |
| Health and HIV services for construction workers are often limited in availability and accessibility for various reasons:<br>Construction workers are difficult to target for HIV programs and services due to their nomadic and isolated lifestyle as they move from site to site.<br>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.<br>Due to fear of losing their jobs or deportation, undocumented and/or casual construction workers may be reluctant to access services even if they are available. | • In cases where local healthcare services do not exist, on-site or mobile health services should be provided and made 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.<br>• In addition, employers should distribute HIV and AIDS education materials and condoms regularly.<br>• Such on-site services should be made a contractual requirement for every project, and be included as part of the budget. |
| The increasing trend towards labor-only subcontracting on construction sites increases the HIV vulnerability of construction workers in two ways: Sub-contracted construction companies (the direct employers of the workers) often claim that they have limited liabilities and obligations towards workers.<br>Targeting the full spectrum of those employed on a construction project becomes difficult when workers have different types of contracts, contract duration, remuneration, entitlement and benefits. | • The client, as the owner of the construction project (and thus the ultimate employer), should take responsibility for the basic health and safety of all workers on site. This includes provision of HIV-prevention services and programs, regardless of the nature of the employment contract under which an individual worker is employed. |

| *Gaps/Challenges* | *Recommendations* |
|---|---|
| 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. | • All new construction projects should conduct a Social Impact Assessments prior to commencement of the project to examine how a proposed construction development would affect the social dynamics of nearby communities in the short and long term. Such assessments should examine the factors that increase disease around construction sites, including the spread of HIV.<br>• The client and employers should engage actively with the local communities before and during the implementation of the construction project, to implement education programs on STIs for local community residents, including HIV, safe sex and other reproductive health issues, targeting local commercial sex workers in particular. |
| ***Research*** | |
| There is currently very little research on the sexual networks and the level of concurrent sexual partnerships that exist among construction workers and those they interact with. | • More research should be conducted on the various determinants of HIV among construction workers, and the sedentary populations with which they interact. Such research may assess the nature of sexual networks and the level of concurrent sexual partnerships that exist at construction sites. |
| ***Others*** | |
| Lack of statistical data: There is limited data on the dynamics of labor migration in the construction sector, particularly of undocumented and/or casual workers. | • Governments should improve and expand statistical data collection on migration, disaggregated by age, sex and country of origin, as well as the nature of mobility of construction workers. |
| Funding is identified by most role players as a challenge in reaching migrants. Most programs are funded year by year so there is no certainty or continuity of effort. | • Donors need to consider longer-term funding schemes (i.e. more than three years) for best-practice HIV programs that target migrant workers.<br>• Non-traditional funding sources (e.g. private sector) should be explored. |

# 6. Localized, Detailed Mapping of Services

The city of Luanda was chosen as the location for the mapping of health services for construction workers in Angola.

***Central Luanda: Private Clinics and Compounds of Construction Companies***



The four companies interviewed (Odebrech, Teixeira Duarte, Queiróz Galvão and Afribelg) have several construction sites around the country, and field visits were conducted to some of these sites in the outskirts of the capital city Luanda. In these sites they have built compounds where the foreign workers (and in some cases also national workers) live. The compounds are:

- Odebrecht – Luanda Sul
- Queiróz Galvão – Luanda Sul
- Teixeira Duarte – Viana and Catete

Out of the four companies interviewed only one (Odebrech, a Brazilian company) has a comprehensive HIV/AIDS program that includes VCT and safe blood donation campaigns inside the medical facilities of the company; peer educators; awareness-raising workshops; IEC materials for the employees; and a referral system for care and treatment. At Odebrecht, if a foreign worker is tested HIV positive, he or she may be referred to the country of origin for treatment, paid for by the health insurance to which each worker is entitled. The worker is entitled to continue working in Angola, and all bio-medical exams and treatment will be referred to Brazil.

The other companies (Teixeira Duarte, Queiróz Galvão and Afribelg) do not have HIV-workplace programs, preferring for their employees to seek information and guidance from private clinics, for which, depending on the individual's health insurance clauses, may or may not be covered.

There are nine main private clinics in Luanda that have agreements with construction companies. These clinics provide HIV testing and IEC materials, but not all have counseling and treatment services. These clinics are the following:

1 Clínica da Mutamba (Medigroup), Rua Pedro Felix Machado, 10-12, Luanda.

2 Clínica Girassol, Rua Comandante Gika, 255, Luanda.

3 Clínica Multiperfil, Rua do Futungo de Belas, Morro Bento, Luanda Sul.

4 Clínica Sagrada Esperança (Endiama), Av. Mortala Mohamed, Ilha de Luanda.

5 Clínica Privada do Alvalade, Rua Emílio M'Bidi, 20, Luanda.

6 Climed – Serviço de Saúde Lda, Alameda do Príncipe Real, 65-67 – Miramar, Luanda.

7 Clidopa Angola Lda – Clínica dos Petróleos e do Corpo Diplomático, Av. Rainha Ginga, 98–106, Coqueiros, Luanda.

8 Clínica Meditex, Rua Ramalho Ortigão 21, Luanda.

9 TotalFina Elf Aquitane Clinic, Rua Dr. Tome Agostinho Neves, Luanda.

# 7. Migrant Stories

Below are two stories of migrants working in the construction sector.

## Migrant Story: Malawian construction worker in Tete, Mozambique

Bright (not his real name) is a 30-year-old Malawian builder currently working in Tete, Mozambique. His wife and two children live in Mwanza, Malawi.

'In Malawi I faced many financial problems. There is little work for me there. I am a qualified builder, having studied at the Blantyre Technical College where I received my level 2 certificate. A Mozambican man came to visit Mwanza in Malawi and saw an office I had built. He liked my work and asked if I would be willing to come to work in Tete. I agreed. I arrived in July 2009. I am contracted to build a double-storey house to rent out to some of the workers who are arriving here. I have quoted a price of 65,000 meticais (USD2,300) to build the house. I did not know the value of the metical or how much local builders would charge. We are a team of 21 workers and the job is for just over two months. We were paid 15,000 meticais in advance and will receive the rest at the end of the job. We have no contract.

'I live with five other men in a three-roomed place in Bairro Primeiro de Maio. We have no water but there is sanitation. We are four Malawians and two Mozambicans. The place is okay and I feel safe to leave my things there.'

'We work long hours because we miss home and want to finish the job quickly. I have enjoyed the work and think if we do a good job we will be asked to build more places because our boss is a big Indian businessman in town and he is building many new houses. Next door is another house being built by Mozambicans. They are jealous of us and have tried to steal our wheelbarrows so we cannot work. The Mozambicans do not like us because we are better trained so we get more work. They say we are taking the jobs from their hands but they are lazy and do not like to work.'

'I do not have any papers. I did not know that I need a work permit. If I am to work here again I will need to find out about how to work here legally as I am not happy to do this illegally. I am a professional, not a migrant.'

'In Malawi an NGO called Banga la Nsokolo worked in our area and told us about HIV. I did a test and it was negative. I made a promise with my wife that we would be faithful to each other so that we will stay HIV negative. At the end of my work I come back to the house, take a shower and listen to the radio. I do not go to the bars and do not drink. I will celebrate when I go home in two weeks with my wife.'

'I do not know where there are any HIV services here in Tete and I have not heard anyone talk about HIV in Tete. I talk to the members of my work team that they must not go to the bars. No one has been unhealthy so we have not needed the health centre but I do not think it would be difficult to find. We would just ask our boss.'

'We Malawians do not forget why we are here. We are here to work hard and get money and then go home. I know many Malawians here and they are serious people. We are loved by our bosses because we are hard workers compared to Mozambicans who are lazy. I do not think we need any help with HIV and health. But a program that helped us get the right documentation would be helpful.'

*(One-on-one interview, Tete, Mozambique, September 2009)*

## *Migrant Story: Zimbabwean undocumented worker in South Africa*

Peter (not his real name) was born in southern Zimbabwe in 1986.

Having completed four years of high school, he could not find a job but stayed at his rural home growing vegetables and doing odd jobs. Since 2000 life was very tough in Zimbabwe due to the political and economic crisis.

After further social and economic problems associated with the violent elections in 2008, world-record hyperinflation, and the cholera outbreak, Peter decided to come to South Africa to find employment as an unskilled laborer in the construction sector.

Having no passport or visa, he decided to jump the border, which he did in February 2009 with a group of several other illegal immigrants. They passed through the border, bribing some South African police to let them through. They then took a taxi, but disembarked before Musina and went into the bush to avoid using the heavily patrolled main roads.

However, they were unaware that on the bush paths used by illegal immigrants lurk *Mgumagumas* – supposedly smugglers who assist people to cross the border illegally, but in reality groups of bandits who demand money from travelers in return for being allowed to pass unharmed. Most of the *Mgumagumas* are from Zimbabwe, reputedly with ex-soldiers among their ranks; they prey on their compatriots for a living.

While journeying, they met a woman whose breast had been sliced open, and a little further on, found the body of a dead man. 'It's rare to move around that area and not see a dead body', says Peter. Then, their group was accosted by the *Mgumagumas*, who demanded money from them. Having paid most of their money to the border guards, they did not have any to give the *Mgumagumas*, which angered them. One of the men in Peter's group was accompanied by his wife. According to Peter, the *Mgumagumas* gang raped her and then forced her husband to have sex with her while they watched.

Peter then tried to escape, but they chased him, hitting him with stones and cutting his back with a machete. When he fell down, they continued to beat him with branches, and took his shoes and trousers. Having got what they wanted, the *Mgumagumas* departed, leaving the group penniless and injured.

Luckily, some nearby villagers helped them by giving them food and clothes. Peter went to a hospital close to Thoyohandou where his wounds were treated. He says that the local hospitals are used to treating injured immigrants and did not ask for his papers or turn him away. He camped out in the bush for several weeks, doing odd jobs for local people until he was strong enough to travel again.

Peter heard of a construction job in Lephalale, building foundations, and he went there to earn some money. While there, the workers stayed in a construction camp, which he says was visited by sex workers every night. Having survived a near death experience crossing the border, he admits that HIV was not foremost in his thoughts. But the local bar did provide lots of condoms.

After a while, his cousin in Cape Town invited him to come and stay with him in Delft, an offer he accepted in the hope of finding more work. However, since arriving in the Cape, he has had very few work opportunities and is still looking for construction jobs every day.

*(One-on-one interview, Cape Town, South Africa, August 2009)*

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# Annex 1: IOM Regional Guidelines on HIV and AIDS for the Construction Sector in the SADC Region

The 'Regional Guidelines on HIV and AIDS for the Construction Sector in the SADC Region' (April 2007) was developed by IOM with the aim to: (1) highlight and raise the awareness of stakeholders in the sectors to the factors that increase HIV vulnerability among its workers; (2) provide stakeholders in the sectors with practical recommendations for action to address HIV vulnerability among their workers; (3) provide stakeholders with tools to advocate for HIV and AIDS programs and policies in the sectors; and (4) contribute to the development of regional/national policies on HIV and AIDS in the sectors 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, with support from the European Union (EU) Regional Funds, channeled through the SADC HIV and AIDS Unit.

The complete guidelines can be found on IOM's website (www.iom.org.za). The specific recommendations that were made in the Guidelines are summarized below.

| Recommendations | Stakeholders |
|---|---|
| ***Coordination, collaboration, dialogue and technical resource*** | |
| Strengthen the coordination and collaboration on social issues related to the construction sector among SADC member states: Since construction workers interact with communities in 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 program 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. | SADC Secretariat<br>Governments of SADC member states |
| 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. | SADC |
| Establish a focal point on migration: A focal point for migration should be established at the SADC Secretariat, focusing on issues related to labor 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. | SADC |

| ***Recommendations*** | ***Stakeholders*** |
|---|---|
| ***Policy development and implementation*** | |
| 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 labor 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.<br>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<br>Governments of SADC member states |
| 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' (SADC, 1996). However, while it facilitates the movement of goods and capital, the Trade Protocol ignores the movement of labor, which is likely to move within and across national boundaries as it follows capital. Thus, SADC should facilitate easier movement of labor in the region. | SADC<br>Governments of SADC member states |
| Actively advocate for the implementation of the SADC Protocol on Health: (SADC, 1999) According to the SADC Protocol on Health, policies should be harmonized to ensure 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. | SADC<br>Governments of SADC member states |
| Ratify international human rights treaties: National governments should ratify relevant international conventions on migrants' human rights, especially 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 (Migration for Employment). | Governments of SADC member states |
| Include migration-related issues in the national AIDS response: National AIDS councils and ministries of health should advocate for the inclusion of policies and programs for reducing the HIV vulnerability of migrant construction workers in national multi-sectoral AIDS response strategies. Also, national departments of public works should develop sector strategies and policies addressing HIV vulnerability in the construction sector. | Governments of SADC member states |
| ***Social impact assessment*** | |
| Ensure inclusion of a Social Impact Assessment (SIA) in all new construction projects: An 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. | The Client |

| Recommendations | Stakeholders |
|---|---|
| ***Rural development and local community development*** | |
| 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 programs. 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. In this way, men would not have to migrate in search for work and could work near their families. Also, the levels of transactional and commercial sex would be reduced if there were alternative channels of income. | Governments of SADC member states |
| 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 programs 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 labor on projects if possible. | The Client<br>Employers |
| ***Health and safety*** | |
| Adhere to Occupational Health and Safety (OHS) standards:<br>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. | Governments of SADC member states |
| The Client and employers should promote, monitor and strictly enforce adherence to OHS standards and labor 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. | The Client<br>Employers |
| 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. | Trade unions |

| ***Recommendations*** | ***Stakeholders*** |
|---|---|
| **Provide health services:**<br>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.<br>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.<br>Trade unions should advocate/lobby with employers that comprehensive healthcare services, including free treatment of STIs, are available at construction sites and that the highest standards of confidentiality are respected and protected. Nearby NGOs, CBOs and other service providers could be contracted to provide this service. | The Client<br>Employers<br><br>Trade unions |
| Develop and implement HIV and AIDS workplace policies and programs:<br>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.<br>Trade unions should more actively encourage the development of workplace HIV and AIDS policies and programs. The ILO Code of Practice on HIV/AIDS and the World of Work (ILO, 2001) should be considered as a useful tool to integrate HIV in the workplace. | Employers<br><br>Trade unions |
| 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 labor standards in this regard should be enforced. Further, a credible complaints procedure/ mechanism accessible to all workers should be established. | The Client<br>Employers |
| ***Employment practices*** | |
| Set and monitor employment practices in the construction sector: Although the economic rationale for subcontracting and/or labor-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 labor: In some SADC member states there are already requirements for certain public works projects to utilize local labor for a percentage of their unskilled and semi-skilled labor 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 |

| ***Recommendations*** | ***Stakeholders*** |
|---|---|
| Review employment mechanisms: As already indicated, there has been a move towards subcontracting, arguably in an effort to circumvent direct compliance with existing labor 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 programs: 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 should be finalized, adopted and implemented after the necessary input and consultation by member states. It is also recommended that HIV and AIDS be mainstreamed in the SADC Declaration on Gender and Development (1997) 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), 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 |

| ***Recommendations*** | ***Stakeholders*** |
| --- | --- |
| Promote safer sexual practices: Governments should put in place policies and programs 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 |
| ***Migrants' rights*** | |
| 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 recognize that human rights, including socio-economic rights and specific health-related rights, apply to all persons – migrants, refugees and other non-nationals. 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. Foreigners (legal or irregular) should therefore have access to health services, including STI treatment, VCT and HIV/AIDS prevention and care programs, indiscriminately. | Governments of SADC member states<br>The Client<br>Employers |
| **Engage in education and awareness programs:**<br>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.<br>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.<br>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' labor and human rights with the aim of mitigating xenophobia and discriminatory practices towards migrant workers. | Governments of SADC member states<br><br>Trade unions |

# *Notes*