Construction industry has its own AIDS problems

HIV/AIDS is a problem for all South African companies, but handling the disease cannot be based on a 'one-size-fits-all' approach. Each industrial sector has particular features that shape possible responses. **David Dickinson** and **Marije Versteeg** examine how the construction industry is dealing with HIV/AIDS.

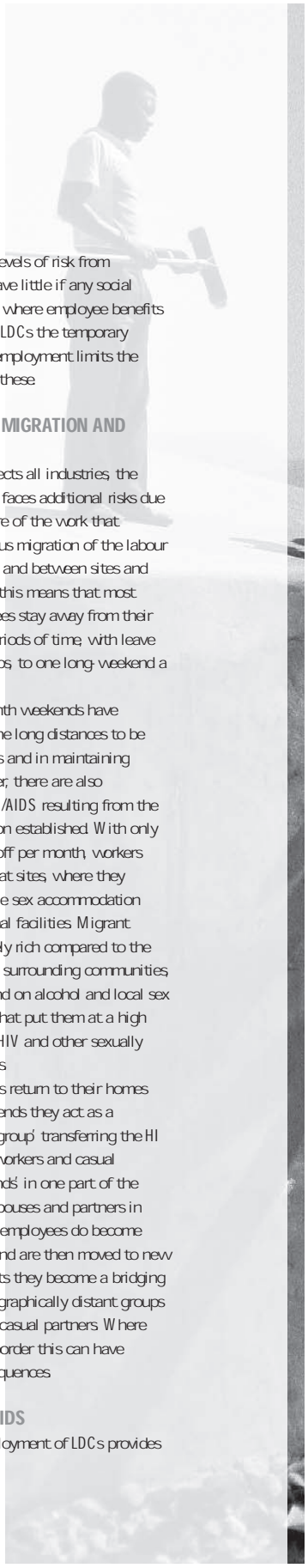
With a contribution to GDP of 2.9% and more than 730 000 people employed in 2002, the construction industry makes an important contribution to the South African economy. After two decades of decline, activity in the building industry is expected to increase again from R25bn per annum to between R32bn and R35bn by 2010.

There is a constant fluctuation of labour demand with peak employment during the actual implementation of projects. This requires a highly mobile and flexible workforce that can be quickly recruited and employed. Sites are spread across the country and in other countries or 'cross-border' projects. As a result, permanent or 'core' employees are moved between construction sites as required.

There are two categories of core employees. Higher skilled employees, such as site managers, engineers, and senior foremen are 'salaried', while semi-skilled employees such as shutter-hands, bricklayers, and truck drivers are hourly-paid. Companies complement permanent employees with low skilled labour from communities near construction sites. The employment of local, temporary workers or 'limited duration contracts' (LDCs) is generally determined by tender requirements. LDCs can amount to up to 70% of the total workforce on site. Most of the permanent staff and LDCs are men and there is a dominance of white males in the higher-skilled job levels.

PREVALENCE IN INDUSTRY

There is little hard evidence on how prevalent HIV/AIDS is within the construction industry.



Where companies send workers to other African countries they are required to provide evidence that workers are HIV-negative. The screening of workers for such cross-border contracts has provided direct evidence of HIV infection among permanent employees. The actual prevalence of HIV/AIDS is likely to vary between different sections of the workforce, but, as we outline in this article, there are risk factors associated with the construction industry that are likely to increase HIV prevalence rates.

HIV/AIDS poses three key risks to the sustainability of the labour force in any industry: destruction of the skills base, increased absenteeism, and the threat to employee benefits or 'social protection'.

While LDCs are easy to recruit and require only limited training, there is a shortage of more skilled workers such as equipment operators. This shortage stems from a range of reasons, including insufficient training and the reluctance of more educated young people to join the construction industry, given the unpleasant work with long periods away from home. AIDS will further impact on this skills shortage. The problem is made worse by the aging nature of the workforce. Given high rates of HIV prevalence among young people, the need to recruit and train large numbers of young people over coming years presents particular risks to the industry's skills base.

At head office level, management identified a rise in absenteeism that was presumed to be HIV/AIDS related. At site level there were a range of views. Some managers were not aware of a rise in absenteeism, but did confirm the rise in death statistics. This may be explained by a 'work-till-you-die' phenomenon among HIV-infected workers, especially LDCs, but also hourly-paid employees. It is believed that fear of job loss, with five days of absence in a row, and in some cases less, considered 'desertion', makes LDCs reluctant to take sick leave. Rather they continue working until, too sick to continue, and then 'disappear'. As one site manager explained: 'I have seen quite a few people dying here of HIV/AIDS... They don't exhaust their sick leave. They just stop showing up [from] one day to the other and then [we] hear one or two days later that the person has passed away.'

EMPLOYEE BENEFITS

A three-tier system of employee benefits – that provides social protection for illness, incapacity and retirement – exists within the construction industry. The tiers of social protection result from different benefit provision in the form of health care, insurance and other benefits provided to the three main categories of employees: salaried and hourly-paid permanent employees and LDCs.

When people are infected with HIV the level of social protection available is critical. Access to antiretroviral drugs means effective treatment that can enable employees to continue working and supporting their families. Until the government roll-out programme has advanced, few workers will be able to access these drugs unless they have medical aid cover or the company introduces a special programme. When workers are incapacitated or die insurance, in the form of provident or pension schemes, provides some income for them and their families.

There are two important questions regarding HIV/AIDS and employee benefits. First, which employees have access to these benefits and are they sufficient to meet their needs? Second, will the scale of the HIV/AIDS epidemic overwhelm employee benefit schemes by increasing costs to an extent that they are no longer viable?

In the construction industry we can make the following generalisations:

- Salaried employees are at relatively low risk from HIV/AIDS, but have the strongest social protection in terms of medical aid and pension funds.
- Hourly-paid employees face higher levels of risk from HIV/AIDS, but have only limited social protection. Most cannot afford the costs of medical aid. While membership of provident funds is widespread, these schemes are under threat because of increased deaths among younger workers (who have contributed less to the schemes but are still entitled to benefits).
- LDCs face high levels of risk from HIV/AIDS, but have little if any social protection. Even where employee benefits are provided for LDCs the temporary nature of their employment limits the effectiveness of these.

CONSTRUCTION, MIGRATION AND HIV/AIDS

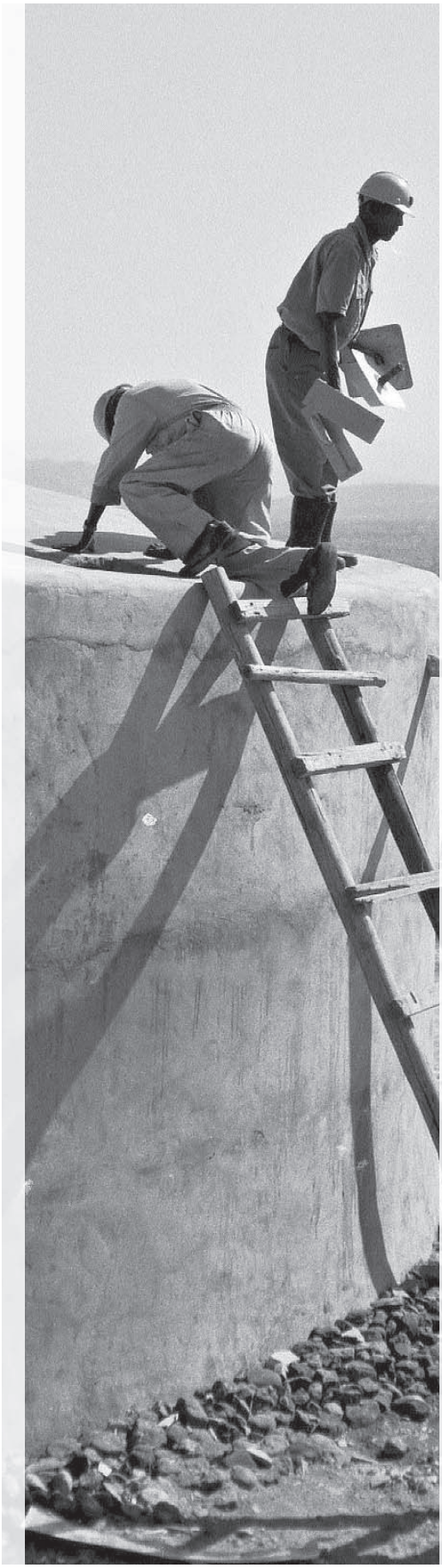
While HIV/AIDS affects all industries, the construction sector faces additional risks due to the project nature of the work that requires a continuous migration of the labour force between sites and between sites and homes. In practise, this means that most permanent employees stay away from their families for long periods of time, with leave restricted during jobs, to one long weekend a month.

The once-a-month weekends have advantages given the long distances to be travelled by workers and in maintaining production. However, there are also implications for HIV/AIDS resulting from the patterns of migration established. With only one long weekend off per month, workers spend long periods at sites, where they usually stay in single sex accommodation with few recreational facilities. Migrant workers are relatively rich compared to the often-impoverished surrounding communities, with money to spend on alcohol and local sex workers, activities that put them at a high risk of infection of HIV and other sexually transmitted diseases.

When employees return to their homes over the long weekends they act as a potential 'bridging group' transferring the HI virus between sex workers and casual partners or 'girlfriends' in one part of the country and their spouses and partners in other areas. Where employees do become infected with HIV and are then moved to new construction projects they become a bridging group between geographically distant groups of sex workers and casual partners. Where projects are cross-border this can have international consequences.

LDCS AND HIV/AIDS

The temporary employment of LDCs provides



much needed employment and some employment is better than none. Nevertheless, such employment provides no long-term prospects for the vast majority of employees.

The use of LDCs has many advantages for the industry as they provide a highly flexible workforce. LDCs can be easily laid off if no longer needed and are easily replaceable in case of unsatisfactory performance or absenteeism. Local labour is cheap and few benefits are offered. There are no costs of transport and accommodation. As a construction site-manager explained: 'It [LDC labour] is cheaper and they are easier to discharge.'

LDCs receive some training to prepare them for basic construction tasks. Training LDCs also helps 'succession planning' in identifying employees who can, if suitable, be promoted to permanent employment in the company. In addition, it can be used by the company as a corporate responsibility output, as the training leaves communities with better skilled workers. However, training sometimes meets with resistance by site managers, whose primary objective is to quickly start the work in order to meet the often-tight timeframes.

Without doubt HIV/AIDS is prevalent in local communities and among LDCs. However, this does not appear to be of major concern to companies. Managers admitted that they '...have no idea what is going on [regarding LDCs and HIV/AIDS]' and do not see it as a problem. Unionisation at local sites is often weak, especially on the matter of HIV/AIDS, and LDCs who usually have limited education may not know their rights. For instance, whereas LDCs are by law entitled to the same amount of sick leave as permanent employees, this works out differently in practise. It seems site managers can to a large extent determine their own 'rules'. While this system of locally recruited LDC labour allows the construction industry to avoid some of the risks of HIV/AIDS these are now shifted to society as a whole.

COMPANY RESPONSES AND LESSONS LEARNT

The nature of the construction industry presents considerable problems in mounting a comprehensive HIV/AIDS workplace programme. Unlike a 'normal' company, the construction industry deals with a constantly changing workforce of LDCs working on short-term contracts and permanent employees who move between projects. To be effective, HIV/AIDS programmes need to be repeated regularly. It is also logistically challenging, with projects in rural, often isolated, areas that have few facilities. These difficulties relate to all facets of HIV/AIDS workplace programmes including awareness and education, voluntary counselling and testing, treatment and community initiatives.

The two companies that we researched were in the early stages of mounting large-scale responses to HIV/AIDS. These were still limited in scope with, for example, no provision of antiretroviral drugs for employees without medical aid. It is likely that these programmes will continue to be stepped up, especially if there is greater union attention.

Any response to HIV/AIDS at work is to be welcomed, but we should take note of important lessons that the construction industry illustrates.

There are vast inequalities between people in employment that is reflected in the level of social protection they enjoy. This differentiates the risk posed by HIV/AIDS: Some face little risk, others face the destruction of hard won employee benefit schemes, while still others have almost no social protection with individuals and their families left to carry the burden.

The nature of the construction industry sets up migrant labour patterns that increase the risk of workers becoming infected with HIV/AIDS and helps spread the epidemic. Construction work will always involve the need for migrant and temporary workforces. However, it is clear that there is much that could be done to improve how this is organised for the benefit of workers and society as a whole.

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Dickinson is senior lecturer in industrial relations at Wits Business School. Versteeg is a social science researcher at the Madibeng Centre for Research.