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Social and cultural determinants of the spread of HIV/AIDS, STIs and gender based violence in high risk areas: A case of road construction sites in Tanzania

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Abstract

High mobility of sexually active population continues to be a risky factor for the spread of STIs and HIV, both in the source and destination sites. This paper analyses the social and cultural determinants for the spread of STIs and HIV along road construction sites which harbour a number of migrant workers from rural and urban areas. The study adopted a cross-sectional study design, using a structured questionnaire for respondents, a checklist for key informants and a guide for focus group discussants. A total of 308 respondents, including eighteen key informants and 20 focus group discussions were involved. Descriptive statistical analysis was employed for quantitative data whereas ethnographic content analysis was used for qualitative data. It was found that the level of knowledge about HIV/AIDS, how the disease spreads and the prevention methods was generally high. However, a corresponding change in sexual behavioural response was low. Many respondents still practise risky sexual behaviour, have many sexual partners and are inconsistent in using condoms. Some misconception about HIV/AIDS spread were also found. Also, there are many incidences of gender based violence which are under reported. Social and cultural factors responsible for the spread of HIV/AIDS include low risk perception and marital instability. It is recommended to the government and NGOs to involve and support local organizations for capacity building against HIV.

Keywords: Four to eight keywords come here. Divide the keywords by semicolon.

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1. Introduction

High mobility of sexually active population is a risky factor for the spread of Human Immunodeficiency Virus (HIV) across the globe. Construction projects invariably involve many transient male workers (ADB, 2014). These workers are away from their families and the social norms applicable to their home communities, hence facing the challenges of adopting new life styles. Many of these workers have few things to spend money on other than entertainment in the form of alcohol and sex. However, most of the construction sites and camps do not have adequate people to provide the needed sexual pleasures. In some places, high demand for sex among construction company workers is an opportunity for commercial sex workers who follow different construction companies from one site to another, thus increasing the risk of contracting and spreading of the HIV. However, most of the host communities where road construction activities are conducted are ill prepared to cope with social and cultural interactions brought by these migrant workers. According to ADB (2014), there is a rapid growth in the sex trade along new road construction sites during construction as well as post-construction periods. This poses a high risk to sexually transmitted diseases, including HIV/AIDS, given the fact that heterosexual contact is the primary means of HIV transmission in the sub-Saharan countries, including Tanzania (TACAIDS, 2013; NBS and ICF Macro, 2011).

The road construction sector attracts a large number of migrant workers from rural areas both within a region and between regions. It is well documented that knowledge about HIV differs markedly in rural and urban areas, with urban areas dwellers being better than their rural dwellers counterparts (TACAIDS, 2011). Evidence from literature shows that the vulnerability of construction workers to HIV/AIDS is ever increasing (ILO, 2007; Akinola et al., 2013; ADB, 2014). For example, an ILO Report in 2007 listed a number of work and lifestyle factors which expose workers to the risk of HIV and STI infection. A number of these factors apply to road construction workers, depending upon their working situations: high mobility, isolation and working in confined environments with limited contacts, being very young adults within the sexually active age group, access to and ready availability of sex workers, and inadequate access to HIV and STI preventive health services (ADB, 2014). High mobility especially among youth has also been frequently cited (Kanda et al., 2009) to be among the risk factors for contracting HIV/AIDS.

In the Tanzanian context, as it is in many developing countries, a significant proportion of workers are migrants from rural areas or different regions from where the construction sites are carried out. These workers join construction companies which are usually isolated construction sites and or camps; they are usually not accompanied by their families, and they do not have time to visit their families and spouses regularly. Hence, they are at the risk of engaging in sexual relationships with casual partners. Migrant workers in road construction companies are most likely to carry the infection and pass on to others at their source communities and others along their migratory route. Though the work of road construction tends to be predominantly a male occupation, there are significant numbers of women engaged in road construction in some parts of Tanzania, where they usually work as fulltime or part time employees. Women road workers are especially vulnerable to harassment and violence on isolated sites, and where the work site is also their home, it is almost impossible for them to have privacy.

Migratory movements have also been reported to carry some benefits to the host communities. On one hand, their presence helps in addressing sub-regional poverty by enabling people to move and exploit new opportunities while travelling along the migration routes. This is an essential requirement for the socio-economic development of regions (Srivastava and Sutradhar, 2016). On the other hand, the presences of such migratory movements offer opportunities for faster transmission of HIV/AIDS and other communicable infections within one region and across the borders of regions. In the context of road and transport sector projects, some groups are at a high risk, during construction and/or after project completion (Barker and Ricardo, 2006; Bowen et al., 2018). These groups include migrant workers (construction personnel, truck drivers) and people ready to provide them with services (formal and informal commercial sex workers (CSWs) and food and other service providers). Men, women, and youth in communities around construction sites and along transport corridors and the wives/husbands/partners in the home communities of migrant workers are vulnerable due to their partners' high-risk behaviours while away from home (Bowen et al., 2018). In workplaces, as it is for the road construction sites, it is a requirement that there should an educating programme to sensitization workers against the risk of HIV/AIDS and other communicable diseases (Bowen et al., 2014). The knowledge acquired by the migratory workers as well as surrounding communities is sometimes inadequate or the practices towards prevention of recommended sexual behaviour is usually inadequate. This paper analyzed the knowledge, risk perception and practices towards HIV/AIDS along the Tunduru-Mangaka-Mtambaswala and Dodoma-Babati-Bonga road construction sites. The paper is based on baseline survey data for project which focused on awareness creation against HIV, TB and STI prevention and interventions for host communities that could be implemented with road construction projects. The project focused on educational and behavioural change communication campaigns among migrant labourers and local residents in communities where road construction activities were being undertaken.

2. Methodology

The study from which this paper is based was conducted in Tanzania, specifically at Tunduru-Mangaka-Mtambaswala road construction sites, in Tunduru and Namtumbo Districts of Ruvuma and Mtwara regions, respectively. Other construction sites were those found along Dodoma-Babati-Bonga highway, in Dodoma and Manyara Districts of Dodoma and Manyara Regions, respectively. The districts for the study were purposively selected as main road construction projects were being implemented to upgrade the gravel and mud roads to tarmac roads. These road construction activities attracted many workers, including casual labourers and food vendors from nearby villages and other areas of Tanzania. Others migrants were road contractors who came from different countries, including China. Several temporary and permanent road construction campsites were established, hence a good case for survey and analysis of the phenomena.

Villages and small towns as well as emerging local trade centres were purposively selected on presumption that they were high transmission areas for HIV/AIDS due to higher influx of migrants who came to seek for employment opportunities in road construction activities. The selection of the sites was guided by

the district HIV/AIDS coordinators and District Community Development Officers (DCDOs) who had a broad experience of the social and cultural dynamics of the areas. From the list of small towns and villages, 12 villages/towns were randomly selected. Six villages/small towns were purposively selected in each construction line. In each village or small town, a total of 30 households were selected using the principle of simple random selection. A total of 360 respondents did participate in the study. However, after data cleaning, a total of 308 questionnaire copies qualified for data analysis. This was equivalent to the response rate of 85% which was considered adequate for both analysis and inference making to the population. The estimation of the sample was based on the guidance by Bailey (1998) that, for any particular population, a subsample of 30 respondents is enough to make statistical analysis and statistical inference for that particular population. A structured questionnaire was the main tool for data collection, and key informant interviews and focus group discussions were used to collect qualitative data that were used to compliment information collected through the structured questionnaire. A total of 20 focus group discussions and 18 key informants' interviews were conducted during the survey. The FGDs were organized for different socio-demographic characteristics, including the youth, men, women and the mixed groups of men and women.

Qualitative data were analysed using ethnographic content analysis technique which involved transcribing the information collected from focus group discussions and key informant interviews to generate and compare key themes and issues emerging from the discussions. Quantitative data, collected using the questionnaire, were analysed with the aid of Statistical Package for Social Sciences (SPSS) computer software, commonly used to analyse socio-economic data. Descriptive statistical analysis such as frequency and cross-tabulations with chi-square analysis was employed to gauge and compare the characteristics and distribution of the socioeconomic characteristics and key study variables.

3. Findings and discussion

3.1. The incidence and perception HIV/AIDS in the study areas

The survey revealed that the prevalence of HIV/AIDS in the surveyed Regions and Districts were below the national average which is 5.2% (TACAIDS, 2013). For example, in Mtwara Region, the HIV prevalence was relatively low (3.6 %). Generally, there has been a down spiral trend from 3.8% in 2009 to 2.6% in 2013. In Ruvuma Region, the average HIV prevalence was 7.0%, which is above the national average. In Dodoma and Manyara Regions, the prevalence was 2.9% and 1.6. % respectively (TACAIDS et al., 2014). Nevertheless, while the general district trend shows low incidence of HIV cases, the distribution of the cases is not uniform. Some areas have higher levels of HIV/AIDS incidences than the respective district, regional and national levels. As compared to the national average, the HIV prevalence in the country stands at 5.1% among people aged 15-49 years. HIV prevalence is higher among women (6.2%) than men (3.8%). According to URT (2013), HIV prevalence estimates indicate that HIV prevalence has declined slightly from 5.7% to 5.1% among adults aged 15-49. Similarly, HIV prevalence has declined among women (i.e. from 6.6% to 6.2%) and men (i.e. from 4.6% to 3.8%). HIV prevalence is higher in urban areas for both women and men than in rural areas. The increased HIV/AIDS prevalence in some areas is associated with increased interactions between local and

immigrants who are pulled by different socio-economic reasons, including seeking for employment opportunities in construction projects. During FGD in Nanyumbu District, the association between an influx of migrants and incidence of HIV/AIDS was confirmed. For example, one of the members of a focus group discussion had this to say:

"...in our area the incidence of HIV/AIDS is attributable to military operation in the area (1987/1988) ... and construction of UMOJA Bridge (2005) whereby we received many migrants and people started developing unusual disease symptoms which were later confirmed to be HIV/AIDS... this new road construction (Mangaka Mtambaswala, 2014) is more likely to bring more HIV/AIDS in our area..." (Male FGD- Mtambaswala).

In the same vein, the participants, in another focus group discussion, admitted that the influx of migrants into their area for different reasons was the cause of spread of STIs and HIV/AIDS in the area: This was particularly evident as one of the participants stated as follows:

"...between 2011-2014 we received many people from other areas who came for mining activities, timber and logs business... since then, sexual behaviours in our villages have changed drastically.... young girls from other places have come to our village and have no other business apart from selling their bodies.....many sexually transmitted diseases now have become a serious problem..." (Mixed FGD- Chipuputa Village).

The situation of interaction between the native population and the immigrants could increase the risks of HIV infections in cases where condom use was generally low or ignored during sexual intercourse. Similarly, at the Dodoma-Babati construction site the practices were not different. For example, the information collected from the dispensaries and Health centres revealed that there was a sharp increase in the incidence of STI and HIV/AIDS which was attributable to the influx of migrants, following the construction of the Dodoma-Babati road. A discussion with a key informant further confirmed this observation:

"...the government and NGOs have big campaigns educating the youth of reproductive age, spouses and partners on practising safe sex, including barrier methods such as condom use; yet there are many new cases which are related to STIs and HIV/AIDS in the recent past. This is probably due to this road construction activities..." (Clinical Officer, Hanet Village-Chamwino District).

These findings reveal that there is high association between HIV and STIs incidences and influx of migrants in construction areas which may fuel HIV transmission through practising risky sexual behaviours. Similar trends have also been reported by scholars, including Kanda et al. (2009) who reported that construction workers in Asian countries, despite having higher levels of knowledge on HIV/AIDS, were facing risk of contracting HIV due to their risky sexual behaviour and practices.

3.2. Level of knowledge about HIV/AIDS

This study found that the level of knowledge about HIV/AIDS was generally high (Table 1). All the respondents in Tunduru-Mangaka-Mtambaswala had heard of the disease. The vast majority of surveyed respondents (90%) knew that people infected with HIV do not necessarily show symptoms of infection. Sex-wise, 88.8% of women and 95.1% of men knew that a healthy-looking person can have the virus that causes AIDS. This implies that there is a minimal difference by sex in the level of knowledge as found on the major misconceptions about HIV transmission. More than four-fifths (81%) of all respondents understood that the AIDS virus cannot be transmitted by mosquito bites, and 86.1% of respondents knew that a person cannot become infected with the AIDS virus by sharing food with a person who has AIDS. The majority of respondents (82.1%) also knew that one cannot get HIV virus by casual contacts such as hugging. The majority of respondents who participated in this study had also tested to know their HIV/AIDS status or knew where the services could be found. Many respondents also revealed correct measures to reduce further spread of HIV/AIDS such as correct and consistent use of condoms (79.7%), abstinence (not having sexual intercourse at all) (67.4%) and having just one uninfected sexual partner who has no HIV/AIDS (87.5%). The findings of this study can be compared with those commonly reported in Tanzania. For example, in the Tanzania HIV/AIDS and Malaria Indicator Survey (2011/12) it was found that Knowledge of AIDS is almost universal, with almost 100% of the respondents having heard of AIDS. There is a widespread knowledge of HIV/AIDS prevention methods. Sixty-nine percent of women and 77% of men knew that a person's risk of getting the AIDS virus can be reduced by using condom (TACAIDS et al., 2013).

Table 1. Level of Knowledge about HIV/AIDS (n = 308)

| SN | Variable/Statement | Tunduru-Mangaka-Mtambaswala (%) | Dodoma-Babati-Bonga (%) | All (%) |
|----|--|---------------------------------|-------------------------|---------|
| 1 | Have you ever heard of an illness called AIDS? | | | |
| | Yes | 100 | 79.1 | 89.5 |
| | No | 0 | 20.9 | 10.5 |
| 2 | Can people reduce their chances of HIV/AIDS by having just one uninfected sex partner who has no HIV/AIDS? | | | |
| | Yes | 91.5 | 83.4 | 87.5 |
| | No | 4.6 | 16.6 | 10.5 |
| | Don't know | 3.9 | 0 | 2.0 |
| 4 | Can people get HIV/AIDS from mosquito bites? | | | |
| | Yes | 8.5 | 8.5 | 8.5 |
| | No | 77.8 | 84.3 | 81.0 |
| | Don't know | 13.7 | 7.2 | 10.5 |
| 5 | Can people reduce their chances of getting the virus by using a condom every time they have sex? | | | |
| | Yes | 82.4 | 77.0 | 79.7 |
| | No | 5.9 | 19.7 | 12.8 |
| | Don't know | 11.8 | 3.3 | 7.5 |
| 6 | Can people get HIV/AIDS by sharing food with a person who has HIV/AIDS? | | | |

Table 1. Cont.

| | | | | |
|----|--|------|------|------|
| | Yes | 5.9 | 9.9 | 7.9 |
| | No | 84.9 | 87.4 | 86.1 |
| | Don't know | 9.2 | 2.6 | 5.9 |
| 7 | Can people reduce their chances of getting the virus by not having sexual intercourse at all? | | | |
| | Yes | 68.4 | 66.4 | 67.4 |
| | No | 17.1 | 31.5 | 24.3 |
| | Don't know | 14.5 | 2.0 | 8.3 |
| 8 | Can people get HIV/AIDS by hugging or shaking hands with a person who is HIV infected? | | | |
| | Yes | 7.9 | 14.1 | 11.0 |
| | No | 78.9 | 85.2 | 82.1 |
| | Don't know | 13.2 | 0.7 | 7.0 |
| 9 | Is it possible for a healthy-looking person to have HIV/AIDS? | | | |
| | Yes | 95.4 | 84.4 | 90.0 |
| | No | 1.3 | 15.0 | 8.0 |
| | Don't know | 3.3 | 0.7 | 2.0 |
| 10 | Have you ever been tested to check whether you have HIV/AIDS? | | | |
| | Yes | 77.5 | 72.4 | 74.9 |
| | No | 22.5 | 27.6 | 25.1 |
| 11 | When was the last time you were tested? | | | |
| | Less Than 12 months ago | 59.6 | 54.0 | 56.7 |
| | 12 - 23 months ago | 16.7 | 24.6 | 20.8 |
| | More than 2 years ago | 23.7 | 21.4 | 22.5 |
| 12 | The last time you had the test, did you yourself ask for the test, was it offered to you and you accepted, or was it required? | | | |
| | Asked for the test | 65.5 | 57.4 | 61.3 |
| | Required | 34.5 | 42.6 | 38.7 |
| 13 | I don't want to know the results, but did you get the results of the HIV test? | | | |
| | Yes | 99.1 | 98.4 | 98.8 |
| | No | 0.9 | 1.6 | 1.2 |
| 14 | Where was the test done? | | | |
| | Public hospital/clinic | 92.2 | 86.8 | 89.4 |
| | Private hospital/clinic | 7.8 | 13.2 | 10.6 |
| | Do you know of a place where people can go to get this test? | | | |
| 15 | Hospital/Health centre/dispensary | 94.7 | 99.3 | 96.9 |
| | Shop/kiosk | 2.0 | 0 | 1.0 |
| | Pharmacy | 2.7 | 0 | 1.4 |
| | NGO/CBO (mention its name) | 0.7 | 0 | 0.7 |
| | Peer educator | 0 | 0.7 | 0.7 |

3.3. Sexual behaviour and practice towards HIV/AIDS

While the level of knowledge of HIV/AIDS is important, it is the changes in sexual behaviour that may prevent further spread of the STIS and HIV/AIDS (Kanda et al., 2009 MoHCDGEC et al., 2016). Table 2 presents findings on sexual history, sexual behaviour practices and condom use among respondents. It was

found that the majority of the respondents (59.1%) were in marital union and 28.1% had casual partners. Friend's home, family event, market and work places were the most common areas where people met and started their sexual relations. More than two-fifths (41.8%) of the reported forms of sexual relationships were quite recent (less than one month preceding the study). It was also found that the frequency of having sexual intercourse was very high with 72.9% reporting having slept with their partners for about 1-7 times during four weeks preceding the study. This frequency is not alarming among those within marital unions, but is a risk factor given the fact that 28.1% had casual partners.

The average numbers of one's lifetime partners were also very high. Males reported an average of 17.6 while women reported an average of 4.6 life time partners. The average for both male and female was 10.2 partners. The reported number of life time sexual partners is higher than that reported in TACAIDS et al. (2013) where it was found that in Tanzania the mean number of lifetime sexual partners among those who ever had sex was a mean 2.4 for women compared with 6.8 for men. It was also found that cultural factors were among the reasons (especially for men) for having multiple sexual partners. Some men felt it was prestigious to have more partners than the case would be for female respondents. For example, during an FGD in Kolo Village, men were of the opinion that it was fine for them to have many sexual partners. One male discussant confidently argued that "*Mwanaume kamili huwezi kuwa na mpenzi mmoja mpaka kufa*" (a real man would not remain with one partner until death). Such attitude is probably amplified by male traditional masculinity in many parts of Tanzania whereas a woman known to have many sexual partners is labelled as being a prostitute.

Table 2. Sexual Behavior and Activity (n = 308)

| SN | Variable/Statement | Tunduru-Mangaka-Mtambaswala (%) | Dodoma-Babati-Bonga (%) | All (%) |
|----------|---|---------------------------------|-------------------------|---------|
| 1 | What was/is your relationship with this partner? | | | |
| | Husband/wife | 48.0 | 70.2 | 59.1 |
| | Girlfriend/boyfriend not living with you | 31.6 | 24.5 | 28.1 |
| | Live-in partner | 17.8 | 3.3 | 10.6 |
| | Casual acquaintance | 2.0 | 0.7 | 1.3 |
| | Someone whom you paid or who paid you for sex | 0.7 | 0.7 | 0.7 |
| | Not in any relation | 0 | 0.7 | 0.3 |
| 2 | What place or event did you first talk to or get to know this partner? | | | |
| | Own or friend's house | 43.1 | 39.9 | 41.5 |
| | Family event/social gathering | 17.6 | 35.9 | 26.8 |
| | Market | 16.3 | 9.8 | 13.1 |
| | Workplace | 8.5 | 9.2 | 8.8 |
| | Bar/nightclub/disco | 10.5 | 0 | 5.2 |
| | Hotel/guest house | 0.7 | 2.6 | 1.6 |
| | Can't remember | 2.6 | 0.7 | 1.6 |
| | Church/mosque | 0.7 | 2.0 | 1.3 |
| 3 | How long ago did you first have sex with this partner? | | | |
| | 0-4 weeks ago | 46.4 | 37.0 | 41.8 |
| | 5-8 weeks ago | 9.2 | 8.9 | 9.0 |
| | 9 or more weeks ago | 44.4 | 54.1 | 49.2 |

Table 2. Cont.

| | | | | |
|---|--|------|------|------|
| 4 | About how many times have you slept with this partner in the last 4 weeks? | | | |
| | 1-7 times | 66.0 | 79.4 | 72.9 |
| | 8-15 times | 29.1 | 16.8 | 22.9 |
| | 16 times or more | 4.9 | 3.7 | 4.3 |
| 5 | In total, with how many different people have you had sexual intercourse in your lifetime? | 9.4 | 11.2 | 10.2 |
| 6 | Do you think this partner has/had other partners? | | | |
| | Yes | 17.7 | 18.7 | 18.2 |
| | No | 10.9 | 46.0 | 28.6 |
| | Don't know | 71.4 | 35.3 | 53.2 |
| 7 | In this relationship, do you feel you can say 'No' to having sex when you do not feel like? | | | |
| | Yes | 79.6 | 56.7 | 68.2 |
| | No | 20.4 | 43.3 | 31.8 |

3.4. Sexual behaviour/activity and condom use

The study also revealed that despite high rates of sexual encounters among respondents, condom use was relatively low. The most common reasons for not using condom during sexual intercourse were: Partner objected (41%), don't like to use condom (36%) and unavailability (14%). There was a remarkable difference in condom use by sex. About 28.5% of men, as compared to 39.2% of women, used condom during their first sex. And only 15.7% of men and 17% of women used condom during their last sex. In Most cases males suggested the use of condoms than their female counterparts (12.8% and 19.9% for female and male respectively). The inconsistent uses of condom during sexual intercourse, especially for unmarried partners, is a risky behaviour, given the fact that the leading cause of spread of HIV/IAIDS in Tanzania is through heterosexual intercourse (TACAIDS, 2013; NBS and ICF Macro, 2011). During FGDs, discussants revealed some of the reasons, misconceptions and stigma associated with condom use in the area, including: unacceptability, unavailability, lack of knowledge and misconceptions. Some of the discussants were sceptical about the condoms supplied for free at health centres, especially on their quality and reliability. They emphasized this by saying:

"... we are suspicious about these condoms that are supplied for free through hospitals... they are smelly, oily and probably have HIV virus in them" (Female youth -Nanyumbu)

In the same vein, one middle aged man added:

"...condoms distributed through health centres or that are provided for free are of poorer quality than those sold in kiosks ... how is it possible that they are all of the same quality ... these whites are fooling us instead of protecting us (Men FGD in Mtambaswala; Chenene and Chemba).

However, the practises were different among commercial sex workers who had positive attitude about the condoms and their uses. Although a similar observation was also made regarding reliability of the freely supplied condoms, one commercial sex worker in Tunduru District reported that:

"... I don't trust the condoms supplied for free or the ones brought by my clients; they may infect them intentionally ... I normally keep my condoms for my clients because ... there are many diseases, and use of condom keeps you safe. I love my life, and this is my only way to survive ..."
(Commercial sex worker: Amazon Club in Tunduru).

Other reasons for low usage of condoms among workers, especially in constructions camps, were inadequate supply and low or lack of resistance from women. For example, in Chenene Sub-Camp (in Chamwino District), the health facilities available were reported to fail in providing condoms and prescribed drugs for STIs.

".... the nearby medical health facility where you can get a condom for free is about 14 km away ...who will walk such a distance for just a condom and sometimes we are asked to pay for them...it is difficult for us to pay for medication let alone condoms...." (Male FGD Chenene Sub-Camp)

In responses to lack of resistance from a female partner, one male worker revealed that:

"....as long as you are able to pay for sex ... the decision is yours whether you use condom or not ... there are also different prices for sex with and without condoms, the latter being less expensive..."
(Truck Driver-Male FGD Chenene Sub-Camp).

3.5. Attitude and practices towards HIV/AIDS

It is widely reported in literature that higher knowledge about HIV/AIDS does not necessarily transform one to adopt HIV/AIDS protective behaviour (MoHCDGEC et al., 2016; Lewis et al., 2010). This study found that, despite high level of knowledge about HIV/AIDS and STIs, many people still practised sexual risky behaviours. The study revealed many reasons including the reasons for such practices. Men revealed the reasons for having sex and how such orientation never faced any resistance from women. One middle aged man reported:

"...we actually practise sexual intercourse for pleasure not to have kids; when you use condom the sexual pleasure decreases ... for the same reasons women in this area do not like to use condom...." (Male FGD- Mtambaswala).

In the same vein, one young man insisted:

"...when you suggest condom use, girls in this village feel like you are looking down at them. ... they will say...do you think I am a prostitute? ... Nevertheless, they don't refuse having sex"

whether you use a condom or not. As long as you can pay, the choice is yours.” (Male FGD-Mtambaswala)

With regard to inadequate supply of the condoms, another man recalled:

“...the last time condoms were distributed for free in our area was during inauguration ceremony of Umoja Bridge. Ever since, if you want a condom you have to buy it from a pharmacy at Tshs 500 which sometimes you don’t have...” (Male FGD- Mtambaswala).

Low or non-use of condom is related to the environment in which the sexual encounters happen. For example, in an incidence of casual sexual encounters, there is no time for one to look for condoms. In the context of construction sites or in nearby villages, casual sex happens in rush, and in most cases in unprepared environment.

During a focus group discussion with women, they agreed that:

“...In our areas there are few places where you can go to buy a condom If a man is willing to pay for “chanjiwa” (short and casual sexual intercourse), you cannot risk losing him, and you don’t have time to look around for condoms...” (Female FGD- Mtambaswala).

They also agreed with the following argument:

“...most men in this village do not want to have prolonged relationship because it is costly and risky to their families...they are willing to pay for casual sexual intercourse ... this is a safe way of enjoying sex; you pay, do it and the relationship ends there... (Female FGD- Mtambaswala).

Extreme levels of poverty were also revealed to be a cause for casual sex encounters. During an FGD with women, it was revealed that men who work in the road construction have become like a new source of income as they have a lot of disposable income and are willing to pay for sex. One middle aged woman insisted by saying:

“...life is difficult here my friend...in some households’ girls are expected to contribute to the household expenditures ... when a girl brings money home she is not asked where she got it from ... even married women are willing to offer sex as long they are paid for...” (Female FGD-Mtambaswala).

The influx of immigrants in the road construction camps also presents more pressure and demand for limited sexual partners. Truck drivers in a road construction camp who participated in an FGD emphasized:

“... in this camp alone we are about 250 workers. Most of us are men and did not come along with our families... there are very few women in this small town, but they offer sexual services to all of us; they attend us all...we have never fought or quarrelled over women ...the only problem

is inadequate supply of condoms nearby our working places... (FGD with truck drivers and operators-Mtambaswala)

3.6. Cultural practices and the spread of HIV-Marital unions and stability

The study revealed that there is progressive erosion in the way marital unions are made. Many elder men and women were concerned on how the traditional marital procedures were being adhered to (See Box 1).

Box 1. The fall in marital processes

Marriage procedures in our areas are now half done: when a man sends request to the bride's parents (a letter, usually accompanied by some cash, between Tshs. 10,000 and 30,000), they are formally recognized as partners, and most of them do not complete marriage procedures; they continue to live as cohabitants until the union breaks down. He insisted: *"Huku kwetu ndoa siku hizi hakuna ... ukitoa barua tu ndo basi..."* (Marriage ties in our area nowadays are increasingly being diluted; once a fiancée is introduced to a daughter's parents, sexual encounters begin as if they were already married) (Commented one old man in a focus group discussion) Men FGD-Chipuputa village,

There is a high incidence of marital breakdown especially due to HIV/AIDS. Women are always deserted when their husbands know that they have contracted HIV. As a result, many women who have contracted HIV do not disclose their HIV/AIDS status to their spouses. A sharp contrast with regard to women autonomy was revealed among some matrimonial traditions where men do not voice over women. Therefore, women were blamed for misuse of their autonomy by being strict over their girls. In an FGD in Chipuputa Village, a man complained about being embarrassed by his wife over issues of disciplining their daughter who was regarded to misbehave. The man complained by saying:

"... girls may go out and return home late and her father is not expected to discipline them ... their mother will defend them and put a shame on you... they are already matured, and if you don't allow them to go out will you satisfy/fulfil their sexual desires?" (Mixed FGD –Chipuputa Mtambaswala-Nanyumbu).

In the same vein, another man was quoted complaining:

"...in our village, a girl also feels proud if she can have an affair with a person who looks much masculine and older than herself... she feels that she has mastered the practice" (Mixed FGD – Nakapanya-Tunduru).

The study further revealed that some elderly men enjoyed having an affair with young girls. One old man confidently narrated this with examples:

"...if you have a good sesame or cashew nut harvest you should find a beautiful young girl to relax with... umeshaona nyani mzee anakula mahindi magumu? (Have you ever seen an old baboon eating hard maize?" (Mixed FGD –Nakapanya-Tunduru)

A wide gap in age between partners can lead to an imbalance in decision making and put pressure on the younger partner. Age gaps also tend to increase marital instability. This is especially true among young people. One old man observed such dramatic changes in women behaviour and called for an intervention as he commented:

"...since the construction workers came into our area, the behaviours of women have changed from obedience to disobedience of their men partners...women have had the desire for men from these construction companies ...if you don't bring this campaign and give advice to our women we are finished...." (Male FGD Chemba village).

3.7. Gender based violence and HIV spread

This study revealed that there were many forms of gender based violence that put not only women but also men to the risks of contracting HIV infections. The forms of GBV found in this study emanated from women's low level of autonomy, especially among married women as well as violent behaviour from husbands and other male partners' behaviour including placing limitation on women's mobility and wife/partner beating. Low level of autonomy, imposed by male among partners in its extreme cases, may lead to separation which may also contribute to having multiple sexual partners. A typical incident of such an option was revealed in one of the female FGDs, conducted in Nanyumbu District, where a woman complained by saying:

"...once you are married in this village it is like you have been bought ... the husband, even the one who cannot provide for the family, will keep on asking you of your whereabouts as if you will not get back home ... I would rather stay single than getting into this new form of slavery..." (Female FGD Mtambaswala-Nanyumbu).

On the same aspect of autonomy, an interview with a food vendor in Bonga (Babati District) revealed that she had resorted to having no permanent sexual partner in order to remain free from the bondage of marriage.

"...sina mpenzi wa kudumu; ntateseka bure kukosa uhuru", which literally means: I do not have a permanent sexual partner for fear of suffering and lacking freedom.

Another female FGD at a village in Mtambaswala revealed that, there was no difference in the level of promiscuity behaviour between the married and singles. The married ones have an added disadvantage as they experience frequent beatings. She added:

"...I don't see much difference in the level of promiscuity behaviour among married and single...only that those with a husband or wife are frequently disturbed and sometimes beaten... I

want my freedom to be able do the things in my own way..." (Female FGD Mtambaswala-Nanyumbu).

The study also revealed that men also do experience gender based violence. In a male FGD it was reported that most men are also mistreated but feel shy to report gender based violence because it is traditionally unacceptable for a man to disclose that he has been mistreated by his partner. However, extreme cases are also reported. One middle aged man reported an incident that once happened in their village:

"... some men are so lazy ... you remember that man who pretended he so much loved his wife and he never reported any violence done to him until one day when it was announced that he was hit by an axe in the head...believe me some men are really suffering here, and we should not wait for such extreme cases..... (Male FGD at Chenene, Chamwino)

While men were known to be the perpetrators of gender based violence, this study also revealed that women are perpetrators of gender based violence against men. In a female FGD in Nanyumbu the scenario was revealed when a middle aged woman narrated:

"...nowadays even men can be chased away from home ... if he doesn't provide for the family and you find another man who can offer better service ... you can show him a door" (Female FGD, Mtambaswala, - Nanyumbu).

Higher incidences of gender based violence, especially among intimate partners, have been widely reported. For example, in a study by the World Health Organization (WHO) in 2001/2002, of 1,820 women in Dar es Salaam and 1,450 women in the Mbeya District, it was found that 41% of ever-partnered women in Dar es Salaam and 87% in Mbeya District had experienced physical or sexual violence at the hands of a partner at some point in their lives. In both areas, 29% of those who had experiencing physical intimate partner violence experienced injuries, with over a third of them having been injured in the previous year (WHO, 2005).

These findings reveal how gender based violence put women and men at high risk of contracting STIs, including HIV/AIDS. In their effort to cope with gender based violence, some men and women adopt sexual behaviour including having multiple sexual partners, which further puts them at a high risk of contracting the HIV/AIDS. Promiscuity is likely to put the community into the risks of HIV and other STIs. Other scholars have also found a relationship between gender-based violence and incidents of HIV/AIDS (Dunkle et al, 2004; Strebel et al., 2006; Phorano et al., 2012).

4. Conclusions and recommendation

4.1. Conclusions

The level of knowledge about HIV/AIDS, how the disease spreads and the prevention methods are generally higher among the two construction sites/communities. However, corresponding change in sexual

behavioural response is lacking. Many people still practise risky sexual behaviours, have many sexual partners and are inconsistent in using condoms. Despite higher level of knowledge about HIV/AIDS, some respondents still embrace some misconceptions about HIV/AIDS (e.g. 11% believe that HIV can be transmitted through casual contact). This implies that there is still inadequate information about the HIV risk, hence a need for correct preventive measures to be adopted to prevent its spread. The use of condom during the first and last sexual encounters is generally low, which implies that the majority of people are at risk of contracting HIV/AIDS and STIs. There are many forms of gender based violence (sexual, verbal and physical) in the study communities, and most of them are underreported or not reported. The current initiatives and interventions to control HIV/AIDS and STI by government and development organization has little or no focus on gender based violence, although they are potential sources of spreading HIV. Men, as well as women, having many sexual partners and sexual encounters across different age ranges is common. There are several seasonal initiatives to control the spread of HIV/AIDS and STIs. However, sustainability of such initiatives is lacking since most of those efforts are said to be seasonal or related to a specific national event. For example, across Dodoma Districts and Babati, such campaigns have sporadically been seen on independence days, *Nanenane* days (National Farmers' Day) and on other public days.

4.2. Recommendations

The study recommends to the government and NGOs to involve and support local organizations and staff (in specific locations) for capacity building and sustainability of the sensitization campaigns against HIV/AIDS, STIS and gender based violence. This could be done by initiating and or strengthening youth clubs and peer educators. Youth clubs have been reported elsewhere to be effective in sensitizing youth against HIV/AIDS and related diseases as well as serving as the centres for distributing condoms.

The government and NGOs should continue to pursue and expedite a dual focus on protection as well as advocating abstinence and consistent and correct use of condoms. Such campaigns should be accompanied by VCT services. HIV/AIDS testing should focus on all age groups with particular emphasis on the group of youth between the ages of 15 to 25 years. More knowledge is needed on controlling the spread of STIs and the referral system for STIs, especially among partners.

Government and NGOs should make effort to incorporate gender issues in the design and implementation of all development programmes and projects, including road construction as it does for HIV/AIDS. The effort should go hand in hand with introducing the gender based violence prevention techniques and plans into programmes addressing HIV, particularly HIV prevention education programmes and counselling programmes. This can be achieved by developing pamphlets, posters, and other materials on different forms of GBV and available services such as a police help desk, community development and social welfare departments in Local Government Authorities (LGAs).

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