

UNDERSTANDING EXPERIENCES

Of Gender-Based Violence Among
Women Who Use Drugs (WWUD) And
Developing Prevention And Response
Framework In Coast, Kenya

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GLOSSARY AND ABBREVIATIONS USED IN THIS REPORT

Arosto:	A state of need for a heroin rush
Kunguru:	A black unattractive scavenger bird found in Mombasa
Maeneo:	Drug consumption spaces (colloquially 'drug dens') (used in the plural throughout)
Mogokaa:	Khat - <i>Catha edulis</i> a chewed herb (leaf) containing cathinone psychostimulants
Mteja (sing.)/mateja (pl.):	A derogatory term for people who use drugs. This refers to people who use drugs, and we only refer to mteja/mateja where mentioned in quotes from participants or to contextualise the narrative.
Uteja:	The identity of mteja (a stereotype)
BAMB:	Bamburi
BOM:	Bombolulu
GBV:	Gender Based Violence
CHO:	Community Health Officer
MAG:	Magadoroni
MO:	Medical Office
MS:	Magistrate Shanzu Law Court
MTP:	Mtwapa
MWM:	Mzee wa Mtaa (a grassroots administrator)
PLWHIV:	People Living with HIV
PO:	Police Officer
PRO:	Probation Officer
RL-I:	Muslim religious leader/Imam
SHZ:	Shanzu
VAC:	Violence against children
WHO:	World Health Organisation
WWUD:	Women who use drugs

EXECUTIVE SUMMARY

Gender-based violence (GBV) is caused by systemic gender inequalities and encompasses all acts of physical, emotional, sexual and psychological violence perpetuated against a person due to their gender (UNHCR, 2020). It is estimated that 35% of women worldwide have experienced some form of physical and/or sexual violence by an intimate partner, or sexual violence perpetrated by a non-partner (WHO, 2013a). Prevalence is estimated to be higher in sub-Saharan Africa (Pack, L'Engle, Mwarogo, & Kingola, 2014).

Although a number of studies have investigated GBV, including both intimate and non-intimate partner violence in the general population and among sex workers, relatively few studies have investigated the experience of GBV among women who use drugs (WWUD). Data on the prevalence of GBV and its underlying factors among this vulnerable group therefore remains relatively sparse and anecdotal. Considering literature that has found links between intimate partner violence, substance use, sexual decision making and HIV/AIDS, there is a gap in evidence on vulnerable populations especially WWUD in sub-Saharan Africa. This study therefore seeks to explore the lived experiences of WWUD and their children in Kenya, in relation to different types of GBV; and structures that perpetuate GBV among this population.

The study sample comprised 43 participants - 36 WWUD and 7 Key Informants. WWUD were recruited using convenience sampling in five geographical locations – Bamburi, Magodoroni, Shanzu, Mtwapa and Bombolulu, and among People Living with HIV (PLWHIV). Focus group discussions and in-depth interviews were carried out among WWUD and individual interviews with the 7 key informants. Ethical and research approval was obtained from KEMRI and NACOSTI respectively.

The majority of WWUD were aged above 30 years old and around three quarters were engaged in sex work. Intersecting forms of GBV reported include psychological/emotional, sexual, physical and verbal. The perpetrators were both intimate and non-intimate partners (sexual partners, family, non-sexual partners in maeneo, and clients), police, and random strangers.

Physical abuse intersected with psychological control and included demands to stay indoors, violence, humiliation e.g. tearing of clothes or destroying WWUD's personal and other effects sometimes in front of a victim's family or their children. The reasons ranged from stealing partner's money or drugs, suspicion of unfaithfulness, stealing from clients, partner's frustration at WWUD for not earning money from sex work, refusing partner selling household goods, and rejection of partner's forceful demands for sex. Physical abuse was aimed at ensuring control and dependence of partners.

Psychological abuse took many forms including family isolation and feelings of diminished worth, and was normalised by WWUD. Children of WWUD also suffered psychological abuse through separation from their mothers and direct verbal abuse from others.

Sexual abuse within relationships entailed forced anal sex, demands for sex when WWUD were hungry, or either in drug withdrawal (arosto); or during intoxication. Often, WWUD accepted sexual abuse to escape physical abuse or being locked out of housing and denied food. Sexual violence in the context of sex work was perpetrated by people who didn't use drugs and included unwanted touch, deliberate tearing of condoms during sex, forced sex, demands for types of sexual activity that made the woman feel uncomfortable, and getting paid less than agreed or nothing for sex work. In maeneo, sexual abuse included fondling and unwanted touch. Sexual abuse was interlinked with physical, psychological/emotional and verbal abuse.

GBV was perpetuated by psychological factors including control that encompassed possessiveness, demands not to socially interact with neighbours and friends and to remain indoors; stalking by ex-partners even when separated; denial of access to children and control of money; and normalization of violence where WWUD. GBV is also linked to cultural demands, limited social support systems, psychological and economic dependence and alienation, and lack of knowledge of what to do. Institutional and community factors that maintained GBV against WWUD included the process of reporting abuse, economic dependency, and community attitudes towards sex being consensual.

Although the Protection against Domestic Violence Act (2015) which criminalises sexual violence; the Sexual Offences Act (2001) and the Children's Act (2001), together with sections of the Penal Code lay out the support and protections that could be provided for women experiencing GBV, these were not being adequately implemented. Further, there's need for capacity building of all stakeholders, including WWUD and their partners, organisations dealing with GBV, health service providers, law enforcement and criminal justice system actors on preserving evidence, reporting protocols and data monitoring and sharing. To improve referral into support services, there is a need for a direct link between focal persons in the maeneo and the police.

1.0 INTRODUCTION AND BACKGROUND

A detailed background of gender-based violence is provided in this section with a focus on understanding the estimates and risk factors/drivers. Further, a review of GBV literature on the specific vulnerable population of WWUD is included.

1.1 Global review of GBV

1.1.1 Defining Gender-based violence

Gender-based violence is caused by systemic gender inequalities and encompasses all acts of physical, emotional, sexual and psychological violence perpetuated against a person due to their gender (UNHCR, 2020). It is a global issue affecting individuals across the gender spectrum, but women are the main victims. The World Health Organization (WHO, 2013a) estimates that 1 in 3 women worldwide have experienced sexual and/or physical violence, either by a partner or a non-partner. The term 'violence against women and girls' (VAWG) is often used interchangeably with GBV, as women are disproportionately affected by types of GBV such as intimate partner violence (IPV), sexual violence and harassment, human trafficking, female genital mutilation (FGM), violence against children (VAC) and child or forced marriage (WHO, 2013a). VAWG is a human rights violation and the United Nations (UN) has set targets for eradicating all forms of GBV under Sustainable Development Goal (SDG) 5 on gender equality (UN, 2015).

1.1.2 Global estimates of gender-based violence

It is estimated that 35% of women worldwide have experienced some form of physical and/or sexual violence by an intimate partner, or sexual violence perpetrated by a non-partner (WHO, 2013a). Intimate partner violence (IPV) is pervasive among vulnerable populations including sex workers, women living in poor socioeconomic conditions and WWUD. Although it remains under-reported, available evidence suggests that 30% of women who have been in a relationship have reported being a victim of IPV during their lifetime (WHO, 2017). IPV rates vary between regions; 25.4% of women report IPV in Europe, 36.6% in Africa, 37.7% in South-East Asia, and 29.8% in the Americas (WHO, 2013a). Estimated prevalence of IPV is generally lower in higher income countries. Data quality on global IPV is poor as stigmatisation and fear of reprisals result in under reporting (Fraga, 2016). In addition, studies often show methodological limitations, such as excluding girls (thus limiting data on child sexual exploitation), and excluding emotional and psychological abuse, despite evidence suggesting that this is one of the most common forms of IPV (WHO, 2012). Thus, data limitations mean that prevalence estimates are not always accurate nor consistent between studies.

Globally, women are disproportionately affected by intimate partner and inter-family homicide. In 2017, around 87,000 women were intentionally killed, and approximately 50,000 (58%) of these were killed by an intimate partner or family member (UNODC, 2018). Women are much more likely than men to be murdered by a partner (femicide). Of those killed globally as a result of IPV, 82% were women and 18% were men (UNODC, 2018). Thus, women are over four times

more likely to be victims of homicide by a partner than men. Across the world, rates of femicide vary significantly. According to the same UNODC data, Africa has the highest rate of femicide in the world, with 3.1 women killed in intimate partner homicides per 100,000 females. Africa also has the highest rates of non-fatal IPV in the world.

1.1.3 Risk factors/predictors of GBV

A range of factors can increase an individual's risk of perpetration and/or victimisation of GBV. These occur on individual, family, community, and structural levels (WHO, 2017). Factors which are consistently associated with both include: poorer education, past exposure to family violence and abuse, gender inequality, poverty, social norms accepting of violence, and a history of drug use (Abramsky et al., 2011; Capaldi, Knoble, Shortt & Kim, 2012; WHO, 2012). A brief overview of these factors is given below.

Education

Lower levels of education have been identified as a risk factor for GBV perpetration and victimisation (Capaldi et al., 2012; Jewkes, 2002). A lack of formal education has been linked to having low levels of female empowerment, which indirectly leads to increased risk of GBV (Kabeer, 2005). Low education is inextricably linked with other inequalities such as low income and unemployment, whereas having secondary school levels of education and high socioeconomic status (SES) have been identified as protective factors against GBV (Abramsky et al., 2011; Garcia-Moreno, Jansen, Ellsberg, Heise & Watts, 2006; Sanz-Barbero, Barón & Vives-Cases, 2019).

Societal and systemic sexism

Violence to women is greatest in societies which exhibit high levels of gender inequality and where sexism is inherent in legislation and societal norms (Jewkes, 2002). Globally, around 50 countries do not have laws to protect women from domestic violence, and 112 countries do not criminalise marital rape (World Bank, 2017). Estimates of GBV prevalence are likely to be much higher than reported as it is highly stigmatised and many victims do not report it for fear of reprisal, especially in countries where protective laws are not systematically enforced (WHO, 2013a).

Normalisation of violence

Witnessing family violence as a child is a risk factor for both men's perpetration and women's experience of GBV (Abramsky et al., 2011; WHO, 2013a). For example, one study of women in northwest Ethiopia found that exposure to parental domestic violence as a child was the greatest risk factor for being a victim of GBV in later life (12.9 times increased risk), and women who had witnessed parental violence were 3.8 times more likely to be victims of rape (Yigzaw, Yibrie & Kebede, 2004). GBV is sustained and perpetuated by widely held beliefs about gender roles (WHO & LSHTM, 2010). The normalisation of GBV is highlighted in data from UN indicators across African countries: for example, in Guinea, 89.9% of women and girls aged 15-24 think that "wife beating" can sometimes be justified (UNFPA, 2020).

History of drug use

Use of illicit drugs and alcohol have been identified as risk factors for both perpetration and victimisation of IPV and sexual violence (WHO, 2017; WHO & LSHTM, 2010). Research has indicated that WWUD are at greater risk of experiencing GBV than women in the general population (Roberts, Mathers & Degenhardt, 2010; Stone & Rothman, 2019), and IPV often features in relationships where one or both partners are using substances as intoxication, withdrawal and arguments about substance use can culminate in violence (Harm Reduction International, 2013; Radcliffe et al., 2019). However, as experiencing violence can also increase an individual's risk of initiating drug use (Abramsky et al., 2011), it is not clear whether the relationship between use of drugs and GBV is (bidirectionally) causal or an association. Different explanations for the association between drug use and GBV have been proposed. For example, perpetration of GBV may be influenced by psychopharmacological changes in mood, thinking and behaviour from taking a specific substance (Simonelli, Pasquali & De Palo, 2014). Conversely, women who have a substance use disorder may be at an increased risk of sexual assault if they engage in sex work to generate income (UNODC, 2018). Mental health problems, poor education, low socio-economic status and family conflict are all shared risk factors for drug use and GBV, making the relationship even harder to understand.

1.1.4 Gender-based violence towards women who use drugs

In 2017, it was estimated that 271 million people (5.5% of the global population) aged 15-64 had used illicit drugs in the past year (UNODC, 2019b). There were an estimated 53 million opioid users, of which 11 million were injecting opioid users. Women make up around 20% of the total global estimate of people who inject drugs (PWID), but there are regional variations: for example, women are estimated to comprise 30% of PWID in North America, 28.6% in Western Europe, 11.6% in sub-Saharan Africa, and 3.1% in South Asia (Degenhardt et al., 2017).

Estimates of GBV against WWUD are limited and likely to be underestimates, as stigma and criminalisation around drug use and GBV impair data collection, making this a hidden population (UNODC, 2019b). Some community-based studies show that the prevalence of GBV against WWUD might be between two to five times higher than that of women in the general population (El-Bassel, Gilbert, Witte, Wu & Chang, 2011; Gilbert, Raj, Hien, Stockman, Terlikbayeva & Wyatt, 2015). Results of one systematic review of international studies (n = 31) reported that 32-75% of WWUD reported being a victim of IPV in the past year, with 34-96% reporting IPV in their lifetime (Stone & Rothman, 2019). WWUD also have substantially higher rates of sexual assault from non-intimate partners than the general population, with perpetrators including drug sellers, sex work clients and police (UNODC, 2019a).

1.1.5 Vulnerable groups

Although there is a significant risk of GBV for all WWUD, there are particular subgroups whose risk is greater. There is a considerable overlap between injecting drug use and engagement in sex work, in exchange for money, drugs or services such as housing (Roberts et al., 2010). Around

a third of WWUD participate in sex work, and the majority are street-based sex workers who subsequently encounter high levels of violence from the state and individuals in the community (HRI, 2013b; International AIDS Society (IAS), 2019). Sex workers are also at greater risk of HIV – a combined risk from injecting drugs and unprotected sex – and may be subjected to violence from clients when requesting that they use a condom.

Homeless women have higher rates of drug use and suffer from poorer physical and mental health than women in the general population (Wenzel et al., 2009). Domestic violence is commonly cited as a factor in becoming homeless, and homeless women may initiate drug use to cope with continuing violence they encounter (FEANTSA, 2019). Drug use can be a barrier for homeless women trying to access housing services, and homelessness can be a barrier to accessing drug treatment services (Roberts et al., 2010).

Women in injecting drug user partnerships are at high risk of IPV, and face other health risks associated with sharing injecting equipment, as well as higher rates of sexually transmitted infections (STIs) and unplanned pregnancy (Roberts et al., 2010). Furthermore, across all contexts, women may use drugs as a form of self-medication after experiencing violence and stigma (UNODC, 2018). This can cause disproportionately worse outcomes for some women, as their drug use and risk of victimisation escalate.

1.1.6 Health and social harms of GBV towards WWUD

GBV can cause serious short- and long-term harm to WWUD, leading to adverse physical and mental health outcomes. It also has social and economic costs for the individual, their family and society.

Mental health: Victims of GBV have high rates of depression, anxiety and post-traumatic stress disorder (PTSD) (Trevillion, Oram, Feder & Howard, 2012). Co-morbidity of mental health and substance use disorders are also high in victims, as they struggle to cope with the physical, mental and emotional consequences of the violence (WHO, 2013a). Many women who are imprisoned for drug-related offences have a history of mental health disorders, substance use and GBV (often experienced through trafficking), and suffer long-term mental health problems as a result of imprisonment (UNODC, 2018).

Lack of access to support services: Many WWUD victims of GBV are unable to access violence support services as they do not provide parallel support for substance use disorders, and women may be denied access if they are thought to be using drugs (HRI, 2013a). As such, WWUD may be forced to stay in violent relationships or face homelessness, increasing their risk of other health and social harms. Other structural barriers include long waiting lists, insufficient support for women's gender-based needs, location and cost of treatment programmes, and lack of adequate information concerning provision of available services (Roberts et al., 2010; UNODC, 2018).

Stigma: Gender norms and stereotypes result in WWUD suffering greater levels of stigmatisation than men, especially if they lose custody of their children (IAS, 2019). GBV remains stigmatised, particularly IPV and non-partner sexual assault, resulting in victim blaming and shaming (WHO, 2013a). In addition to the pre-existing stigma associated with GBV, WWUD also face risk of arrest and criminalisation due to their drug use. This creates further barriers to accessing support services (HRI, 2013).

HIV/AIDS: Aggregated data from 30 countries indicate that HIV prevalence is higher among female IDUs (13%) than male IDUs (9%) (United Nations Programme on HIV/AIDS [UNAIDS], 2014). Intimate partner violence in IDU partnerships has been found to be associated with HIV, STIs and risky sexual behaviours (Roberts et al., 2010). Sex workers who inject drugs are at increased vulnerability of violence and also HIV, as a result of inconsistent condom use, exposure to multiple sexual partners and from sharing injecting equipment in non-sterile environments (IAS, 2019).

Unplanned pregnancy, miscarriage and abortion: GBV (particularly IPV and sexual assault) is associated with higher risk of unplanned pregnancy, and this is even higher for WWUD as their rates of contraceptive use are lower than in the general population (Cornford, Close, Bray, Beere & Mason, 2015; Drescher-Burke, 2013). Victims of IPV are more than twice as likely to have an induced abortion, 16% more likely to have a miscarriage and 43% more likely to have a pre-term birth than non-victims (WHO, 2017) and drug use can cause complications in pregnancy. Thus, both GBV and drug use increase the risk of health and social harms during pregnancy.

Impact on children: Children who grow up around parental violence and drug use are more likely to suffer maltreatment and neglect, and have worse physical, mental, intellectual and emotional health outcomes including later experiences of violence and drug use (Abramsky et al., 2011). There is also an association between IPV and higher rates of child and infant mortality (WHO, 2017).

1.1.7 Responses to gender-based violence

At present, there is a lack of research that has investigated responses to GBV against WWUD, so this section provides a brief overview of some general responses to GBV and WWUD.

The WHO (2016) has produced several guidance documents and reports around GBV, arguing that a health systems-based approach is pivotal for prevention and response, as victims are most likely to seek health services as a first point of contact. Key features of responses to IPV and sexual violence include: women-centred care; clinical care for victims of sexual violence; adequate training for healthcare providers on the issues; integration of policy and provisions into existing health services; and mandatory reporting of IPV (WHO, 2013b). In 2016, WHO published the *Global Plan of Action*, which incorporates the UN's SDGs, and calls for collaboration between governments, policy makers, funders, health care providers and non-governmental agencies to implement strategies to end gender-based violence.

The WHO has also collaborated with UN Women and other agencies including UNFPA, UNODC and the World Bank Group to launch the *RESPECT Women* framework, based on existing UN prevention frameworks and evidence from systematic reviews. There are seven strategies based around: strengthening relationship skills; empowering women; ensuring service provision; reducing poverty; preventing child abuse; creating safe environments; and transforming attitudes and norms (WHO, 2019).

Additionally, the EU and UN have partnered to create the *Spotlight Initiative*, a global effort to end all forms of VAWG by 2030, in line with the SDGs. The initiative deploys targeted financial investments to the Global South, working with national agencies to address legislative and policy gaps, provide quality services for victims, and promote gender-equitable attitudes (Spotlight Initiative, 2019, 2020). Some examples of its results to date include: passing new legislation to end VAWG in Liberia; empowerment training and mentoring for adolescent girls in Malawi; and undertaking qualitative research to understand and challenge male attitudes to GBV in Argentina.

1.1.8 Responses to GBV for WWUD

Harm reduction approaches are appropriate for WWUD who may not be ready or able to enter treatment programmes. Harm reduction is key in prevention of the spread of HIV infection amongst IDUs. The WHO, along with collaborating organisations such as UNODC and UNAIDS, have compiled a comprehensive set of policies, programmes and services aimed at reducing harm for IDUs and their sexual partners (UNODC, 2017). These include: needle and syringe programmes (NSP); opioid substitution therapy; antiretroviral therapy; HIV testing, management and counselling; and condom distribution programmes. There is a large body of evidence to show that NSP are effective in reducing HIV transmission (WHO, 2004). However, findings from UNAIDS research indicate that NSP are only available in 90 countries worldwide, and only 12 countries provide the recommended minimum number of sterile needles per IDU per annum (UNAIDS, 2017).

The International AIDS Society (IAS) have devised a matrix of recommended services and policies for WWUD based on existing global recommendations, research and UN resources. The IAS takes a human rights perspective, calling for meaningful involvement of WWUD throughout the development, implementation and monitoring of services (IAS, 2019). Services should be tailored to women's gendered needs and integrate harm reduction, medical care and mental healthcare. Furthermore, the UNODC argues that harm reduction services are well positioned to help WWUD at the intersection of drug use and GBV, especially as they may be turned away from shelters. Harm reduction services can help inform WWUD of their rights, offer STI services and psychosocial support, and help refer victims of sexual assault to clinical care for emergency contraception and to legal services (UNODC, 2016).

1.2 Gender-based violence in Kenya

Although global lifetime IPV prevalence rates range between 10%-60% (Fonck, Els, Kidula, Ndinya-Achola, & Temmerman, 2005), this is estimated to be higher in sub-Saharan Africa (Pack, L'Engle, Mwarogo, & Kingola, 2014). Public humiliation, forced sex and threats were found to be the most prevalent forms of IPV in a survey of 200 women living in Kibera, Nairobi with an overall lifetime prevalence of 84.5% (Swart, 2012). Further, the CCGD report (2014) indicated high prevalence of sexual violence (49.26%). In this report, physical violence was reported by 20.37% (n = 1317) while psychological violence was reported by 1.92% (n = 124) of respondents. Similarly, Mathur and colleagues (2018) indicated high prevalence of IPV (19.1%) and non-partner violence (21.4%) in the past year among a sample of women in Kenya (N = 1,778). This corroborates the findings of a study by Wilson and colleagues (2015) (N = 357) in which one-fifth of women (20.5%) reported ever having experienced physical abuse since the age of 15 by a non-intimate partner. Further, a lower proportion (10.1%) reported non-partner sexual abuse since the age of 15. Physical violence by intimate partners was most common (10.6%), followed by emotional violence (10.1%) and sexual violence (3.6%). Cumulatively, 40% reported ever experiencing IPV by the partner. Finally, financial violence in the form of refusal to allocate any funds to a partner, has been reported in qualitative studies on GBV (e.g. Gillum, Doucette, Mwanza, & Munala, 2016).

There are close relationships between the different forms of abuse perpetrated by intimate partners. For instance, Brooks and colleagues (2019) found that all women in their sample (N = 600) in Nairobi, Kenya reported emotional abuse; while 20%, 17%, and 15% reported controlling behaviour, physical abuse and sexual abuse respectively. Independent of other factors, controlling behaviour was highly correlated with IPV (Wilson et al., 2015). In an earlier Kenyan study, Emenike, Lawoko and Dalal (2008) found that of all the women exposed to IPV (N = 4312), more than a third (38%) had experienced physical abuse, while 24% and 14% had experienced emotional and sexual abuse respectively. Cumulatively, these studies indicate high prevalence of IPV targeted at women in the general population, and thus further studies among a vulnerable population of WWUD is warranted.

As described in section 1.1, one of the most important predictors of both intimate and non-intimate partner sexual violence is a history of drug use. Although the mechanisms underlying these associations have not yet been elucidated, it is assumed that drug using women are more likely to have drug using partners which increases the risk of victimisation. Further, disinhibition due to drugs is likely to predispose women to high risk situations, or be viewed by their partners as 'available' and hence make their partners justify sexual violation (Okal, Chersich, Tsui, Sutherland, Temmerman, & Luchters, 2011; Pack et al., 2014). In fact, findings of a study by Mwangi, Karanja, Gachohi, Wanjihi, and Ng'ang'a (2019) indicate that 74% of women who inject drugs (WWID) in Kenya were introduced to substance use by both intimate sexual and casual partners, and confirms the resulting diverse forms of violence directed towards women from both partners.

Another line of research (Mburu, Limmer, & Holland, 2019) suggests that drug using women are likely to engage in transactional sex which is accompanied by sexual violence from intimate and non-intimate partners in exchange for drugs. It is also possible that as victims, such women may engage in drug use to cope with the negative consequences including trauma (Adudans, Montandon, Kwena, Bukusi, & Cohen, 2011) and the resultant stigma and discrimination (Mainline, 2016), hence supporting earlier findings by Kimuna and Djamba (2008) among a nationally representative sample. This link between substance use, sex work and violence is important in understanding GBV among vulnerable sub-groups like WWUDs. This link is reiterated in the CCGD (2014) report that shows sustained drug and substance abuse responsible for 5.99% of GBV; and in Okal et al. (2011) who found that sex work transforms women into commodities that gives men undue advantage. The connection to poverty cannot thus be minimized. Study findings from Kenya (Dimovitz, 2015) show that poverty is inextricably linked to drug use, transactional sex and GBV singularly or in combination. Therefore, to understand GBV among WWUDs, it is important to trace the role of transactional sex.

Additionally, GBV has been explained in terms of its normalization in African culture and in the existing unequal power distribution within families (Kimuna & Djamba, 2008). The latter influences decision making on family related issues and is associated with partner violence. Empirical evidence to support this position is provided in qualitative literature (e.g. Gillum et al., 2016) who found that violence was culturally condoned as a way of discipline. In fact, women endorsed the idea of submission and hence community members could not intervene in cases of violence. This is coupled with women's own perceptions concerning partner abuse. For instance, participants in the Pack et al. study (2014) who had positive perceptions of partner violence had an increased risk of recent IPV as compared with those who had a negative view of it. This could also be true of vulnerable populations, although evidence is currently lacking.

2.0 JUSTIFICATION FOR THE STUDY

Although a number of studies have investigated GBV, including both intimate and non-intimate partner violence in the general population and among sex workers, relatively few studies have investigated the experience of GBV among WWUD. Data on the prevalence of GBV and its underlying factors among this group therefore remains relatively sparse and anecdotal. Considering literature that has found links between intimate partner violence, substance use, sexual decision making and HIV/AIDS, there is a gap in evidence on vulnerable populations especially WWUD in sub-Saharan Africa. This study therefore seeks to explore the lived experiences of WWUD and their children in relation to different types of GBV; and structures that perpetuate GBV among this population. It was the aim of this study to shed light on circular dynamics between GBV and harm reduction to effectively provide a comprehensive package to WWUD via an understanding of the co-occurrence of these dual issues. This is important because women are unable to fully benefit from harm reduction services until their safety needs are met. To be able to develop appropriate interventions, it is important as a first step to document the experiences and prevalence of GBV among WWUD. Hence, we also investigated the links between GBV and uptake of harm reduction services and consequently, add a new dimension to the understanding GBV among vulnerable populations and interventions for successful integration into mainstream society.

3.0 METHODOLOGY

a) Study sites

The study was carried out in Mombasa and Kilifi counties (Kenya) where MEWA provides harm reduction services to WWUD. Four study areas, Magodroni, Bamburi, Bombolulu and Shanzu are in Mombasa County, while Mtwapa is located in Kilifi County.

b) Study populations

(i) Criteria for inclusion of subjects

- All WWUD were registered by, and currently received harm reduction services from MEWA in Mombasa and Kilifi County only;
- The total sample size of WWUD to be within the upper limit of 35 (± 1). This was established on the basis of time and resource constraints, and the number of participants estimated to lead to data saturation;
- For the key informant interviews (KII), in the absence of the target person/officer, any other person/officer referred/recommended or seconded to act in place of the target person/officer participated.

(ii) Criteria for exclusion of subjects

- Interview participants did not also participate in focus groups to increase the diversity of experiences shared by other participants;

- Children of WWUD, and persons of diminished capacity due to unstable psychological states were excluded because of their inability to provide informed consent and participate voluntarily;
- Participants did not consent to having the sessions recorded (by note taking and/or audio-recording).

c) Sampling

MEWA harm reduction services reach up to 694 WWUD (including people living with HIV – PLWHIV) in Mombasa County and Mtwapa in Kilifi County, and zoned into areas according to their geographical location; Magodoroni ($n = 196$), Bamburi ($n = 154$), Bombolulu ($n = 78$), Shanzu ($n = 66$) and Mtwapa (200). Further, WWUD from among people living with HIV (PLWHIV) ($n = 60$) were sampled. Six participants were sampled from each of the 5 geographical zones and the PLWHIV category were purposively sampled based on availability for a total of 36 participants.

Purposive sampling was used to select service level key informants from the following departments: Interior (1 Police Officer); Social protection (1 Probation Officer); Judiciary (1 Judicial Officer); Health (1 Medical Officer of Health and 1 Community Health worker); 1 religious leader (Imam) and one local leader (Mzee wa Mtaa). The total study sample was 43 participants, comprising 36 WWUD and 7 key informants.

d) Procedures

The study adopted a qualitative approach. Specifically, we:

- Conducted a desktop literature review to assess the state of GBV among WWUD globally and locally;
- Conducted six FGD among 30 WWUD using a focus group discussion guide. Each FGD consisted of five WWUD;
- Conducted individual IDI with six WWUD, one each from the five geographical locations of the study and one from PLWHIV;
- Conducted nine individual IDI with key informants using a semi-structured interview guide.

Participants were required to sign written consent forms prior to data collection. They were offered opportunities to ask for, and receive, information or answers to any questions prior to consenting to participate.

e. Aims and Objectives

The aim of the study was to better understand the lived experiences of GBV among WWUD and their children; and hence provide information to develop more effective prevention and response frameworks. The exploratory study sought perspectives on the prevalence and forms of violence faced by WWUD, as well as the structural factors that perpetuate GBV and avenues of reporting available to them.

Specific objectives were to:

1. Assess the prevalence and lived experiences of GBV among WWUD and their children in the last one year;
2. Assess the mental health, economic, social and sexual health needs and coping strategies of WWUD who experience GBV;
3. Evaluate psychological and structural factors that protect and perpetuate GBV among WWUD;
4. Develop a model of interconnections between GBV and uptake of harm reduction services by WWUD.

4.0 FINDINGS

4.1 Description of sample

Data were collected from 36 WWUD and 7 (of 9) service level key informants using FGD, IDI and KII. The sample of WWUD is described in Table 1. Throughout this Section the following codes are used. F1 = Number denotes the participant number e.g. F1 MTP = Participant No. 1 in Mtwapa FGD IDI = Used for IDI participants only e.g. F1-IDI-MTP = Mtwapa IDI participant

	f	%
Age		
20 and below	2	5.6
21-25	4	11.1
26-30	12	33.3
31-35	11	30.6
36-40	6	16.7
Above 40	1	2.8
Marital status		
Single	20	55.6
Live-in-boyfriend	7	19.4
Married	6	16.7
Separated	3	8.3
Educational level		
No school	3	8.3
Primary	17	47.2
Secondary	7	19.4
College	2	5.6
No. of children		
None	5	13.9
1-2	12	33.3
3-4	1	2.8
Partner's drug use		
Heroin	21	58.3
Methadone	10	27.8

Others	2	5.6
Partner's occupation		
Matatu tout/conductor	13	36.1
Drug selling	6	16.7
Collecting scrap	3	8.3
Others	8	22.2
Residential status		
In rented house with partner	25	69.4
In partner's family house	5	13.9
Street	6	16.7
Sex work as livelihood		
No	9	25.0
Yes	27	75.0

The majority of the respondents were aged above 25 years ($M = 30.50$, $SD = 5.57$, range 19-42); were single or living with a boyfriend; had a primary education and had between 1-2 children. However, only 29 and 18 respondents gave information on education level and number of children respectively. Over half of all respondents had drug-using partners.

Three quarters of WWUD reported engaging in commercial sex work due to lack of other means of livelihood to finance drug use (F5 PLWHIV); to help family meet their basic needs (F1 PLWHIV); because current partners did not provide basic needs for sustenance (F1-IDI BOM); and as protective behaviour to prevent partners from theft to finance drug purchases (F1-IDI-PLWHIV).

The sample of key informants comprised two criminal justice system officers (Magistrate, Shanzu Law Courts and a police officer), one probation officer, 2 officers from the Ministry of Health (Medical Officer and Community Health Officer), a religious leader (Imam), and a local administration leader (Mzee wa Mtaa).

4.2 Identifying WWUD suffering GBV

Discussions with key informants revealed that it was believed that it was only possible to identify WWUD who had experienced GBV after it had occurred. Participants believed that the characteristics indicative of WWUD who have suffered GBV include being intoxicated; lack of coherent expression; being unkempt, i.e. "they just do not look like the average person"; not organised; and possibly homeless (PO); and most will accost men who used them on the roadside demanding for payment for sex services offered (MWM). Some key informants were able to identify them by their complaints or by unwanted pregnancies (CHO); stress, loss of hope and are "not healthy". In the words of the Magistrate Shanzu Court (MS), they "are not people you would want to be in custody for quite some time". For the probation department that receives offenders, looking at underlying psychological and emotional instability was a

pointer towards identifying current GBV.

4.3 The prevalence and lived experiences of GBV among WWUD and their children.

4.3.1 Experiences of GBV

The most common GBV violations reported included verbal abuse, physical assault, sexual violations (including rape), theft and robbery of property especially money (RL-I; PO); forced sex (RL-I); and psychological and emotional threats and violence (MO). This was especially prevalent among WWUD who engaged in sex work to afford drugs. Sometimes women were not paid for sex work and were assaulted when they asked for payment (MWM). It was believed that sexual violence also extended to teenage boys and men who could not afford drugs (MWM); and in cases of men who use drugs, introducing underage daughters (usually step-daughters) to sex work (MO; MWM). The Medical Officer described five sexual violence cases reported in her facility in the current year (2020), three of whom arrived in disoriented mental states and a further two who arrived beyond the maximum 72 hours limit after the incident.

Most of the cases of violence received in court were believed to be drug related arising from WWUD who “tend to always be on the lookout for money to finance the addiction” (MS). These included cases of physical assault regarding money to finance drug dependency; WWUD who were assaulted by their non-drug taking partners because of their drug use; a drug using couple fighting over money earned; or a woman assaulted because it was considered culturally accepted (MS). For children, the main perpetrators of sexual violence were fellow children/youth (PRO). Physical abuse among people who use drugs resulted from questions raised about spending on drug purchases (RL-I) instead of household food. Close family members were thought to perpetrate physical and verbal abuse in the context of the family home, including where men who used drugs believed they had lost ‘authority’ by his inability to provide for his wife.

Interviews and focus groups showed that GBV experienced by WWUD could be classified under the following intersecting categories:

4.3.2 Experiences of Physical Abuse against WWUD and their Children

Physical violence was the most reported form of violation. The predictors of physical abuse intersect with other forms of violations and could be categorised into abuse by sexual and non-sexual partners, persons representing institutions (law enforcement officers), and strangers. Some WWUD were physically abused for stealing partner’s or clients’ money, in the home and in maeneo. From the beatings, some women (F2 MTP) reported that they had developed “ailments”; vomited blood (F4 MTP); and suffered back injury (F1-IDI-Magodoroni, 33); broken

teeth (F1-IDI-SHZ; F1-IDI-PLWHIV); and head injuries, bruises on legs and a dislocated arm (F1-IDI-MTP).

a. Physical abuse from partners

Physical violence perpetrated by partners includes getting locked out of, or only being allowed in the house intermittently; strangling and being hit with a blunt object; threats of death accompanied by serious beatings, including in front of the victim's parents (F1-IDI-BOM); tearing clothes off WWUD (F1-IDI-SHZ) and being beaten with a walking stick (F1-IDI-MAG); and being hit against a wall and slaps (F1-IDI-PLWHIV) among others. These acts of physical abuse were perpetrated by male partners who it was thought wished to maintain a "macho image" – and who did not apologise for the offence because "he has the right to do anything" (F1-IDI-PLWHIV).

WWUD reported receiving physical abuse due to theft of partners' money (F5 PLWHIV); hiding the partner's kete (sachets of heroin) (F4 PLWHIV); suspicion of unfaithfulness following jokes full of sexual undertones from an acquaintance in maeneo (F3 PLWHIV); and stealing from clients in sex work (F4 SHZ). For some participants (F3 BAMB), stealing was their response to the injustice of not getting paid for sex work, and for an immediate need for drugs. Other WWUD reported suffering beatings for leaving the home; or going out for sex work and not coming home with money (F2 BOM).

WWUD reported being assaulted by partners in maeneo (F1 PLWHIV; F5 MAG), which was closely related to the partner's attempt at control. One partner reported that if a partner found a WWUD in a maeneo smoking with an acquaintance, it could be concluded that they were sexual partners and the ensuing verbal confrontation led to physical violence (F4 MAG). Violence in a maeneo was normally accompanied by threats from partners who do not want women to be there. As reported by F5 PLWHIV: "He told me to move out of maeneo...if he found me in maeneo, he would beat me".

Other reasons include the partner doubting the paternity of a pregnancy or children (F1 MAG). This violence was accompanied by public humiliation including being undressed, sometimes in front of the children, and general brutality towards the children (F1 BOM).

One of the most often cited causes of physical abuse was partners' lack of money. F1 MAG was physically abused as a way of managing her partner's frustrations, especially if she came home empty handed. This was enabled because they lived in the partner's family house. Additionally, if she left the house to steal but returned home without money, she would suffer physical and verbal abuse. In most cases, WWUD suffer physical (and verbal) abuse when they did not bring (enough) money from sex work, because "you gave out yourself for free the entire night?" (F1-IDI-PLWHIV).

Rejecting partners' demands to sell household goods to purchase drugs was also related to physical abuse (F1 MTP). Other reasons for being "turned into a drum" [i.e. receiving a beating] (F2 MTP) included, WWUD demand for drugs from their partners, insistence to go to maeneo to find drugs against partners' wishes; partner's control over spending, rejection of forceful demands for sex (F1-IDI-MAG); and partner's possessiveness in terms of demanding that she be indoors in the home when the partner returned, lost earnings from peddling and failure to do chores e.g. laundry (F1-IDI-PLWHIV).

Some forms of physical abuse were aimed at entrenching interpersonal dependency by humiliating the victims. Some cases of beatings were accompanied by burning of property – mattress, basin, shoes, clothes; cutting of hair; and these were sometimes carried out in front of the child (F1-IDI-SHZ). F1-IDI-MTP also reported that her current partner would sell her household goods, take her money and become violent when confronted. Further, physical violence followed a cycle of abuse where WWUD were abused, they forgave the perpetrator, had moments of relative calm, but then the abuse would resume (F1-IDI-SHZ).

An important point in considering physical abuse relates to their attributions. Some WWUD normalise violence by justifying the causes – ranging from their partners' "unbalanced moods", "a wire that has snapped" (F2 BAMB); the partner during arosto (need for a rush) and frustrations for not obtaining money (F1-IDI-MAG). Having been strangled, suffered swollen eye and being bedridden for a week, F5 MTP believed that physical violence was a normal occurrence because "as a Mteja married to a Mteja, you must be beaten with or without a reason."

b. Physical violence by boda boda

A case of generalised violence was reported to have been due to mistrust between boda boda (motorcycle taxi) operators and a woman who used drugs with the former accusing the latter of stealing from them. F5 MTP reported that she was beaten 'half-dead' because she was a 'Mteja'.

c. Physical violence by Law Enforcement Officers

WWUD reported that violence was mostly perpetrated by the Police "since our houses are in the maeneo" and because "Mteja has no rights" (F2 PLWHIV). Police are always likely to arrest them, physically assault them and book them in the station over trumped up charges. The arrests were reported to typically place on Fridays, with victims having to endure the physical pain from police beatings until they appeared in court the following Monday. Participants reported that they were physically assaulted by police while lying on their stomachs in the dirt in Bamburi maeneo (F1 BAMB, F5 BAMB). The reason these participants gave for this was because "all mateja are disrespected and harassed" and "we always wonder if Mteja is not human"! (F3 PLWHIV).

d. Peers

Other forms of physical abuse were carried out by non-sexual partners. The reasons given were closely associated with the loss of drug earnings. For instance, F1-IDI-BAMB reported being savagely beaten for hours in a maeneo in Bamburi after being accused of hiding drugs while in the company of other drug users who ran away when Police raided the establishment. She was accused of having hidden the drugs for her own benefit.

e. Physical Abuse against Children of WWUD

Physical violence has effects on WWUD and their children. In a number of cases, their children who were perceived as “burdens” by their stepfathers lived with their grandparents in order to protect them from physical violence (F1-IDI-BOM).

For some whose mothers who were engaged in sex work, children experienced being locked up in rooms alone at night and lacking food and school fees (F4 MTP). In other cases, children were forced to live with other family members because of fear of sexual abuse or exploitation by partners (F4 MAG), death threats to the child and doubts over the child’s paternity (F1-IDI-PLWHIV), or verbal abuse which often degenerated into physical abuse.

4.3.4 Experiences of Psychological/Emotional Abuse against WWUD and their Children

Psychological/emotional abuse was presented in a number of forms affecting both WWUD and their children.

a. Stigma and discrimination against, and isolation of WWUD

i. By Family Members

The range of psychological isolation reported ranged from being “hated” by own and partners’ family; to a loss of contact with others. For instance, F4 BOM reported that she believed she was hated by everyone in her family due to her drug dependency, while F2 MAG reported that the partner’s family does not keep contact with them and did not value her, despite her ill health; and similar to F1-IDI-BOM who reported that she had not spoken to her family in a year. The lack of “trust” by the partner’s family was also raised as a concern (F1-IDI-MAG), and this had serious implications. For instance, during the entire duration of F2 MTP child’s sickness, she did not receive any support from family members because they thought that she wanted money to purchase drugs. Further, the participant reported that her child had died in her arms whilst she was waiting for treatment in at the hospital, and the body was buried without her knowledge. This experience of trauma was believed to underpin her subsequent drug overdoses.

WWUD cited the lack of acceptance in their partners’ family and involvement in their social interactions as part of the psychological isolation. Some participants (F5 MAG; F1-IDI-BAMB) had never been introduced to their partner’s family or involved in social functions including weddings, funerals, etc. This discrimination was both direct and indirect by the entire partner’s family. F1-IDI-PLWHIV reported that neither she nor her child had been accepted by her

partner's family who were keen on a reunion between their family member and his former wife. She could not cook in the family kitchen because of demeaning statements from family including "how can a Mteja cook our food...will she not put dirt in our food?" Similarly, F1-IDI-BAMB reported that her partner did not want to introduce her to his mother because he seems to have been "passing time with me" – further evidence of self-deprecation; and that she was homeless during the period of her pregnancy but was never accommodated in her partner's family house.

WWUD who lived in their partners' family home were more likely to be given excessive household chores and blamed for everything that went wrong in the household. In such cases, the WWUD was isolated by both the partner's family and the partner himself. The parents were usually unlikely to intervene during episodes of physical and verbal abuse, but blamed her for introducing their son to drugs (F4, 31, MAG).

Some WWUD reported that their partners' families were unwilling to see their sons' personal responsibility in drug dependence and instead blamed the women. This led to isolation from their partners' families. For instance, F2, PLWHIV's sisters-in-law would not accept anything she did and she was not allowed to have food in the family house. Her partner blamed her for conflict with his mother (her mother-in-law). A number of participants (F1 MAG; F1 BOM; F1-IDI-PLWHIV) also reported carrying the blame for their partners' drug dependence and criminal behaviour, but were in fact introduced to drugs by their partners.

In some cases, the devaluing of WWUD was encouraged by their own families who did not allow the children of WWUD living in their custody to help their mothers (F5 MAG), and ended up "tiring" of their daughter's behaviour (F4 MAG). Without such material support, some women relied on criminality for support.

ii. By Partners

Dependence on a partner for economic and emotional resources underpinned other forms of abuse. For instance, asking for and not being given money led to verbal abuse (F1-IDI-PLWHIV) and frustration, which was dealt with using more drugs, paid for by sex work (F1, BOM). In other cases, the partner spend all the money on drugs, leaving the household with no food (F3 SHZ), hence putting further pressure on WWUD to engage in sex work. However, participation in sex work interacted with a culturally-embedded identity where men are typically seen as providers, which further eroded self-esteem and a sense of abandonment when this material support wasn't forthcoming. Dependency on a partner was also associated with increased verbal abuse and self-deprecation, where WWUD were made to feel like a "burden" and "idler" when they asked for money or drugs. In other cases, economic dependency resulted from being disinherited (F1 MTP) or having their savings taken by their partners (F1-IDI-MTP who lost \$630).

The consequences of social dependency lingered beyond the breakup of relationships and some women still maintained contact with partners. While some WWUD reported being able

to leave the relationship, they were 'lured back', with familiar outcomes of physical assault, and denial of food, money and drugs (F1-IDI-MA; F1-IDI-PLWHIV)). For example, one participant (F1-IDI-PLWHIV) believed that it was still her responsibility to ensure that her former partner adhered to his ARV treatment as they shared HIV positive status, and believed that if she left him, he would die. She spoke about death of her partner's mother and the impact this had on him, leaving him feeling suicidal and hence feared that she he would die if she left. Her concern for his health and wellbeing was reciprocated with verbal abuse. This was sustained by daily 'guilt trips' where "each and every day he keeps on blaming me over the HIV issue" and constantly referred to her in demeaning terms like "prostitute" even in front of his friends in the maeneo. Others (F1-IDI-BOM), were desperate to leave relationships, but did not know how.

The unending sense of loss of identify and repeated humiliation led to emotional fatigue where the WWUD wished to quit sex work but was faced with the reality of lack of basic needs. F2 SHZ related her emotional turmoil of working to cater for her needs and those of her husband who neither supported her nor his children.

A narrow but important aspect of emotional abuse stemmed from their HIV status. WWUD felt wronged for getting infected and also unfairly blamed for having infected their partners. F1-IDI-MTP reported that her former partner would cheat on her while she was pregnant and infected her and consequently her child with HIV. Emotional abuse was tied to physical abuse in the case of F5 PLWHIV who was infected by the partner, then abandoned and blamed for infecting him. "I was staying at his place until he did not want to see me...chased me away". Further, F1-IDI-PLWHIV indicated that her partner was bitter at her for infecting him and "each and every day he keeps on blaming me over the HIV issue". While he believes that she may have contracted the virus during her sex work, she feels emotionally disturbed because she blames the partner's promiscuity for the virus. In some cases, WWUD HIV status was used against them to deny them access to their children. F1-IDI-MTP reported that her first partner's denial of his HIV status denied her child (also positive) of ARV treatment. Instead, the partner felt that she could not sustain the child because of her condition, and this demeans her among her friends and acquaintances.

Most WWUD reported that they felt that they were not valued – from being referred to as 'Mteja' in public (F3 PLWHIV) and even by children (F2 PLWHIV); to negative comparisons to non-drug using partners. For instance, F5 MAG, the second of two wives, the other of whom did not use drugs, reported that her partner only valued her when she had money but abandoned her for the other woman when she had nothing. She was also verbally abused before other people in reference to the non-drug using co-wife. Further, the partner's family valued the "other woman".

iii. From the Public

Women who use drugs suffer multiple stigma – from their drug dependency, health status, place in society and their children. This led to discrimination in residential settings and in

employment. When WWUD move house, they are likely to be isolated by fellow residents and any property lost is blamed on them (F4 PLWHIV) in addition to their children being isolated and constantly reminded that their mother is a 'Mteja' (F1 BOM). Similarly, they were more likely to be referred to as "those mateja from MEWA" and not as women or using their names. This has implications for their work, since men saw them not as women but as 'things' that primarily dealt with male sex urges. For some, the uteja reputation, and their current partners' social and health status (HIV+) decreased their chances of having serious romantic relationships, with new potential partners put off (F1-IDI-BOM).

The stigma associated with being labelled as 'Mteja' had further negative effects on WWUD. In their places of residence, they feared being associated with others with similar identity labels because of criminal acts perpetrated by some of them. If they spoke out in support, they were perceived to be protecting them (F4 PLWHIV). In other cases, WWUD served jail time for handling stolen goods and whose cases were fast tracked because they were labelled as 'mateja' (F4 BAMB).

Participants reported being accosted by members of the public on suspicion of carrying stolen goods. "If you are carrying your purse...what is she carrying...it must be stolen...give chase...don't you know that mteja from Bamburi"? (F6 BAMB). They were also demeaned on the basis of HIV status with claims that "you move around painting [infecting] others with the (HIV) virus" (F1-IDI-MTP).

Due to public perceptions that WWUD were only looking for money to buy drugs, it was difficult for women to seek assistance from others (F1 BOM). This added to women's feelings of alienation and loss of worth (F4 MAG). In common parlance, 'mateja' are described as having lips as 'dark as kunguru (the raven)' (F1 BOM) – a pejorative remark. Such demeaning physical descriptions were related to other forms of abuse because they connect the uteja with the individual. Consequently, they were abused because someone "takes advantage that I am a mteja so there's nothing I can do" (F5 MTP). More specifically, WWUD face the paradox of being demeaned by non-drug using men during the day, but sex working to make money for them during the night (F1 MTP). This double standard was indicative of the lack of respect shown towards WWUD as human being.

WWUD also faced stigma from their own families by being isolated and kept away from the family home or having them arrested (F5 MTP) thus removing an important source of social support. Others self-stigmatised because of perceptions of benefitting from proceeds of stealing (F1-IDI-MAG) and in the end do not feel that they have enough mental or economic resources to take care of their own children (F4 PLWHIV).

Interestingly, with the belief that having something of their own returns their worth, it was reported that references to 'mteja' stopped once one is able to take care of her child well, pay her bills and have some property e.g. a bed (F4 PLWHIV).

b. Self-stigma

Society's devaluation of WWUD led to self-stigmatise. In the words of one woman, being labelled a 'Mteja' means not being valued by a partner who may also be using drugs, and other people who have license to use demeaning language (F1-IDI-BAMB). Their worth in the eyes of their partners was dependent on having money to purchase drugs (F4 MAG). The alternative is verbal abuse. They were also seen as worthless in the residential area and could be trusted to pay rent by their landlords (F1-IDI-Mtwapa). Their own families did not trust them as in the case of F2 SHZ whose young niece was instructed to track her from the bathroom to the bedroom to ensure she did not steal anything from the house. She had to request to use the bathroom and before she changes into other (clean) clothes, the room must be cleared of everything else. Instead of confronting this behaviour, WWUD self-blamed (F4 SHZ) through generalization – that they were not to be trusted because all Mateja are not to be trusted.

The normalisation of abuse arising out of the devaluation was in itself a self-fulfilling prophecy. Despite their obvious difficult circumstances, some (F5 MAG) felt that they would be a "burden" if they went back to their families for support, and also feared questions about why their partners could not take care of them. In partners' families where there were no other instances of substance use, WWUD were demeaned (F1 BOM). Others have lost all their friends and were the subject of jokes and humiliation (F3 SHZ). This was compounded by challenges of disclosure for inexperienced WWUD who were not comfortable having their family aware of drug use or the impact of violence or abuse on their mental wellbeing.

Self-stigma could also lead to dependency on others. One participant who had no living parents could not leave a abusive relationship because "when my parents died I had no choice but to be with him because when you have children you have more responsibilities beyond drugs and 'hustling' (F1, BOM). This need for companionship and support was the foundation of the abuse she experienced.

Self-stigma was also a result of the behaviour of partners. Participants reported having their clothes and toiletries sold by their partners and the resultant "total heartache...and big problems" for having a partner who used drugs (F1 SHZ). Shoes and clothes were destroyed and other property such as personal mobile phones were sold. Women also had no rights over any household property, including her own (F1-IDI-BOM). Participants reported being mistreated in other ways, such as partners making phone calls to an ex-partner in her presence; allowing the ex-partner spend days at the family house, as well as finding "other naked women in intimacy on my bed with my partner" (F1-IDI-PLWHIV).

As part of the devaluing process that leads to self-deprecation, WWUD suffered emotional violence in many forms. These ranged from favouring other partners, demeaning and controlling behaviour, and threats of future violence (F1-IDI-PLWHIV). Threats could be verbal ("you will not stay here a further year...not even a further month" (F1-IDI-PLWHIV)), or accompanied by a weapon, especially when the woman was seen in the company of another

man (F2, PLWHIV). Additionally, they were not cared for when sick, or their partners would not share their drugs with them.

WWUD perceived that emotional abuse was a product of their devalued state. As a consequence, F1 MTP reported being disinherited of her late parents' property because "I have no voice" while F1-IDI-SHZ attributed it to her state of being an orphan and being isolated from her family.

c. Stigma and discrimination against children of WWUD

The devaluing of WWUD extended to their children, who were victims of verbal abuse in relationships where WWUD's partners were not the biological fathers of the children. This was perpetrated by both partners and their families. In the case of F5 MAG, who lived with her 17 year old son, the family did not value him "because it is me who is bringing him up". He was discriminated by the larger family and may not get what his cousins/nieces get from their uncles and aunts and it makes him feel isolated. He did not feel like going back to visit the family. She was conflicted between letting the child have a positive attitude towards the family and the rejection he would receive on account of her circumstances. The child suffered because "the parent (grandparents) have not lived with the child but already wrongly judged him because he is brought up by a 'junkie' and must behave as such". The child believed that he had no grandmother or aunts. To add to the devaluing, she did not receive any support from the partner or his family; while others participants remained on permanent bad terms with their partners' parents (F1 MAG).

WWUD also suffered from the relocation of their children with the attendant changes in routine and denial of time to earn a livelihood. For instance, in the case of F1-IDI-MAG where the children were taken care of by a sister-in-law, she was the sister-in-law's de facto house help because she had to spend the whole day in her house doing chores including laundry, cooking, etc.

Children also suffered direct and indirect verbal abuse from step-fathers. In the former, the child's parentage might be spoken of in disparaging terms like "your father must have been a bhang [cannabis] addict" (F2 BAMB); or be the target of verbal abuse and physical violence when it was perceived they had disrupted with intimate moments. The resultant social isolation, lack of money for the day's provisions and threats of being abandoned affected the child both directly and indirectly. This situation was worsened by the COVID-19 pandemic when WWUD could not find alternative sources of income through sex work due to prevailing restrictions including strict curfew hours. For some children who witnessed the physical abuse of their mothers, their reactions took the form of constantly asking their mothers to move house, and in one case ended up being brought up by relatives (F1 MTP). Verbal abuse aimed at children was cited in the responses of F1-IDI-PLWHIV who reported that while nursing her baby in her partner's family house, one sister-in-law would comment "this house is full of Mateja" while F1-IDI-SHZ alluded to other people's references to her child as "prostitute".

4.3.5 Sexual Violence against WWUD

Reports of sexual violence could be categorised into those perpetrated by sexual and non-sexual partners and in the context of sex work. Further, there was a strong link between sexual violence and other forms – physical, verbal, and psychological. The main perpetrators of sexual abuse were intimate partners (PRO); fellow drug users or “partners in crime” as PO referred to them; non-drug users (CHO) pretending to help them but taking advantage because they know “this is a drug user who is confused because of drugs” (PO); and male clients in sex work (MO) who undermined WWUD because they do not know their rights and are overwhelmed with life due to drugs (CHO). In the context of sex work, the main perpetrators of abuse were non- men (F5 BOM; F5 MTP).

Reported consequences of sexual violence included an unwanted pregnancy from random sexual partners (F1 MTP); contracting HIV from a boyfriend (F2 MTP); and random predators taking advantage of women’s vulnerability at night (F4 MTP).

a. Sexual Abuse by Partners

Within relationships, refusal of partner’s demands for sex when WWUD were hungry or in drug withdrawal (‘in arosto’) resulted in verbal abuse followed by physical abuse and forced sex (F5 MAG). Luring WWUD to their houses, former partners were reported to have perpetrated rape (F3 BAMB); attempted rape (F1 BAMB); and bodily harm, including strangulation, bruises and bites while threatening with a weapon (F2 BAMB). Current partners were also cited in reports of forced anal sex and physical abuse in case of resistance (F3 MTP).

The acceptance of sexual violence was used by WWUD to escape physical abuse. For instance, F4 MAG gave in to forced sex because she feared that refusal would result in physical assault and being locked out of the house to spend the night in the maeneo. On the contrary, F4 MAG rejected a partner’s sexual advances because she believed that he did not care for her, and equated his actions equivalent to rape by a stranger.

Male partners also misinterpreted womens’ relaxed state that followed heroin use to mean that they desired them, which also led to demands for sex (F1 BOM). At times, demands for sex when the female partner was in drug withdrawal result in sexual and other violence (F3 BOM). Verbal abuse was also evident through the use of demeaning words like ‘prostitute’, ‘dog’, ‘worthless’ and ‘homeless’ (F1-IDI-MAG); or occurred when drunk (F1-IDI-MTP); or as when given drugs as payment for sex (F4 BOM).

b. Sexual Abuse by Clients

The majority of women interviewed reported getting paid less money or nothing for sex work as the most common violation (F3 PLWHIV; F5 PLWHIV; F3 BOM; F5 BOM; F4 MTP). This was usually accompanied by physical violence including strangulation and beatings, being thrown out of the room at night (F4 BAMB; F4 MTP), and death threats (F1 SHZ). Demands for forced sex also end up in physical violence (F2, 22, BOM) because of ensuing arguments. WWUD reported experiencing sexual violence during the act of sex and after (mostly physical) (F5

MTP); and rape on the streets (F1-IDI-BOM) accompanied by threats with weapons (F1-IDI-PLWHIV).

The devaluation of WWUD engaged in sex work was partly responsible for sexual violence. Most sex work was done out of the public eye in locations such as empty alleys, football pitches and bushes at night with no agreement in advance on how much would be paid (F3 PLWHIV) and where the likelihood of perpetration was increased (F1 SHZ). As a consequence, clients' sexual fantasies were reported to be one of the motivations for sexual violence. A number of WWUD reported that some clients strangled them in the act of sex and then whispered "give me my money"! Their money was then stolen (F3 PLWHIV; F1-IDI-BOM). In other cases, sexual partners demanded sexual acts that women thought were unacceptable; or men took longer than previously negotiated and refused to pay for the extra time (F4 MAG). Women reported being beaten with objects such as a metal bar after receiving demands for particular sexual acts; and demands for anal sex with bundles of monetary notes being waved before them (F1, 33, MTP; F4 MTP). Other men deliberately tore condoms (F1-IDI-BOM). Other sex acts included unwanted touching from drunk men and physical assault (F1-IDI-MAG).

Further, strangers would forcibly drag WWUD into alleys at night with the justification that "are you not just looking for heroin? Are you not a common prostitute?" (F1-IDI-PLWHIV). As well as being the victim of serious sexual assault, women's partners would also physically and verbally abuse them for not making money from the episode.

Other physical violence in the context of sex work was related to WWUD stealing money and phones from their clients (F3 PLWHIV). Sometimes a client would claim that a WWUD had stolen from him when they were not keen on paying for sex. In other cases, WWUD were threatened using weapons and robbed of all their money after negotiating for and offering sex (F3 PLWHIV; F5 BAMB; F4 MTP; F1-IDI-MAG). This was also done in conspiracy with guesthouses' security guards who do not stop the perpetrators even when notified by the victim. Sometimes, weapons were also used in rape attempts (F1-IDI-BOM).

WWUD reported the likelihood of increased sexual risk when they encounter a client who wanted unprotected sex for a supposedly higher rate, especially moment when a women was in drug withdrawal and needed money for drugs or other provisions. (F4 BOM; F5 MTP).

c. Non-sexual partners

In maeneo, WWUD reported fondling and other unwanted touch by random men who used drugs (F2 MAG; F4 MAG; F5 MAG). This was also in addition to constant sexual innuendos that demeaned WWUD and the prevailing sexual risk where WWUD would spend the night in the open (F4 BOM). The devaluation of WWUD by drug taking partners was associated with sexual violence in maeneo. For instance, unwanted touch on buttocks could be because "you are just a common prostitute". For rejecting a non-sexual partner's advances, demeaning rumours that "her private parts stink" may be spread (F1-IDI-PLWHIV).

Rape was also reported in the context of loss of drug earnings where F1-IDI-BAMB reported having been raped by two non-sexual partners in the drug trade alongside her other male non-sexual partner who was also raped. This has serious effects on her mental wellbeing, especially as the perpetrators were not charged.

d. Sexual Abuse by Law Enforcement Officers

A small number of WWUD considered law enforcement personnel as perpetrators of sexual violence. For instance, F1 MTP reported that she offered sex for her freedom when arrested by the Police, and F1-IDI-BOM exchanged sex for her freedom when arrested by a County Government enforcement officer.

4.3.5 Verbal Abuse

Verbal abuse is the pivot upon which all other forms of abuse started or ended. While some was short term, and discounted as being 'in the heat of the moment', other WWUD reported it as a daily occurrence. Verbal abuse took the form of demeaning language, and could be received from sexual or non-sexual partners at home or in maeneo; in the streets during sex work or by the public, or family (F1-IDI-BAMB).

Verbal abuse in maeneo were reported by many WWUD (F1 PLWHIV) and were delivered in such a way that women thought "it were better if he beat me up" (F2 PLWHIV). Some verbal attacks were meant to humiliate WWUD before their peers in maeneo (F1 BAMB). In the household, verbal abuse may be as a result of unfinished chores, or money meant for food spent on drugs (F1-IDI-MAG). However, for many, verbal abuse was normalised and attributed to partners' "high tempers" when asked for money for drugs (F2 MAG); or as venting frustrations of not having enough to sustain the household (F4 SHZ; F1-IDI-SHZ) -"I have got used to his insults" (F3 SHZ).

Some women were verbally assaulted in the presence of their children (F5, 37, MAG), which had negative psychological effects on them (F1 BOM). Children also suffered verbal abuse by the larger community when they were described in relation to their mother's 'uteja' (F4 MTP).

Some verbal abuse was also reciprocated as a means to fight back against partners. For instance, when F4 MAGs partner called her a "prostitute", she answered back that he was "a weak man who allows his wife to go sell herself!"

4.4 Psychological and Structural Enablers of GBV against WWUD

GBV against WWUD requires was perpetuated by structural and other societal factors. Discussions showed that these factors range from personal (including psychological) to community (including family, beliefs, structures of government).

a. Psychological Factors that Protect and Perpetuate GBV against WWUD

i. The concept of 'Control'

An important and distinct aspect of psychological abuse is control. WWUD reported several intersecting aspects of control. In some cases, control was referred to in the context of

possessive partners. For instance, F5 PLWHIV reported that her partner was so possessive to the extent that he did not want her to leave the house. He would follow her and check with other people where she had been during the day. Such behaviour on the part of her partner was related to physical abuse (an eye injury caused by being hit with a bottle) and separation. Similarly, F1 PLWHIV reported that her partner kept tabs on who she relates with in maeneo and even tried to accompany her to the research interview. Other WWUD were not allowed out of the house so that they “do not mix with other men” including neighbours (F4 MTP), friends more than a block away (F1-IDI-SHZ; F1-IDI-BOM) or not at all (F3 MTP), or drug-using acquaintances (F1-IDI-MAG). Controls were also placed on what they wore (F2 BAMB) and their daily schedules controlled (F1-IDI-MTP). Both F1-IDI-SHZ and F1 BAMB were questioned by partners about their location and have to be indoors when the partner gets home. Further, F1-IDI-SHZ was questioned if she even visited the shop. Physical abuse towards WWUD was associated with attempts at control. For instance, F1-IDI-MAG reported that her partner fought her and the man she was taking drugs with, and this led to a back injury. She was isolated by everyone else because her friends (including female friends) tried to avoid her partner. Similarly, F1-IDI-BAMB’s current partner did not tolerate seeing her keeping the company of other men and he would assault and rob the other man. Her former partner would take her phone so that she could not communicate with anyone else. During pregnancy, F1 MAG was not allowed by her partner in maeneo and she could not talk to any other men. If she did attend the maeneo and had no money, nobody would buy her drugs until he arrived because he would assault any man keeping her company.

Control also manifested in partners’ ability to stalk and find where WWUD had moved to after fights. Both F2 MAG and F3 MTP reported that their partners would still find and return them home even when they moved house while F4 MTP’s partner stalked her long after they were separated. In the former case, a return home was also followed by physical abuse.

Psychological control was evident in partners’ control over money. In some cases, partners always wanted to know the source of money if WWUD were seen to be intoxicated (F4 BOM); or they would take WWUD’s money (F1-IDI-MTP); insist on using WWUD money, while she had no access to his money (F1 SHZ); or threaten to withhold rent payments, food and clothes when confronted with questions about promiscuity (F1-IDI-MTP). In cases where the WWUD had no means of earning a livelihood whether through control, choice not to engage in sex work or illness, their partners decided if and how much provisions are made available. WWUD were sometimes dependent on food provided by a philanthropist in Mombasa (F1-IDI-BOM); or simply went without (F3 MTP).

There was also the suggestion that some partners depended on WWUD. For instance, F2 SHZ’s husband actively encouraged her to go find sex work to provide for them; while F1 MTP’s boyfriend encouraged her to do sex work. Refusal often resulted in physical abuse. WWUD interpreted being sent out by the partner to find money by whatever means to mean either stealing or sex work because “when a man tells you to go find work, he has already accepted

that you are going for sex work...going to steal...". This often ends in physical assault by clients (F₄ MAG).

Denial of access to WWUD's children was another aspect of psychological coercion, which resulted in denial of social support, identity and in some cases material support. This denial was overt and crude. For instance, upon separation, F₁-IDI-MAGs partner blocked her from visiting her children using death threats – that "he would chop me into pieces if I ever went to [partner's family house]" and instructed children "not to talk to me".

Some WWUD experienced the dual effects of not receiving economic support from their partners and at the same time had no freedom to do as they wished with their households. Further, F₁-IDI-MTP reported that her partner controlled all her schedules and threatened her with death if she left him, yet she also took care of all her own bills.

ii. Normalization of violence

Low reporting of GBV was partly due to the normalisation of abuse by some women. These women did not interpret the experiences as abuse and even felt sorry for the perpetrators. F₅ PLWHIV reported that she would feel pity for the perpetrator as if she reported the incident, he would be jailed, and so she forgave him. Abuse was sometimes represented as insignificant, like the case of F₂ PLWHIV who thought it to be "a small matter that does not need to be reported". For others like F₃ PLWHIV, it was a case of learned helplessness because "so what can I do?" This may also be indicative of lack of knowledge about who or where to go as reiterated by F₄ MAG. Further, WWUD have found ways of temporarily withdrawing from the abusive situation e.g. leaving the house or getting inside the house, getting a rush or remaining silent (F₅ MAG); or simply stopping to count the frequency when it goes beyond 100 (F₄ MAG).

Dependence presented as "love" was also found to predict low reporting rates. F₁ MAG reported that she could not report physical abuse because she loved her partner and would not want to see him in jail because she will "suffer more". Upon separation and subsequent threats, F₁-IDI-MAG did not report because "in any case it is the children's father and I loved him a lot!" while F₁-IDI-SHZ withdrew the case because she had lived with him for a long time, she knew him and had been by her side for a long time.

Similarly, F₅ MTP suffered physical abuse from her boyfriend but never reported because "he was my boyfriend" and had been together for 7 years. F₁-IDI-MTP never reported abuse because "I have a very kind heart...I have been to prison so I know how it looks like"! F₅ BAMB has endured violence to the point of "being normal" and attributes it to her partner's lack of education because "even speaking English next to him is offensive". Partners are also likely to seek for forgiveness and have the cases withdrawn by WWUD (F₄ MTP).

Some WWUD reported that by the very nature of their lives (constantly looking for money for drugs), they would not have the time to report and follow up on the cases (F₃ PLWHIV; F₁-IDI-MAG). As stated by F₁-IDI-MAG: "Do you go looking for drugs or reporting?" Others feared the consequences of reporting including actual harm (F₅ BOM), and the responses of the partner's

family (F2 PLWHIV) to avoid blame (F4 MAG). By reporting an incident, the victim would become the offender in the eyes of the family. Considering the lack of police action, the victim risked actual harm (F4 MAG). This became a reality for F1-IDI-MAG whose partner found the Occurrence Book number (police incident) in her possession, tore it up and beat her for “attempting to send me to jail”. She spent 3 days bedridden. For some WWUD, it was too expensive to get to a police station to report an incident, and so they were more likely to spend the money for bus fare on drugs (F1 BOM; F1-IDI-BOM).

Normalisation of abuse was also related to WWUD’s limited social support systems in the form of friends or family to share the experiences; and that because of self-stigma, some would not to expose themselves. For instance, F4 MAG never shared her experiences with anyone because she felt “shy”; and F1-IDI-MAG felt that “I will be embarrassing myself” - and that she had not found someone to “push her to report”. Neither the partners’ families nor friends provided a safe environment for WWUD because families feared their violent sons (F1-IDI-MAG), supported their behaviour (F1-IDI-SHZ); and friends made it public (F1-IDI-PLWHIV). In fact, friends were thought to be out of the question because “they make it a song!”(F1-IDI-SHZ). Importantly, real concerns about welfare were considered in decisions of reporting, with money earning partners less likely to be reported (F1-IDI-MTP). F4 MAG suggested that their own families were “tired”; and F2 BAMB did not raise the alarm (during a savage assault) because of her fear that people would not help and would instead think that the man who assaulted her was her partner. F5 BAMB suggested that it was difficult to report incidents to family members because they “hated” them because of thie use of drugs (F1-IDI-MAG).

b. Structural Factors that Protect and Perpetuate GBV among WWUD.

i. The Process and Financial Burden of Reporting Cases

There were reports of processing delays at police stations across Mombasa, specifically Bamburi and Nyalii; and at the referral hospitals where P3 forms were signed. The P3 form is issued for free at the police station but a small fee is charged at the hospital (free if escorted by a police officer). While some victims of GBV may not have the Ksh. 40 (\$0.4) for photocopying the P3 form at the police station (CHO; MWM; PO); others feared the police and did not report incidents at all, or lacked witnesses. Others did not have bus fare to the referral hospital (PO) because in the coronavirus period “do you look for money for food or fare to court?” (MWM).

Inefficiency at the police stations was widely reported as a factor that perpetuates abuse. The “long process”, “taken around in circles” and “having other things to do” were major reasons for lack of reporting (F2 PLWHIV). F1-IDI-SHZ reported her assault at a police station (Bamburi), and was given a P3 form which she presented to the referral hospital four times being “taken round in circles because of COVID-19”. On following up at the station, she was told that the officer handling the case was unavailable. F3 MAG had reported 4 cases of physical assault but after being given the OB number, she was not able to access the officer in charge of her case because, she claimed, “money exchanged hands” – suggesting that police

could be corruptly influenced not to proceed with some cases. In fact, getting the police to make an arrest was believed to require money in terms of “the Cruiser (Police vehicle) needs diesel...they want soda...do you know where the perpetrator lives? Ksh. 500 (\$5) in diesel plus their soda...Okay?” (F5 BAMB). Sometimes victims would be told that there was no stationery to photocopy the P3 form. For a mteja, that mean that a crime would usually go unreported. For instance, F1-IDI-BAMB did not have Ksh. 1000 (\$10) to “fuel the police car” at a police station to travel to arrest perpetrators of her serious sexual assault (rape by two men). WWUD report that police were more enthusiastic about making an arrest if there was a likelihood of making money (demands of Ksh 500 (\$5) were typical), even if the perpetrator was easily accessible. In one such case, F1 SHZ was paid Ksh 20,000 (\$200) by the perpetrator’s family as pay out for a brutal physical assault (of being dragged on the asphalt road), and half of this was shared with the police (the officer who had made the arrest and his superior). The financial incentive was the sole motivation for the arrest. Overall, for reporting, arrest and follow up of cases, police demanded bribes in the form of ‘credit’, ‘fuel’ or ‘lunch’ (F2 SHZ; F3 SHZ; F1 MTP; F4 MTP). The result was “leaving it to God”, “healing on your own” and “silence” as F3 BAMB suggested that “nowadays you need money or someone to hold your hand...so I just kept silent because I did not have the money or someone to help me.”

Low reporting rates were also attributed to perceptions of police as being unhelpful and uninterested in follow up because they attach no value to WWUD (through labelling as a ‘mteja’). When a woman goes to the reception desk to report a case, it is more likely to hear a police officer say loudly “This is just a mteja...our mteja” or telling another officer: “Don’t bother with a mteja” within earshot of the women reporting (F4 MAG; F1 SHZ; F1 MTP); or that “this is the mteja from Shanzu” in the presence of everyone at the reporting desk (F5 MTP). This was cited as a reason for not going back to report or follow up. F5 BAMB concurred, adding that it is the norm for the police not to be concerned about WWUD. On reporting they were more likely to be disregarded because “mteja are used to stealing from men” (F1 SHZ). Instead, police asked them to apprehend perpetrators and take them to the station themselves, but to act swiftly if the arrest would lead to extortion of WWUD foreign sex clients (i.e. through received bribes).

Police behaviour was aligned with the cultural perspective that ‘lovers’ should be left to sort out their problems. For instance, during interrogation, when the police established that the perpetrator in the case reported by F2 BAMB was her acquaintance, they told her to go sort it out with him. Police did not consider reports of sexual violence because they deemed them to be consensual (F3 SHZ). Further, victims were more likely to be influenced by the same cultural norms that gave more respect to the “family man with children” and hence easier to withdraw cases against such perpetrators (F1-IDI-BAMB; F1 SHZ).

Clients referred to the police station as a result of a GBV incident experienced poor attitudes from officers, and reactions and responses that suggested that they did not take the incidents seriously (MO). Further, the police service suffered from lack of personnel – since cases of GBV

were though to be best handled by female officers who are in short supply; a lack of resources such as vehicles; and a lack of information in relation to who and where the violations occurred (PO). Police stations would have poorly resourced gender desks whose officers were also assigned other duties (MS).

The law demands that once someone is arrested for a crime, that they have to be presented before a court within 24 hours. However, some issues require time for investigation. For instance, for cases of sexual violence, the victim must be taken to hospital to have P3 filled. When the mandatory period elapses, the suspected perpetrator must be released (PO) and hence cases suffer from shallow investigations (MS), because the police do not interview the right people in the time provided. Having perpetrators back on the streets with their victims increased the likelihood of further abuse. Further, whereas it was legal, the procedure that allowed perpetrators to post bail at the police station was though to increase the chances of arrestees jumping bail more than when they were given court bail (MWM).

At times the victims of violence did not know how far up an investigatory chain of command they need to go in relation to reporting a crime. The police frustrated them by not following up cases. As a consequence, when the matter came up in court, the police file was often missing or incomplete, and the correct witnesses were not in attendance (MS). Community members did not understand why perpetrators were released, why cases took so long and how files got lost in court (MWM). It was believed that the lack of robust investigation and process provided perpetrators with opportunities to commit further assaults (CHO).

Courts depended on doctors to testify but at times they failed to appear – either because of frequent strikes, lack of time, or attendance at a different court (MS). Consequently, victims were unable to find a medic to complete the P3 form (PO) or to testify in court. This had been partially solved by having cases in the GBV category scheduled for Tuesdays at Shanzu Law Courts (MS). Further, when violations happened during the weekend when government institutions are closed, such cases were referred for the next working day – Monday – which would have implications for gathering and processing of evidence. This was compounded by the perceived lack of prioritisation of these types of incident by government officers due to issues of workers' strikes and salary delays (CHO).

Additionally, beyond treatment and collecting evidence, health providers have limited powers in relation to legal interventions for victims of sexual violence; hence it was believed there was a need to create synergy with the police. Finally, it was often difficult to find witnesses to GBV because of hesitancy in drug using communities to come forward and engage with the police and legal system (MWM).

Police work was believed to be challenging in cases where there was no perpetrator to arrest after incident reporting; when the identity of the perpetrator or their abode is unknown (F5 SHZ; F5 MTP; F4 MTP); or when family members of the perpetrator or victim (F1-IDI-SHZ) attempted to influence prosecution of cases and the release of the perpetrator. For instance,

F2 SHZ reported her partner for assault and he disappeared for a month until police gave up looking for him. F5 SHZ did not report a case of sexual assault because she did not know the identity of the perpetrator that she had met on the streets. Family members may interfere by bribing police officers or influencing victims to withdraw cases and in the process, any refusal by the victim to accept the demands is seen as being uncooperative, useless and stubborn with the mteja stereotype lurking in the background (F2 SHZ). Some of the perpetrators were already known to the police and that is why women such as F1-IDI-MTP feared retribution when the perpetrator threatened her with "I have my people" or that "the police station is our home" because of the belief that such people could not be arrested or the police would use delaying tactics when a report was made.

Because of the money-related barriers to reporting, it was noted that the only recourse for WWUD experience GBV was organisations such as MEWA or ReachOut (F3 MAG) and that their overwhelming desire was for police to view WWUD as "normal people" and consider their cases.

ii. Lack of Social Support System

Cases reported at police stations and even in court were sometimes withdrawn after the perpetrator spent a few days in the cells. This was because the complainant was economically dependent on the perpetrator (MS). More often, the victim withdrew the complaint, arguing that have forgiven each other and that "it was a small mistake". Some took too long to complete the P3 while some do not return because they have settled the issue or feel ashamed (PO). The cycle of violence was repeated once a partner wanted money to finance his drug use (MS).

For individual victims of GBV perpetrated by drug using partners, it was sometimes difficult to report because perpetrators lived in gangs and victims feared them (MWM). At the same time, community leaders could only advise and do not have powers of arrest, and faced resistance by others members of the community who did not want a spotlight on their lives. In many instances, cases of GBV were associated with societal beliefs about the place of women and consequently, the partner's family may support him in cases, making it difficult for the woman to seek further intervention (RL-I).

By the very nature of their lives, drug users were less likely to follow up on their cases even when they reported an incident (MWM). It was suggested, although supporting evidence wasn't provided, that some use the OB numbers and P3 forms to blackmail their partners for monetary advantage and when fulfilled, the cases disappear (MWM).

It was believed that there was a need for family support for effective follow up cases, because WWUD did not report their cases while in their "rightful mind" (i.e. not in a state of distress, periods of substance use, or intoxication). Women need someone else to support them and to see that the legal process is pursued to the end (MO). This similarly applied to support during

treatment because more often than not they have no telephone contact and cannot be traced when they default (MO) or in the case of minors suffering abuse (MS). Family support can also help to deal with stigma.

iii. Faith/Morals

The community's morals derived from Islam put emphasis on the concept of Sabr (patience/perseverance/persistence), and this is a part of faith which has implications for abuse. This demands that partners including those undergoing abuse to be 'patient'. It was believed that this could lead to continued silence over GBV, normalising its occurrence (RL-I). Additionally, among local cultures, perpetrators were more likely to be covered by their families even when children were the victims of violation (MO). More so, local communities were not aware of legal sanction against sexual abuse until they were labelled as violations in hospital or court (CHO).

4.5 Needs/gaps in dealing with GBV

a. Knowledge Gap of Legislative Framework

The Protection against Domestic Violence Act in Kenya enacted in 2015 anchors legislation on GBV and criminalises sexual violence. However, the low numbers charged under the law implies that the police are not aware of its reach or are enforcing its powers. It criminalises sexual violence (MS). Together with the Sexual Offences Act of 2001, The Children's Act of 2001 and sections of the Penal Code, the law is prohibitive enough although people still commit sexual offenses. Despite the available framework, there's need to strengthen processes that lead to prosecution of perpetrators (CHO).

WWUD are given the lowest bond terms so that they're able to secure it and go home to fend for themselves. In the words of one magistrate: "any opportunity is given so that they can go back home" (MS).

WWUD may also be treated differently in the legal system because what motivates them to use drugs might be different from what motivates men to use drugs. Whereas it was believed that men might take drugs to commit crime, women may be using drugs to deal with stress revolving around their children's welfare (MS).

Cases of GBV against WWUD also need to be given priority and classified in an independent category with own protocols. For instance, in the magistrates' court (Shanzu), Tuesday is allocated for all GBV cases from assault to defilement. For children's cases, there is aspiration to finalise them within 6 months in accordance with the law.

b. Gaps related to Law Enforcement

It was noted that police often humiliated WWUD during arrests in maeneo, which made it difficult for them to trust the police. Going forward, police should arrest and book WWUD without subjecting them to physical assault and allow the law to take its course (F2 PLWHIV).

Directly exposing victims to the police to report and follow up cases was criticised. It was suggested that a separate GBV desk within NGOs working on GBV among WWUD would be better to receive complaints then channel them to the police. The alternative was to have an office in the police station separate from the general office because the general reception desk is normally crowded and victims may feel hesitant in reporting or feel intimidated (PO). Such offices should be manned by female middle-aged police officers working with local advocacy groups (PO). Involving other stakeholders to present cases of violation to the police including linkages with law enforcement and other stakeholders (local administration, religious organisations, residents, NGOs (MWM; PO) including women's rights organisations like FIDA-Kenya (MS).

Women should be empowered to report whatever happens to them and not to suffer in silence (MS). This necessitates the establishment of reporting centres (RL-I); resource centres (MS); and/or having gender based violence as a special department in health facilities with its own reporting tools and human resources just like other specialised departments like TB and HIV (MO); and decentralisation of P3 forms issuance and processing (CHO). The need for independent departments arises from the fact that violation brings with it stigma and makes it difficult for such women to be open about what happened especially if they were under drugs. Therefore, they need spaces and opportunities to explain after psychological help (CHO)

To improve referral, there's need for a police hotline in health facilities and a contact person in each police station to receive and process all referrals (MO; MS). Organisations carrying out work on GBV need the capacity to develop staff resource to deal with GBV among drugs users. Then, select persons from maeneo (from among gender based survivors) to oversee and report any cases within that small group. The focal person brings to the facility any client suffering GBV and is then connected to the contact person in the police station using the hotline. The contact person in turn completes the legal interventions (MO). Further, it would be easier to have MEWA keep the OB number to facilitate follow up cases after reporting to the police (F4 MAG); and have a help desk specific to GBV with an advocate at MEWA in similar fashion to ReachOut (F5 BAMB; F1-IDI-BAMB). Alternatively, a contact person could be found to take up all cases on behalf of WWUD to reduce negative interactions with police. A single successful conviction would change the way they are handled (F2 BAMB) by changing the public's perceptions of mteja as a valued person (F3 BAMB).

Training of police at gender desks warrants urgent attention to "take their work seriously" including proper investigation to prevent evidence loss and ensuring processes are followed. For instance, in cases of assault where blood is found on clothes and police do not take that

piece of evidence seriously, when the matter gets to court, the perpetrator poses the question: “Is the dress you were wearing when I assaulted you presented as evidence in this court?” The absence of that piece of information weakens the victim’s case because “that is a very important piece of information” (MS). Police need training to know that it is not enough to have the victim taken to a health facility to be treated but also the condition they were found including bleeding or injuries must be preserved by taking a photo and if possible taking a piece of the cloth worn (MS).

Lack of knowledge about protocol often makes reporting difficult. The requirement that victims must be checked in a public health facility led to F2 BAMB giving up on her head injury case because she had visited a private facility. This lack of knowledge also applies to the range of violations WWUD can report – for instance, F4 BOM had no idea that forced anal sex was a violation. Lack of knowledge of the existence of gender-related rights (F2 MAG); and GBV reporting desks or paralegals at MEWA also hinders reporting (F3 SHZ; F1-IDI-BAMB; F1-IDI-SHZ). In addition, the schedules of the MEWA contact person are not flexible to WWUD (F1-IDI-BAMB).

Finally, there is under reporting of cases of GBV among WWUD among the police, courts and probation offices and hence a deficiency of local data. This casts doubt on the accuracy of available data (MS) as most suffer in silence (MO).

Consequently, there is need to involve more paralegals to help WWUD to know what to do when they face physical violence, especially when the police do not follow up reports because it is ‘mteja’ reporting. Such paralegals should reach out to WWUD in maeneo to help them speak out (F3 PLWHIV) for rights awareness (F1 BOM) and exchange of ideas among WWUD (F1-IDI-SHZ).

c. Gaps related to WWUD and Partners

The police respondent suggested establishing awareness centres that provide consistent and up to date information and create an environment where victims can report freely. Additionally, MEWA can invite the police to provide information to WWUD (PO).

Awareness in the form of at-risk guidance should be extended to young girls to make them aware that drug users have no intention of marrying them and when they do, the relationships do not last (MWM); with emphasis on the role of religious organisations in offering moral guidance (MWM). This is in addition to rights awareness by grassroots organisations working with community leaders on what constitutes abuse and what to do when abused (MWM; RL-I). The basis of maintaining the conversation about GBV is that if not done “future generations will copy wrong models (of violence) and aspire to break previous records” (RL-I). To achieve this, community awareness and advocacy on GBV is required at the level of maeneo to educate WWUD on how to preserve evidence and when to present to the clinic in cases of sexual abuse (MO); and access to legal interventions and family support (MO). Further, organisations dealing with gender based violence should know where their clients are and bring them out for

the services. By becoming more relatable to maeneo attendees, it will be easier to reach those who experience GBV and are neither reported nor known in the health facility but remain the community. The achievement of this goal rests entirely on creating bonds with WWUD and hence increasing their knowledge on GBV helps to address the problem (MO).

WWUD need to be made aware that there are protocols to be followed whenever somebody has been violated. These include getting the P3 form and having it filled (CHO); aside from knowledge about their rights in health facilities (CHO). Further, there's need for provision of education towards self-exploration to identify their worth "what they are doing, what they want and where they are...that is the only way to stand on their own two feet". They need to know what to do when violated/to know their rights and how to live with others (more of life skills) (MWM) in addition to have networks, persons or centres to help them deal with negative emotions (RL-I). The media can be used to sensitize WWUD on where to report, find rehabilitation and the need to belong to support groups (PRO). Further, WWUD need to be helped to establish legal means of earning livelihoods to deal with dependency.

d. Community Gap

Within the community, the existing knowledge gap is represented as a clash between the law, culture and common expectation. For instance, the belief that it is difficult for one of two people who were "under the same blanket" to claim rape (PO). Secondly, there's the conflict between religion, law and culture, each with its own demands. For instance, someone could cite culture as a reason for physical violence, and claim that he paid a dowry for the partner. There are also differences in the likelihood to engage in physical spousal abuse depending on cultures – whether paying the bride or her family respectively. When paid to the family, the woman is essentially bought and is under the control of the partner. Should the woman leave, the dowry must be repaid. Considering that she may come from a financially unstable family, such a woman "must die an officer's death" (persevere without end) (MWM). In that case, whereas the law gives her leeway to fight for her legal space, culture and religion cancel it out. Ignorance of the law on acts that constitute GBV will be blamed on people's culture; and such beliefs even influence the likelihood of neighbours intervening when someone is abused. Claiming that "wife beating is allowed" or "a partner must beat the wife to show love in our culture" (MS) denies perpetrators the right to own up to violence (PRO). Such societal beliefs also mean that witnesses will be unwilling to testify out of fear of clashing with their cultures. There's therefore need to need to align traditions with legislation on GBV, for instance, concerning traditions of physical violence towards spouses (RL-I).

4.6 Interconnections between GBV/Uptake of harm reduction

WWUD are alienated from mainstream society. They experience a lack of financial support to buy sanitary pads (PO); and engage in sexual behaviours that leads to pregnancies, and HIV/STIs (MWM; MO) because they do not have someone to take them to hospital [on time] (PO). These women also suffer physical and psychological injuries and the double stigma of both sexual violation and HIV infection at the same time (CHO). GBV heightens the likelihood

of sex work and further problematic use of substances because of the need for money outside the other partner's support (RL-I). This adds to the layer of family breakup and its resultant outcomes including children being placed with relatives and WWUD losing the custody of the children. Such women "live like outcasts...nobody wants to deal with them...they lose their respect and eventually they lose their lives" (MS). They are more likely to be involved in criminality to survive the dual tragedy of family disowning them and the struggle for survival. The cycle of dysfunction continues with drugs and crime, homelessness and their children becoming victims of the justice system. In extreme cases physical assault leads to disability (PRO).

Interviewees believed that there was a need for a multidisciplinary approach to offending in general, including the need for professionals to better understand WWUD; research on motivations for continued drug use among WWUD (MS); action to address underlying economic issues by establishing a fund to empower victims (CHO); provide life skills of how to relate (RL-I) and awareness of conflict resolution mechanisms during the COVID-19 pandemic period when people are suffering serious economic effects (CHO); including using religious principles that forbid marital abuse (RL-I). This is because, by the time the public gets to know of abuse, it usually has happened (MWM). In the immediate aftermath of violation, required tests should be prioritized as an immediate response; in addition to moral support and counselling (CHO) because sexual violations come with attendant psychological trauma (MS).

It is important to put in place a social support network comprised of survivors of GBV to share experiences and provide mentorship. This underlies the suggestion to look out for each other by referring to MEWA those who are violated and have no idea where to report (F2 MAG). Additionally, there's need for MEWA staff to expand the content of their visits to maeneo to include finding out challenges faced aside from the usual supplies (F3 MAG) and to help WWUD know their rights (F1-IDI-MAG). This is likely to help WWUD find courage to talk because prevailing societal attitudes and self-stigma after being labelled a 'mateja' hinders disclosure. Therefore there's need for counsellors twice a week in maeneo to be up to date with WWUDs emotional issues (F1-IDI-PLWHIV) and help victims deal with trauma (F1-IDI-BAMB). In fact F1-IDI-PLWHIV felt that the interview had helped her "relieve myself".

WWUD can benefit from paid work to prevent them from engaging in sex work and criminality. For instance, the current Kazi Mtaani project (a national response to support vulnerable people during the coronavirus pandemic) discriminates against them in allocating positions for work because of who they are – just as they missed out on other programmes such as the County Food Relief project (organised by the County Government of Mombasa). It is because of this exclusion from support programmes that makes WWUD steal (F2 MAG; F4 MAG). Alternatively, WWUD could benefit from micro-credit to set up small businesses to escape sex work (F3 BOM; F1-IDI-BOM; F1-IDI-MAG; F1-IDI-MTP); including group projects like hairdressing and dress making (F1 SHZ). This was explained succinctly by F1-IDI-MAG – that the process of finding money predisposes them to GBV. In her words, "it is difficult to violate

the rights of a clean person". Another suggestion was to identify and support WWUDs and their partners' talents and skills e.g. music (F1-IDI-PLWHIV) to deal with idleness for WWUD on MAT; or cookery (F2 SHZ) for which she requires Ksh. 5000 (\$50) to restart her viazi (potatoes) business and become "a normal woman"; or driving (F1-IDI-MTP) "to keep us busy...because idleness is making others backslide"; and respect sex work as a means of livelihood (F5 MTP).

WWUD suggest a need for understanding the legal status within the relationship in the case of come-we-stay relationships (not legally recognised). It appears that such kind of relationships harbour the likelihood of abuse because... "the mistake we make is referring to come-we-stay men as our husbands yet you only met because of drugs" (F4 MAG).

An interesting suggestion concerns the need for rehabilitation to be like "other normal human beings" (F5, 34, MTP) to help them recover (F1-IDI-MAG); the need for personal attitude change to allow them go home and change their ways (F1-IDI-BOM) which for some is being achieved by adherence to MAT (F2 SHZ; F1-IDI-MTP) and prayers (F1-IDI-MTP). The latter may be a pointer to the need for a spiritual dimension in therapy.

For medical management of infections, healthcare providers need HIV and STI test kits, and Hepatitis B and C test kits. Resources for psychosocial counselling, possibly support groups (MS) because of trauma are also in need (MO).

5.0 RECOMMENDATIONS

Based on the finding of this study, the following are recommended:

- Work towards eliminating bottlenecks in the reporting process at police stations and public health facilities
- Work with the Police Service to eliminate inefficiency and report police brutality and corruption to deal with perceptions of police as unhelpful and uninterested in WWUD cases. This requires training in work operations, ethics, awareness of the needs of WWUD, etc.
- Facilitate establishment of gender desks and other reporting centres manned by trained female officers, and ensure functional toll free hotlines from focal persons in maeneo to organisations dealing with GBV to the police.
- Work with legal teams to shed light on laws that allow police bond for perpetrators even after medical reports confirm abuse
- Empower clinical personal personnel within organisations that deal with WWUD e.g. MEWA to act in place of medical officers in filling P3 forms through training and accreditation.
- Work with local administrators e.g. Mzee wa Mtaa to help police apprehend perpetrators whose identities and abode are unknown.
- Link up an advocate to MEWA to follow up on cases reported to police stations
- Focus programs on economic empowerment to deal with dependency
- Religious leaders to play a leading role in “moralizing” GBV to complement law enforcement efforts
- Train prosecutors on the full breadth of the Protection against Domestic Violence Act (2015) to sustain convictions for GBV
- “De-securitize” maeneo and instead make them focal points for mental health management and not security operation zones
- Establish awareness centres that provide constant information and create an environment where victims can report freely
- Training of WWUD, organisations dealing with WWUD, healthcare providers and the police on evidence preservation in cases of GBV
- Further research on offender’s mind set and motivations for continued use of drugs among WWUD
- Need for life skills training for WWUD and their partners in relationships
- Put in place resources for social support include psychosocial counselling incorporating GBV survivors to help WWUD share experiences and provide mentorship to each other
- MEWA to robustly include mental health as part of the maeneo package to deal specifically with emotional issues
- Advocacy for the integration of WWUD in paid public work programs e.g. Kazi Mtaani (‘Work in the Locality’) and/or facilitate micro-finance to establish group income generating projects
- Help WWUD formalise come-we-stay marriages in line with the law

- Training for judicial staff on the unique and intersecting challenges of WWUD
- Provision of education for self-exploration and identification of, and support for talents and skills e.g. music to raise WWUD self-worth
- Support for healthcare providers who deal directly with WWUD in stocking test kits for HIV/STIs, Hepatitis B and C
- Increase uptake of GBV data
- Public discussions on the contradictions of culture and the law to change perspectives on GBV

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