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Structural, everyday, and symbolic violence and the heightened vulnerability to HIV of women who use drugs in Tanzania

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Abstract

Women who use drugs shoulder a disproportionate burden of the HIV epidemic in Tanzania. The mechanisms through which violence contributes to their excessively high rates of HIV have not been explored. In this paper, we use concepts of everyday, symbolic, and structural violence to critically examine the relationship between violence and heightened HIV vulnerability of women who use drugs in Dar es Salaam, Tanzania. We conducted cross-sectional surveys with 200 women who use drugs and follow-up, in-depth interviews with 30 survey participants who identified as living with HIV between November 2018 and March 2019. We drew from grounded theory methods to analyze qualitative data and complemented qualitative findings with survey results. Structural violence perpetuated constraints on women's economic opportunities and reduced their agency in sexual encounters manifesting in their disproportionately high rates of HIV. Nearly all women in our study engaged in sex work to meet basic needs and to support their drug use. Their involvement in overlapping drug use and sex work scenes exposed them to physical and sexual violence. Despite the pervasiveness of structural and everyday violence, some women reenacted agency by adopting strategies to maintain control and safety, and to exercise harm reduction. A

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Declaration of competing interest

None.

Ethics approval

Ethical approval was granted by Institutional Review Boards at the Muhimbili University of Health and Allied Sciences and the Johns Hopkins Bloomberg School of Public Health, as well as the National Research Ethics Committee at the Tanzania National Institute for Medical Research.

CRedit authorship contribution statement

Haneefa T. Saleem: Conceptualization, Methodology, Formal analysis, Writing – original draft, Funding acquisition. **Leanne Zhang:** Formal analysis, Writing – original draft. **Claire Silberg:** Writing – original draft, Writing – review & editing. **Carl Latkin:** Writing – review & editing. **Samuel Likindikoki:** Conceptualization, Supervision, Project administration, Writing – review & editing.

multi-pronged, structural harm reduction strategy is critical to reducing violence experienced by women who use drugs and their ability to protect themselves from HIV.

Keywords

Tanzania; HIV; Structural violence; Everyday violence; Symbolic violence; Women who use drugs

1. Introduction

Women who use drugs, specifically heroin, shoulder a disproportionately large burden of the HIV epidemic in Tanzania. Mirroring gender disparities within the general population, recent HIV prevalence estimates among women who inject drugs in Tanzania are high, with estimates ranging from 25% to 41% compared to 7%–15% among men who inject drugs (Likindikoki et al., 2020; Mmbaga et al., 2017) and 4.7% among the general adult population ((TACAIDS) & (ZAC), 2018). Women who use drugs are at high risk of HIV due to both parenteral and sexual risks. Risky injecting practices (McCurdy et al., 2010; Mlunde et al., 2016), engagement in sex work (McCurdy et al., 2005; Zamudio-Haas et al., 2016), and experiences of physical and sexual violence (McCurdy et al., 2005; Zamudio-Haas et al., 2016) have all been shown to contribute to heightened HIV vulnerability among women who use drugs in Tanzania.

Though research has demonstrated an association between experiences of violence and heightened vulnerability to HIV in diverse settings (Jewkes et al., 2010; Li et al., 2014), the mechanisms through which different forms of violence contribute to the excessively high rates of HIV among women who use drugs in Tanzania have not been fully explored. Researchers posit that gendered power differentials between men and women are the basis through which specific forms of violence towards women manifests (Jewkes et al., 2010). These power inequities have implications for women's sexual risk-taking behaviors and have been shown to directly contribute to women's ability to negotiate for safer sex, such as condom use (AIDS, 2004; Dunkle & Decker, 2013). Dunkle et al. suggest that women with violent sexual partners prioritize their physical safety over sexual safety and will forgo condom negotiation in order to placate sexual partners to ensure their immediate safety needs (Dunkle & Decker, 2013).

Other research on this relationship has demonstrated multi-directional pathways between violence and HIV. A longitudinal study conducted in Dar es Salaam, Tanzania found that women living with HIV were over two times more likely to experience at least one episode of intimate partner violence within a three-month period as compared to women without HIV (Maman et al., 2002). The cyclical nature of violence as both a contributor to and a result of an HIV-positive serostatus can impede the ability of women who use drugs to effectively access and utilize harm reduction services and drug treatment. A study in Dar es Salaam among women who use drugs found that being in a violent intimate relationship and having a drug-using partner were associated with women not enrolling in opioid use disorder treatment, which often serves as a bridge to HIV care and treatment (Balaji et al., 2017). Another study from Tanzania found that the risk of violence that women who use

drugs face in predominantly men-occupied drug hangouts, typically areas with abandoned or unfinished buildings, along main roads or near bus stations, where people use and sell drugs (Commission, 2015), lead many women to isolate themselves, making it more difficult for outreach workers to reach them with harm reduction interventions (e.g., opioid use disorder treatment, condom distribution, syringe distribution) and link them to HIV services (Zamudio-Haas et al., 2016).

Concepts of structural, symbolic, and everyday violence have been used to critically examine the relationship between violence and health risks. They might be useful for understanding the heightened vulnerability to HIV experienced by women who use drugs in Tanzania. Structural violence, at the root of this framework but largely analytical in its utility, refers to “avoidable limitations that society places on groups of people that constrain them from meeting their basic needs and achieving quality of life that would otherwise be possible (Lee, 2019, pp. 123–142).” Structural violence is rooted in structural systems of oppression, i.e., laws, economic and social policies, and institutional practices, that reinforce unequal power relations and marginalize certain populations, manifesting in disproportionate rates of disease, illness, disability, and other poor health outcomes in these groups (Farmer, 2004). Everyday, normalized violence and symbolic violence are derivatives of structural violence (Lee, 2019, pp. 123–142). Everyday violence describes the normalization of routine perpetration of violence against marginalized groups and the concurrent blame-shifting and individualizing of suffering that is fundamentally structural in nature (Bourgois et al., 2004; Scheper-Hughes, 1996). Symbolic violence captures the internalization of structural violence by those who are subject to it, as well as the misrecognition of violent experiences as simply natural and unavoidable parts of life (Bourdieu, 2001).

Previous research in the U.S. and Canada has demonstrated that the interacting structural forces of poverty, policies criminalizing drug use and sex work, and hegemonic masculinity both perpetuate and simultaneously render invisible the everyday gendered violence enacted against women who use drugs (Bourgois et al., 2004; McNeil et al., 2014). Attempts to avoid or mitigate this everyday violence manifests as the devising of complex and strategic movement patterns to avoid particularly ‘dangerous’ places, or as the developing of relationships with men who use drugs—relationships which are often themselves dangerous, dependent, or expose women to other forms of structurally rooted violence (Bourgois et al., 2004; McNeil et al., 2014; Shannon et al., 2008). The commonplace experience of violence, coupled with the lack of apparent recourse and functional disregard for the lives of women who use drugs by authority figures or society at large, can lead some women to internalize blame for the violent acts committed against them and to decline to seek forms of justice or advocate for themselves and their safety (Bourgois et al., 2004; McNeil et al., 2014; Shannon et al., 2008). In Tanzania, gender norms and expectations that reinforce social and economic inequities between women and men, the criminalization of heroin use and possession and sex work, strict police surveillance, and societal stigma and discrimination against people who use drugs and sex workers may contribute to increased exposure to different types of violence and increased vulnerability to HIV for women who use drugs.

In this paper, we examine the mechanisms through which structural, everyday, and symbolic violence heighten the vulnerability of women who use drugs to HIV in Tanzania, and the ways in which women attempt to prevent or mitigate violence victimization.

2. Methods

Data for this analysis come from a mixed-methods study conducted between November 2018 and March 2019 in Dar es Salaam, which examined social networks and HIV prevention and treatment engagement among women who use drugs. Though the analysis presented in this paper is mainly qualitative, we complemented qualitative findings with results from a cross-sectional survey conducted as part of the study. After obtaining informed consent, a cross-sectional survey was interviewer-administered in Swahili by trained research assistants to 200 women who were aged 18 years or older, reported heroin use in the past 30 days, and resided in Dar es Salaam. Survey participants were recruited through respondent-driven sampling (RDS) methods (Heckathorn, 1997). Survey participants were compensated 10,000 Tanzanian shillings in cash to complete the survey and incentivized with 4000 Tanzanian shillings per eligible woman recruited for the survey (up to three women). The survey questionnaire included modules on drug use, HIV testing and treatment, physical and sexual violence, housing, mental health, and social networks. Surveys took 30 to 40 minutes to complete. Detailed descriptions of survey recruitment methods and measures have been previously reported (Saleem et al., 2020). Of the 56 women who self-reported being HIV-positive in the survey, we purposively sampled 30 to participate in follow-up, in-depth interviews. In-depth interview participants received 10,000 shillings in cash to complete the interview to compensate them for their time and other costs associated with study participation. Interviews were conducted in Swahili using a semi-structured interview guide that followed a life history format with probes on drug use and HIV treatment experiences, and social support networks. Each interview lasted between one and 2 h and was audio-recorded with the participant's permission.

We analyzed survey data using STATA version 15. We calculated descriptive statistics, including frequency distributions of key variables by self-reported HIV status, to provide a snapshot of women's drug use practices, violence victimization, mental health, structural vulnerabilities, and HIV risk behaviors. We used chi-square tests to identify statistically significant differences by HIV status, defined by a p-value of .05 or less.

In-depth interviews were transcribed and translated into English by a study-hired translator and reviewed for accuracy by the original interviewer. We imported interview transcripts to NVivo (QSR International, Melbourne, Australia) for data management and coding. Drawing from procedures outlined by Charmaz on data analysis in ground theory research (Charmaz, 2006), coauthor LZ conducted initial line-by-line coding on a small sample of transcripts then the first author, HS, and LZ developed focused codes using a constant comparison method based on the initial codes. The first author then used the focused codes to develop a codebook, which LZ used to code all interview transcripts in NVivo. We then used the constructs of structural, symbolic, and everyday violence to examine data through a theoretical lens to further interpret findings and connect to the broader violence literature. The first author and LZ developed analytic memos throughout the analysis process

to capture connections and comparisons related to theoretical constructs and to serve as a bridge to identifying key themes that addressed our main research questions.

We obtained informed oral consent from all participants. Ethical approval was granted by ethical review committees at the Muhimbili University of Health and Allied Sciences, the National Institute for Medical Research in Tanzania, and the Johns Hopkins Bloomberg School of Public Health.

3. Results

Structural, everyday, and symbolic violence were evident in the accounts of the women who use drugs included in the study. Structural violence perpetuated constraints on women's economic opportunities and ability to maintain control over their sexual behaviors, manifesting in their disproportionately high rates of HIV. Nearly all women reported engaging in sex work to meet basic needs and to support their drug use. Their involvement in the overlapping drug use and sex work scenes exposed them to everyday violence, including physical and sexual assault. Despite the pervasiveness of violence, some women were able to employ strategies to maintain some semblance of control and safety, and to exercise strategies for harm reduction. Below, we present findings based on key themes that demonstrate the mechanisms through which structural, everyday, and symbolic violence heightened the HIV vulnerability of the women who use drugs in our study.

3.1. Disproportional patterns of HIV and HIV risk behaviors of women who use drugs

Table 1 presents characteristics of the survey sample, including structural vulnerabilities, violence victimization, and HIV risk behaviors. There was high prevalence of known HIV-positive serostatus among women surveyed. Out of the 200 women surveyed, 56 women (28%) self-reported having been diagnosed with HIV. Fifty-nine percent of all women surveyed reported using heroin for less than five years, and 85% reported daily heroin use. Most reported smoking heroin as their main method of consumption. Only 26 women (13%) reported having ever injected drugs. Among those who had ever injected, only half said that they had ever shared injecting needles. Nearly all the women who reported an HIV-positive serostatus were unaware of how they contracted HIV. Eighty-five percent of the women reported having ever sold sex for food, money, shelter, or drugs. Women reported a high number of sexual partners, mainly due to their engagement in sex work. The median number of sexual partners in the last month reported by all women who completed our survey was 5.5 (IQR: 1 (25th percentile) and 45.5 (75th percentile)). Only 30% of all surveyed women reported consistently using a condom with casual sex partners, including sex clients, with about 20% reporting never using a condom with casual partners.

3.2. Punitive policing and the everyday violence of sex work

Gendered structural and economic inequities, which are forms of structural violence, left women who use drugs with limited options for earning money, with many engaging in sex work for money to not only purchase drugs but also to meet other living expenses. The illegality of both sex work and heroin use in Tanzania exacerbated women's exposure to everyday violence in the sex work scene presenting at the interpersonal level as pervasive

and normalized physical and sexual violence, which in turn contributed to increased risk of HIV. Punitive police practices targeting sex workers, an example of the origins of structural violence, limited the spaces where women could safely work, forcing them to engage in sexual transactions in more isolated places, such as abandoned buildings or fields, which placed women at increased risk of sexual or physical violence from sex clients: “There are some events that happened to me as I went to the fields at night, being taken by two, three men. Leaving with one, but when you get there, you find three of them... I have encountered such things, having sex by force.” (Participant #2).

Nearly all participants in the study (81%) reported a history of arrest (Table 1). About a third of women surveyed reported experiencing sexual violence and rape, often because of their involvement in sex work to support their drug use. This was further elaborated in qualitative interviews. A few women interviewed even reported being victims of rape committed by multiple perpetrators, or group rape. The commonly negative interactions with law enforcement officers because of the illegality of sex work and drug use resulted in a sense of apathy among women, and led some women to avoid engagements with the police even in the wake of violent sexual acts. As one woman said, “From what they [the police] know, you [sex workers] are all the same.” (Participant #1) This matter-of-fact perspective reflects the symbolic violence experienced by women who use drugs and sell sex, resulting in the normalization of mistreatment by police and a reduced willingness to advocate for recourse. Structural and symbolic violence manifested as diminished women's agency during sexual transactions, including when negotiating condom use. The following exchange between an interviewer and participant captured the risks some women face as a sex worker and person who uses drugs, and their reduced ability to control what happens with a sex client:

Participant #23: Suppose during your [sex work] activities you go to sleep with a man with a condom, but he busts it intentionally then wants to sex without a condom. I have faced that challenge.

Interviewer: So, what did you do when he changed [and wanted to have sex without a condom]?

Participant #23: Nothing. Can you fight with a man?

Interviewer: Did you take any further step afterward?

Participant #23: What step could I take? I'm just an addict. I don't have money. Maybe I could go to the police. But even so, where would they catch him?

The participant's use of the stigmatizing label, “just an addict,” used within the community for people who use drugs, illustrates her internalization of broader societal stigma against people who use drugs, a form of structural violence.

The immediacy of obtaining drugs to ward off withdrawal symptoms also reduced women's agency when it came to sexual transactions and self-protection with sex clients. Women who use drugs may have even less negotiating power compared to sex workers who do not use drugs as they might need money quickly to buy drugs to manage withdrawal symptoms:

[B]ecause of withdrawal symptoms you may face challenges. Sometimes you may go to look for help and someone might say that he wants you. Like you must give him something to get his money even if you don't want him. Do you understand? He will tell you to offer sex so that he can give you money. You will have to do it [have sex with him]. Someone else will call you and you will do it again. [...] You might get diseases or anything. (Participant #18)

The dual forces of gendered structural constraints on how women can earn money and withdrawal management interacted to contribute disproportionately to HIV risk behaviors among women who use drugs, such as condom-less sex: “There are challenges, someone may not have money and go to look for any man to get money, then they have sex even without a condom ... as you need money for drugs.” (Participant #20).

Many women also described experiencing physical violence because of stealing from others or being accused of stealing from others, often sex clients. This suspicion of women involved in sex work and women who use drugs increased their risk of violence. Many of the women interviewed admitted to committing theft particularly when they needed money quickly to buy drugs.

I was going to the roads to steal from men. Some caught me. When I go the roads to sell my body, the city vehicles come, and they catch us [and arrest us]. With all that, it was because I was looking for money to buy drugs. Do you think I was looking for money to build a house? It was money to smoke [Laughs]. (Participant #2)

3.3. Transitional periods and increased vulnerability to HIV

Women's violence victimization was not restricted to periods of life when they were engaged in drug use and sex work. Many women narrated life stories with critical transitional periods that further exacerbated social and structural vulnerabilities resulting from structural violence that affected HIV risk. Common patterns included separation from a partner, which participants described as low points in their life histories and impacting the trajectory of their lives: “After separating from my husband is when I entered the bars, in these groups. I even started selling my body.” (Participant #3) The loss of a parent often precipitated a turning point in their lives, resulting in social and economic hardships: “My mother passed away and then my father passed away. Since I was at home, I started struggling, engaging in commercial sex work, prostitution.” (Participant #7) Some women described moving in with relatives who became their primary caregivers after losing their parents, and in a couple of cases subsequently experiencing neglect and abuse. One participant described moving in with her aunts along with her siblings after her mother died when she was 15 years old: “We had our young aunt. She was arrogant and couldn't even raise us ... If she called me and scolded me or slapped me or did anything, I would stay quiet though I might cry. I didn't talk back. Even though I could fight back, I just ignored it since she was my elder.” (Participant #24) She accepted the violence inflicted on her by her aunt, who was her elder, as the status quo, a reflection of symbolic violence.

About a quarter of participants reported migrating to Dar es Salaam, the largest city and commercial capital of Tanzania, in search of a better life. However, migrating to Dar es

Salaam from other regions, including more rural or semi-urban areas, often placed women in unstable and unfamiliar situations that made them more vulnerable to violence victimization and increased their exposure to HIV. Some described difficulties finding stable housing in the city, in some cases leading them to sleep in areas with high drug activity, at times on the streets: “When I left home [Tanga region] looking for a better life, I had no place to live here in Dar es Salaam ... Then I met my friend who influenced me to begin using drugs. That friend used to go and steal things and when she came back, we would enjoy the drugs together.” (Participant #22).

Not all participants who moved to Dar es Salaam lived in areas with high drug activity. However, even women who secured housing and found more formal employment were at risk for gendered violence. A few women spoke of finding employment in bars or restaurants, which at times came with violence and sexual health risks:

I kept looking for a job and I got one in a bar and engaged myself in drinking... Alcohol became my life, one day someone snuck a drug in my alcohol that made me pass out after drinking. Coming to my senses I was naked. Everything was stolen even the business money as I was at the counter. They had raped me and since I was unconscious, I couldn't remember anything. A month later I had severe abdominal pains... We kept looking for the culprits of the incident and it turned out they were related to my boss, so the case was closed, and I kept working at the bar. After the rape came the abdominal pains. I went to the hospital and was found to have a sexually transmitted infection, I got treated. (Participant #6)

Another woman interviewed described being raped by several men in the restaurant where she worked after migrating to Dar es Salaam. She expressed uncertainty about whether she was infected with HIV through this violent encounter or from her partner: “The [rape] affected me, yes. And now people are saying that even my husband who I was living with was sick. Even before I got pregnant by him, I was told he was sick. Now I don't know if I was infected with [HIV] by the people who raped me or my husband.” (Participant #7).

3.4. The everyday violence of drug scenes

Women interviewed described being perceived by others in society as “not a human being”, as a “thief”, “bad person”, “addict” (“teja” in Swahili), and thus lesser than. This societal morality valuation, a form of structural violence, resulted in everyday violence through the justification and normalization of violence against women who use drugs. As one woman described when asked about differences in how women who use drugs are treated compared to men who use drugs:

A man who is using drugs can be valued. Men always. People say that men are the true mirror of society. For us women... we are just kept at the back always. Who will value you? (Participant #12)

Further compounding this everyday violence against women who use drugs were the gender structures in society that deem the normative societal role of women as mothers and caretakers. Women who use drugs, according to some women interviewed, were often

perceived as deviating from this norm and therefore failing to meet society-imposed gender expectations. One woman explained these gendered perceptions of people who use drugs:

Because a man is regarded as this perhaps is his tragedy, but in reality, it's not a man's tragedy. It is a catastrophe for us all. A woman is considered as a mother in society and she can educate the community, but if we get lost like this [lost to drug use] someone becomes astonished. (Participant #21)

Gender inequities that economically and socially marginalize women were mirrored in the microcosm of the drug scene. The social dynamics of the drug scene, specifically drug hangout spots known as *vigenge* and *maskani* where people buy and use drugs, contributed to women's exposure to violence and heightened their vulnerability to HIV. Many of the women interviewed described spending time almost every day in these drug hangout spots and other places where they searched for sex clients. Women might engage in sex work to get money to pool resources with other people who use drugs in drug hangout spots, including men, to procure drugs.

When you arrive there at the *vigenge*, they [other people who use drugs] ask you, 'What is going on? I feel *arosto* [withdrawal symptoms]. Do you have *duso* [change money]? I also have *duso*. Should we go and get [some drugs]?' That is how it is. Or they might tell you when it is in the evening or the afternoon, go and approach a man. (Participant #3)

Some women were also exposed to violence from the men who use drugs whom they encountered in these places. One woman interviewed recounted being lured to an abandoned building by a male acquaintance under the guise of taking her to find good quality drugs. When she arrived, there were several young men who physically and sexually assaulted her:

"They claimed to punish me saying that they always buy drugs for me so that is the impact of that, telling me to hustle by myself to afford the high cost of drugs. Then after, they left me outside of that building." (Participant #26)

3.5. Controlling and abusive intimate partners

Over half of the women surveyed reported being in an intimate relationship, whether married or having a cohabiting or non-cohabiting partner. The dependency on partners reduced the ability of some women to exercise agency or choice in various aspects of their lives, and ultimately increased their vulnerability to violence and HIV.

Physical and emotional violence perpetrated by intimate partners were reported by a few women interviewed. Having a controlling and abusive partner who prevented her from seeing family and friends was described by one participant as the impetus for her to smoke marijuana:

This is what I can say maybe was a reason for me to start using drugs, he used to forbid me from leaving our home, not going to my friends, even my relatives. He used to smoke at home, when he left for work, I would take it and smoke. I was doing it as I was just staying at home, I was not even getting out, I was just inside as he didn't like to see me out. I was doing my activities at home while smoking marijuana, sometimes I would become tired, then I go to bed. My joy

ended after getting away from my family, I desire even right now to be back with family. (Participant #10)

Upon separating from this partner, she was left without a place to live, and her children remained with her partner. She ended up living with a friend and described using heroin and selling sex to earn money to take care of herself:

I separated from my husband, so I used to go to my friend who I knew for a long time ... My friend had the behavior of going to the disco. She was selling sex at night and her husband was a drug [heroin] addict. If she didn't go to [sell sex], then they had nothing to eat. Her husband depended on her for everything ... It was after going to the disco [to sell sex] that I was living with them [her friend and her friend's husband]. I was using heroin instead of marijuana with him. This is how I started being a drug addict. (Participant #10)

The quote above also illustrates that for some women with partners who also used drugs, their partners might actually depend on them to get money to support both of their drug use.

Another woman interviewed described being physically abused by her partner because of her heroin use: "He beats me or destroys the [drugs]. If he finds someone giving me drugs, he grabs it. He throws the drugs away if he finds me smoking it. He says ... take this two thousand [shillings] and buy food for the kids." (Participant #7) When asked how she felt about the violence inflicted on her by her partner, she said, "He does it for my own good, though I get angry sometimes." In this scenario, the participant justifies the violence perpetrated by her partner, a manifestation of symbolic violence.

One woman interviewed accused her partner, whom she had met while working as a barmaid in Dar es Salaam after having fled from an arranged marriage to an older man when she was 16 years old, of instigating a situation in which she was raped by several of her partner's friends in his home. She described this event as affecting her psychologically:

It was so painful to know that somebody who I loved could plan and do something like that to me, from that time I promised myself not to love again and there is when I started to believe that drugs were everything to me ... It really affected me psychologically. I was like a confused person ... on crossing the road I had no time to look if cars were coming or not to wait for them before crossing. I was so tired with life, so getting in an accident and dying was all that I wanted. (Participant #24)

She described drinking excessively and later using heroin and engaging in sex work. She recounted sleeping with any man who approached her regardless of how much money he offered her because she had "lost the hope to live." She was diagnosed with HIV after being taken in and provided a place to live by a mother figure who encouraged her to test for HIV.

3.6. The symbolic naturalization of injustices, mental health, and increased vulnerability to sexual risks

Structural violence and the pervasiveness of everyday physical and sexual violence naturalized violence against women, which was then internalized by some women. This form of symbolic violence manifested in some participants viewing violence as the status

quo and, in certain cases, blaming themselves for the injustices that increased their vulnerability to violence and HIV. The pervasiveness of deceit and betrayal by male partners in intimate relationships reported by many of the women in our study can be viewed as a symptom of the structural constraints that women face in society and expectations of obedience. A few women reported being expected to tolerate betrayal from a partner, such as an infidelity, or abusive behaviors. As one woman said when describing that her partner abandoned her by denying that he had fathered her child and then marrying another woman:

Mama told me that she also suffered when her husband had another woman and told me that those are life's challenges, and I must tolerate it. I responded to mother that it's okay. I tolerated those challenges. (Participant #12)

This abandonment by her partner placed her in a precarious social and economic position, and with the limited income-earning options available to women, led her, from her own account, to sell sex to support herself, her mother, and child and then later to start using alcohol, cannabis, and heroin.

Shame stemming from one's drug use and the trauma of past experiences of sexual violence and rape manifested in high internalized stigma, depression, and suicidality among some participants. One woman interviewed expressed the following after recounting an experience of rape by multiple perpetrators:

I felt that I do not have life anymore ... I am someone to vanish from the world. You see? I am not worthy in the society. I am not worthy to be close to my child. It is the thing that makes me not to be close to anyone. I feel like someone who should be trashed or even die any time. I do not care anymore. I do not care about life anymore. Ehh! I was ready to let go of life at any time. (Participant #2)

Depression was high among the women surveyed in the study; almost a third had moderately severe to severe depression, while over half demonstrated symptoms consistent with mild to moderate depression (Table 1). Structural violence and the pervasiveness of physical and sexual violence resulted in a sense of hopelessness and worthlessness for some women. Coupled with the need to manage heroin withdrawal symptoms, this led some women to engage in risky sexual behaviors.

After the incident I was not picky about which man to have sex with. I was just okay with anyone who approached me with any amount of money. Whether it was 15,000, 10,000, or even 5,000 [Tanzanian shillings] or any amount, I would just sleep with them. That was the kind of life that I chose because I had lost the hope to live. (Participant #24)

3.7. Strategies to maintain control and safety in the face of everyday and structural violence

Some women adopted coping and social strategies to reenact agency and exert some semblance of control and safety in the face of everyday and structural violence. These included using distrust as a defense mechanism, as well as avoiding unsafe places and abusive partners.

Previous experiences of childhood neglect and violence victimization led several women to adopt distrust as a mechanism to reduce their vulnerability to falling victim to future exploitation and violence. This distrust manifested in women's romantic relationships, including difficulty trusting new intimate partners after being deceived by a former intimate partner. One participant expressed how she developed a "tough heart" and took measures to physically protect herself from perpetrators of physical or sexual violence.

I cried so much, it was so painful to know that somebody who I loved could plan and do something like that to me [plan for his friend to rape her], from that time I promised myself not to love again and there is when I started to believe that drugs were everything to me. (Participant #24)

In addition to not trusting others as a defense mechanism, some women also engaged in avoidance coping (i.e., avoiding dealing directly with trauma or minimizing it rather than confronting it) in response to the pervasiveness of violence in the drug use and sex work scenes:

I don't want to think about [being raped] sometimes because when I think about it, I feel guilty. You know? I feel like I am someone who should not live. I am not worthy. But you know, there are things that one could survive with. I just try to forget about them sometimes. I just try to participate in prayer. (Participant #2)

A few women described avoiding places where they had previously experienced violence, or places and times of the day that they perceived to be unsafe as a measure to reduce exposure to potentially violent situations with sex clients or strangers that might result in risky sexual encounters, such as forced and/or condom-less sex.

I said to myself, I will not come back home at night. It's better to survey [for sex clients] during the day on the street than getting out at night and coming back home during the night. (Participant #1)

Finding ways to avoid conflict in intimate relationships emerged as another way to reenact agency for those women exposed to intimate partner violence, be it physical or emotional. One participant reported remaining with her verbally and physically abusive partner because of their 9-month-old child. She described the cycle of violence perpetrated by her partner and followed by her partner asking for forgiveness. Instead of leaving her partner, she actively avoided being around him for extended periods of time.

For example, when I come home, if he is there, if I have chores then I will do them so that I am not close to him...And when I am done with my activities, if he is still in, I might go out. You see? I might leave and go with my baby to the road...He is just an unforgivable person. I am going through a very difficult time. I pay the rent on my own. I am the one with the lease, but he tries to chase me out. He wants me to leave so that he can do his things. 'If you want to leave, why don't you just leave?' If I tell him that, it is a problem. He beats me. Is that fair? I get money from home to rent a place. I rent a place for this baby. If I were alone, I would have not rented a place. I could live anywhere. But where will I go and live with this [baby]? Someone can take you in if you are alone. That person cannot take you in if you have a burden. You see? (Participant #2)

Limiting one's exposure to an abusive intimate partner, particularly during times of conflict, was echoed by several participants. One participant even described fleeing a domestic violence situation with an abusive and controlling partner: "Our neighbor would plead with him to treat me well and not beat me, but it was of no use. I decided to flee as I was tired. I left my belongings and cash there." (Participant #6) Here, the participant actively removed herself from the abusive situation when pleas from others to her partner had failed.

4. Discussion

In this paper we sought to examine how structural, everyday, and symbolic violence heighten the vulnerability of women who use drugs to HIV, and how some women reenact their agency to prevent or mitigate violence victimization. Our findings revealed structural violence manifested in high prevalence of HIV among study participants, punitive policing, and the pervasiveness of physical and sexual violence perpetrated against women who use drugs. Transitional periods, such as the death of a parent, the end of an intimate relationship, or migration to the commercial capital of Dar es Salaam from other regions of the country, placed women in precarious situations that increased their vulnerability to everyday violence and HIV. The inability to gain employment because of structural violence and dependency on intimate partners for housing, drugs, and financial resources further exposed women to acts of physical and sexual violence. Neglect or abandonment by an intimate partner left some women unable to provide for themselves and their children, leading them to engage in sex work, which was often their only viable option for income generation due to gendered structural constraints that limit economic opportunities for women. Some women naturalized the structural and everyday physical and sexual violence inflicted on them, a form of symbolic violence, which contributed to feelings of shame and hopelessness. Structural constraints placed on women, broadly, and women who use drugs and also sell sex, specifically, reduced women's agency to protect themselves during sexual encounters, contributing to HIV risk. Women adopted various coping and social strategies in an attempt to maintain agency and protect themselves.

The disproportionate rate of HIV found among women who use drugs in this setting compared to HIV prevalence estimates in the general population is a manifestation of structural violence that appeared to be partly influenced by the illegality of sex work and heroin use. Gender roles and norms limited income-generating opportunities for women and was particularly apparent during periods of migration and transitions, which were common in the life trajectories of the women in our study. Poverty, linked to migration, has been found to create vulnerability to sexual coercion and facilitate entry into sex work (Nelson, 2020). This points to the need to tackle underlying structural, social, and economic inequities that reduce women's agency and safety (Bungay et al., 2010). Poverty-reduction policies and economic strengthening interventions and programs that attend to existing gender inequities will help to address underlying structures that limit economic opportunities for women. For example, interventions that combine economic strengthening with gender transformative approaches, e.g., interventions that provide opportunities for economic empowerment while also creating space for people to challenge gender norms that harm women and address power inequities, have been found to have positive outcomes for intimate partner violence and HIV risk behaviors (Gibbs et al., 2017).

Similar to research from other settings, we found a synergistic relationship between sex work, drug use, and the immediacy to relieve withdrawal pains, which reduced women's agency to practice HIV protective behaviors, such negotiating condom use with sex clients (Nelson, 2020; Shannon et al., 2008). Most of the women in our study reported not having a stable place to live, which increased their HIV vulnerability. Women who use drugs have been found to face increased risk of housing vulnerability given the pervasiveness of structural violence against them (Collins et al., 2019). The interrelation of housing instability, violence, and HIV risk has been reported elsewhere (Collins et al., 2019; Reed et al., 2011). Housing instability can result in women being at higher risk of violence (Marshall et al., 2008; Shannon et al., 2008) and having more difficulty in negotiating HIV risk-reduction strategies during sexual encounters with clients (Collins et al., 2019; Shannon et al., 2008). Interventions that address underlying structural vulnerabilities that constrain women, such as supportive housing for women, access to drug treatment programs, and long-term, economic opportunities to support transition out of survival sex work, could not only reduce women's exposure to physical and sexual violence, but also HIV risks (Shannon et al., 2008).

The lower value of women in Tanzanian society compared to men, especially women who use drugs, contributes to their vulnerability to violence and HIV, particularly in the street-based drug use and sex work scenes, which appeared to overlap in the study setting. The criminalization of drug use and sex work can reinforce harms among women who use drugs and sell sex (Cusick, 2006; Shannon & Csete, 2010). Participants described dangerous and unsafe places and times of the day in which they had previously experienced violence or feared encountering violence, such as abandoned buildings or empty fields late at night. For women who use drugs and sell sex, policing practices are an important structural HIV determinant (Footer et al., 2016). The relationship between policing practices, using drugs in isolated places, and increased risk of physical and sexual violence, and the ability of women who use drugs to practice HIV prevention and harm reduction is well documented in North America (Bourgois et al., 2004; Bungay et al., 2010; Shannon et al., 2008), and was mirrored in this study. Legislative actions that decriminalize sex work and drug use, as well as sex worker- and people who use drugs-driven organizing for human rights, should be key components of a comprehensive, structural harm reduction strategy aimed at improving the safety of women and reinforcing their agency and control over their bodies.

Women who use drugs may be viewed by the community, and even within their networks, as deviating from their expected roles as “respectable” women in society— “good” wives, “good” mothers—, which appeared to affect their exposure to violence. Some women in our study appeared to internalize the perception that they were ‘disposable’ or at fault for the injustices and violence inflicted on them, particularly when it came to intimate partner violence, and at times encountered apathy from others for their victimization. This form of symbolic violence may have contributed to the pervasiveness of shame and depression among our sample of women, which appeared to manifest in sexual risk-taking. In a study on female sex workers in South Africa, researchers reported on the immense vulnerability of female sex workers to sexual violence (Coetzee et al., 2017). Consistent with what we found among women who use drugs in this study, they described how hostilities towards women involved in sex work are grounded in moral ideologies surrounding gender normative

behaviors, which sex workers transgress, and how this contributes to violence against sex workers being perceived as “justifiable violence” by perpetrators who are infrequently held accountable for their actions. The women in our study were multiply stigmatized for their drug use and involvement in sex work. To address the internalization of stigma, mental health services delivered through programs tailored to women who use drugs and those who also sell sex are warranted, as well as legal accountability for perpetrators of violence against women. Gender transformative approaches, which seek to dismantle inequitable power relations between men and women (Casey et al., 2018), might also help to address the multiple forms of stigma and discrimination experienced by women who use drugs. In addition, engaging male partners, law enforcement agencies, and other people who use drugs in such programming can help shift structural power dynamics by explicitly addressing gender norms that reinforce gender inequities that underlie violence against women.

Some study participants described maintaining safety and exerting some control in the face of everyday and structural violence. They reported restricting the scope of their activities to avoid perceived dangerous places and soliciting sex clients earlier in the day to reduce their risks of violence, similar to what has been reported in North America (McNeil et al., 2014). Furthermore, women with controlling and abusive partners reported minimizing their exposure to intimate partner violence by physically avoiding male partners. Women in this setting can be supported in their efforts to maintain safety through additional environmental supports, such as safer sex work and drug use environments facilitated by decriminalization, supportive housing to reduce dependence on partners, drop-in programs specific for women who use drugs that offer a range of supportive social services, and gender-based violence programming for people who use drugs. Pre-exposure prophylaxis (PrEP) to prevent HIV acquisition, particularly the promising long-acting, injectable cabotegravir (“Statement—NIH Study Finds Long-Acting Injectable Drug Prevents HIV Acquisition in Cisgender Women,” 2020), will also be an important tool for women who use drugs to reduce their HIV risks.

This study has limitations. First, the study was not specifically designed to examine violence among women who use drugs. Second, we used self-reported HIV status in the survey and to recruit women living with HIV for follow-up qualitative interviews. Third, we only conducted follow-up, in-depth interviews with women who reported living with HIV. Women without HIV may have had different life trajectories and experiences that could have enhanced our understanding of the differences in HIV vulnerabilities experienced by women with and without HIV throughout the life course. Fourth, we did not link survey responses to in-depth interviews, which limited our ability to explore connections between lived experiences and specific demographic, mental health, and behavioral variables from the structured survey. However, based on the information captured in-depth interviews, it is likely that the distribution of key variables for the women interviewed did not differ significantly from distribution for all women living with HIV who completed the survey reported in Table 1. Finally, we focused on the experience of women residing in Dar es Salaam, the largest city and commercial capital in Tanzania. The experiences of women who use drugs in rural or peri-urban communities are not represented.

Despite these limitations, the study had several important strengths. We drew from a cross-sectional survey to complement the qualitative interview data to address our primary research questions. We drew from the theoretical constructs of structural, symbolic, and everyday violence to better inform and frame our analysis and interpretation. Through this study, we add to the existing literature by highlighting the gendered nature of multiple types of violence with implications for HIV prevention and treatment in Tanzania among a sub-population often overlooked in the scientific literature, public health programs, and policy decision-making. We also call attention to the ways that women who use drugs in this setting react to pervasive violence victimization and find ways to reenact agency in their lives.

5. Conclusions

Structural, everyday, and symbolic violence are symbiotic and reinforcing, heightening the HIV vulnerability of women who use drugs. Violence manifests through various mechanisms from migration patterns and limited income-earning opportunities to drug dependence and physical spaces that increase exposure to violence, and contributes to overlapping HIV vulnerabilities. Despite pervasive violence, women may adopt strategies to shield themselves from violence victimization. Adopting a multi-pronged, structural harm reduction strategy will be critical to reducing exposure to physical and sexual violence experienced by women who use drugs and their ability to protect themselves from HIV and other harms.

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Table 1

Characteristics of women who use drugs surveyed in Dar es Salaam, Tanzania by self-reported HIV status (N = 200).

Sample Characteristic	HIV-negative/ Never tested	HIV- positive	Total
	(N = 144) % (n)	(N = 56) % (n)	(N = 200) % (n)
Demographics			
Age *			
28 years and younger	36% (52)	14% (8)	30% (60)
29–39 years	44% (63)	59% (33)	48% (96)
40 years and older	20% (29)	27% (15)	22% (44)
Education level			
Primary or less	85% (123)	88% (49)	86% (172)
Secondary or higher	15% (21)	12% (7)	14% (28)
Relationship status			
Not in a relationship	28% (40)	32% (18)	29% (58)
Non-cohabiting partner	27% (39)	21% (12)	25% (51)
Married/cohabiting partner	31% (44)	32% (18)	31% (62)
Divorces/separated/widowed	15% (21)	14% (8)	15% (29)
Drug Use			
Duration of heroin use *			
Less than 5 years	63% (91)	46% (26)	59% (117)
5 years or more	37% (53)	54% (30)	41% (83)
Daily heroin use	86% (124)	80% (45)	85% (169)
Ever injected heroin **	9% (13)	23% (13)	13% (26)
Mental Health			
Depression			
No to minimal depression	16% (23)	9% (5)	14% (28)
Mild to moderate depression	58% (84)	52% (29)	57% (113)
Moderately severe to severe depression	26% (37)	39% (22)	30% (59)
Anxiety			
Minimal to mild anxiety	56% (81)	55% (31)	56% (112)
Moderate to severe anxiety	44% (63)	45% (25)	44% (88)
Drug use-related stigma (range: 0–24, with higher scores indicating more reported stigma)			
Enacted drug use-related stigma, mean (sd)	12.4 (7.3)	12.5 (7.5)	12.4 (7.4)
Internalized drug use-related stigma, mean (sd)	12.7 (7.9)	13.6 (8.1)	12.9 (7.9)
Structural Vulnerabilities			
Housing instability in past 6 months			
Stably housed	64% (92)	68% (38)	65% (130)
Unstably housed	36% (52)	32% (18)	35% (70)
Ever engaged in transactional sex	82% (118)	93% (52)	85% (170)

Sample Characteristic	HIV-negative/ Never tested	HIV- positive	Total
	(N = 144)	(N = 56)	(N = 200)
	% (n)	% (n)	% (n)
Ever arrested	81% (117)	80% (45)	81% (162)
Number of times arrested in past 6 months **			
None	13% (15)	38% (17)	20% (32)
1–3 times	52% (61)	38% (17)	48% (78)
More than 3 times	35% (41)	24% (11)	32% (52)
Reason for arrest **			
Using drugs	47% (55)	47% (21)	47% (76)
Selling drugs	7% (8)	2% (1)	6% (9)
Selling sex	28% (33)	22% (10)	27% (43)
Aggravated assault	5% (6)	2% (1)	4% (7)
Other	10% (12)	7% (3)	9% (15)
Incarcerated in past 6 months	63% (91)	50% (28)	60% (119)
Violence Victimization			
Physically assaulted in past 12 months	62% (88)	61% (34)	62% (122)
Forced sex in past 12 months	36% (50)	35% (19)	36% (69)
HIV Risk Behaviors			
Number of sexual partners in last month, median (IQR upper and lower limits)	5.5 (1–49)	6 (1.5–33)	5.5 (1–45.5)
Consistent condom use with casual partners	27% (39)	36% (20)	30% (59)
Ever shared injecting needles ^a	38% (5)	69% (9)	54% (14)

X² Results:

* $p < .05$

** $p < .01$.

^a Among respondents who reported having ever injected heroin.