

UCLA

UCLA Previously Published Works

Title

'I feel safer in the streets than at home': Rethinking harm reduction for women in the urban margins

Permalink

<https://escholarship.org/uc/item/434624bm>

Journal

Global Public Health, 15(10)

ISSN

1744-1692

Authors

Ritterbusch, Amy E

Nino, Eliana Lizeth Pinzon

Páez, Ricardo Antonio Reyes

et al.

Publication Date

2020-10-02

DOI

10.1080/17441692.2020.1751234

Copyright Information

This work is made available under the terms of a Creative Commons Attribution License, available at <https://creativecommons.org/licenses/by/4.0/>

Peer reviewed



Global Public Health

An International Journal for Research, Policy and Practice

ISSN: 1744-1692 (Print) 1744-1706 (Online) Journal homepage: www.tandfonline.com/journals/rgph20

'I feel safer in the streets than at home': Rethinking harm reduction *for* women in the urban margins

Amy E. Ritterbusch, Eliana Lizeth Pinzon Niño, Ricardo Antonio Reyes Páez,
Julie Pardo Triana, Daniela Jaime Peña & Catalina Correa-Salazar

To cite this article: Amy E. Ritterbusch, Eliana Lizeth Pinzon Niño, Ricardo Antonio Reyes Páez, Julie Pardo Triana, Daniela Jaime Peña & Catalina Correa-Salazar (2020) 'I feel safer in the streets than at home': Rethinking harm reduction *for* women in the urban margins, Global Public Health, 15:10, 1479-1495, DOI: [10.1080/17441692.2020.1751234](https://doi.org/10.1080/17441692.2020.1751234)

To link to this article: <https://doi.org/10.1080/17441692.2020.1751234>



Published online: 20 Apr 2020.



Submit your article to this journal [↗](#)



Article views: 549



View related articles [↗](#)



View Crossmark data [↗](#)



Citing articles: 2 View citing articles [↗](#)



'I feel safer in the streets than at home': Rethinking harm reduction for women in the urban margins

Amy E. Ritterbusch^a, Eliana Lizeth Pinzon Niño^b, Ricardo Antonio Reyes Páez^c, Julie Pardo Triana^c, Daniela Jaime Peña^c and Catalina Correa-Salazar^d

^aDepartment of Social Welfare, University of California, Los Angeles, CA, USA; ^bSchool of Government, Instituto Nacional de Salud, Bogotá, Colombia; ^cSchool of Government, Universidad de los Andes, Bogotá, Colombia; ^dCommunity Health and Prevention, Drexel University, Philadelphia, PA, USA

ABSTRACT

Through qualitative data collected with women affected by drug use and drug-related violence in Bogotá, this article explores the convergence of harm reduction rationales and violence prevention programming in the urban margins to advocate for women's health empowerment and health rights as victims of intergenerational trauma and violence. We propose a methodological shift of public health praxis from street-based outreach models to intimate spaces of intervention for health outcomes embodiment¹ as we continue to develop our community health model to work with marginalised communities in the urban global South. Through this work committed to social justice in marginalised urban communities, we seek to support women's health needs through harm reduction in historically marginalised communities in urban settings. Our results expose how multi-level gender-based violence affects women's health in their living spaces in the urban margins. Drawing from women's voices and narratives of urban violence, we call for a feminist alternative to traditionally masculinist and public-space oriented harm reduction practice for health empowerment in the urban margins.

ARTICLE HISTORY

Received 24 November 2019
Accepted 25 March 2020

KEYWORDS

Gender-based violence; harm reduction; women; interventions; drugs; urban health

1. Introduction: Gender-based violence, armed violence and 'drugs' in Colombian cities

In this paper, we present qualitative data collected during a harm reduction initiative with women in the urban margins in Bogotá and call for the radicalisation of the field of harm reduction through the centring of women's voices in our community-driven public health work. We also pronounce our political commitment to advancing justice-seeking for and *with* women in the urban margins in ways that divest from the activist-academic gaze² on urban drug users and sex workers' lives.

There are multiple reasons why this work is positioned in Bogotá, Colombia. Bogotá, a city that has been central in all of our trajectories, and Colombia, *nuestra tierra querida* (our beloved land), is where our activist-scholarship took place for many years both in the streets and in the Colombian academy. This positionality informs our political commitment to supporting women in the urban margins of Bogotá. Our city is not only a study site, as justifiable through the staggering incidence of gender-based violence against the most marginalised groups of women in the city, but, more importantly, is a site of political action and deep commitment to the strong women and places that have shaped our knowledge base and radical praxis as activist-scholars.

In addition to the history of civil unrest and armed conflict in Colombia, there are troubling trends in terms of violence against women. According to the WHO (2002), all levels of inflicted violence (self-directed, interpersonal and collective) impact women's physical, sexual, and psychological health (Heise, 1998). Over the last twenty years, female homicide has been on the rise (Franco, 2003; The World Bank, 2017), but successful public policy initiatives and interventions neglect to directly target and characterise risk factors for women grounded in the contexts where they live and work (Concha-Eastman et al., 2002; Guerrero, 2002, 2006).

In this paper, we discuss our home-based harm reduction initiative that directly intervened *in* women's lives *where* they most urgently needed support reducing gender-based violence and other forms of harm and risk in their daily lives. This shift is consistent with the revolution we propose within the field of harm reduction; a public health practice that often focuses on the daily mechanics of reducing street-based risk of drug use and associated risk behaviours in sex work and is less focused on pushing back against the structures that drive women to the streets and to drugs (and drug consumption zones in the first place). This was our attempt to shift collectively from the public space of the streets to the intimate spaces of women's daily lives where gender-based violence (violent partners, family members and family structures), structural violence (the conditions of multidimensional poverty, institutional violence and the everyday consequences of forced displacement and war), and historical violence (intergenerational trauma and abuse, child abuse, sexual abuse, psychological bullying within the family) weigh down on women.

Additionally, we understand the household as harm reduction intervention site as a social space in which power differentials are constantly being affirmed, challenged, and renegotiated (Nawyn et al., 2009). It is in these private spaces that micro-level factors influencing risk of disease and *harm* connect to macro-level factors contained in temporal and spatial contrasts of population rates of morbidity and mortality, including social inequalities in health (Krieger, 2005). Our multi-level qualitative analysis is mindful of how gendered micro-level processes connect to other levels on which power is operating and shaping gender relations (Nawyn et al., 2009).

This feminist harm reduction initiative represented the beginning of our attempt to strike a balance between our political commitments to advancing justice in Colombia and our public health-oriented scholarship. We understand and conceptualise health empowerment as the realisation of the full potential of all dimensions of health across socioecological levels, as well as the materialisation of health and sexual and reproductive rights for *all* women (United Nations General Assembly, 1948). We contend that health empowerment will ultimately catalyse the rise of women in both spaces that limit their freedom, social mobility and access to resources in the forgotten zones of cities throughout the world. We remain committed to building radical encounters and connections between women that promote healing and care as acts of resistance against oppressive systems that restrain their bodies and restrict their freedom to the spaces constituting 'home' (Mohanty, 2019).

The theories and frameworks underpinning our point of departure for understanding women's health in the urban margins include human rights advocacy that has informed our feminist activism over the years (Giacomello, 2013; Uprimmy et al., 2016), intersectionality theories connected to social liberation movements of women of colour that informs our understanding of women's complex positionalities in the urban margins (Cho et al., 2013; Crenshaw, 1991), and Latin American social movement and community psychology theories that inform our action-oriented research praxis and understanding of the role of the academy in supporting historically marginalised communities in cities (Fals Borda & Anisur Rahman, 2001; Freire, 1970/2000; Montero, 2010, 2012). In this paper, we argue for an epistemological and methodological shift in harm reduction practices *with* women in the urban Global South. We argue that the rationales driving traditional harm reduction programming are based on the assumption that women enjoy the same materialisation of rights as men in both the public and economic space of the streets, but also in the private setting of the household. Women's health is impacted differentially by the social determinants of health through intergenerational household dynamics that affect practices of care and well-being, migration histories, armed conflict experiences and interpersonal violence (Nawyn et al., 2009).

Our work over the last decade with street-connected communities in street spaces in Bogotá and other urban contexts in the global South led us to explore the pitfalls of harm reduction in public space. Based on this experience, we thus shifted the geographies of our harm reduction practices into the intimate spaces of women's lives in the context of marginal housing in the South of Bogotá.

Socioecological models position violence and drug-related dynamics and behaviours as major determinants of women's health (World Health organization [WHO], 2002; Heise, 1998) in urban contexts and slums (Winton, 2004) and post-conflict communities (Browne et al., 2019). These realities are especially pervasive in drug-production countries (Corda, 2015; Giacomello, 2013; Uprimmy et al., 2016) like Colombia. Thus, our overarching social justice aim was to develop an anti-violence movement *with* women in the urban margins that prioritised self- and collective care in household spaces that push them to the streets and toward drugs as a mechanism for freeing themselves of violent structures that keep them in their *place* (in the city streets, in sex work, in Ciudad Bolívar, out of universities, out of opportunities, out of the spaces of the urban elite) (see Hawthorne, 2006). The shift from the public spaces where social justice activism is usually mobilised to the intimate spaces of the household was based on our social justice aim of creating sustainable health interventions for women. Here, we understood that it is crucial to strike a balance between collective efforts to fight oppressive structures and the everyday dynamics of marginalised women who are not able to 'actively participate' in transformative struggles due to their daily struggle to meet basic needs for their families (see Collins et al., 2012).

For decades, evidence in the field of public health has reaffirmed the vulnerabilities of women within the household (Dutton et al., 2015) but rarely are these everyday intimacies of harm targeted for health interventions due to a lack of access that practitioners and psychologists have to these spaces. Building on previous relationships forged during our work as activists in street spaces, we retreated from the streets to women's living spaces in urban marginality as a point of entry for imagining intervention work that catalyses violence prevention and women's health empowerment in marginalised urban communities affected by different forms of drug-related violence and forced displacement. In this paper, we present an intergenerational case study conducted from January of 2017 to June of 2018 designed for women and their immediate family members including an assessment of the forms of violence that are necessary to intervene in this case. We conclude with our reflections about our final expulsion from the household by male members of the family unit who perceived our presence as threatening to the power dynamics implicit in patriarchal family structure.

1.1. Conflict-related violence in Colombia

Colombia has endured decades of armed conflict over the land, the territories of drug trafficking and political difference, among other historical factors underpinning the waves of violence for more than fifty years (LeGrand et al., 2017; Phelan, 2019). All social classes and sectors of Colombian society have been affected by conflict-related violence perpetrated by state actors, by paramilitary actors and by guerilla groups, all of which have been central to conflict-related massacres and acts of violence throughout the country (LeGrand et al., 2017; Phelan, 2019). Health-related consequences of the armed conflict disproportionately affect women and gender and sexual minorities (Ritterbusch, 2016; Zea et al., 2013) and the peace accords of 2016 incorporate health-related commitments in the overarching framework of restorative justice for rural and urban victims of the armed conflict (Maher & Thomson, 2018).

It has been argued by feminist scholars that during armed conflict, the cultural status of women makes them vulnerable to diverse forms of violence, especially sexual violence, which is oftentimes considered 'private violence' because it occurs in the intimate spaces of the household (Nawyn et al., 2009). Thus, women rarely receive protection from violence perpetrated by non-state actors, who are often family members given that *gendered* relations in the household connect to societal views and ideologies in larger structures of violence at the national and global level (Nawyn et al., 2009).

Consequently, these experiences are also state-instituted: public and private expressions of violence that materialise social deprivation over women's lives (Zierler & Krieger, 1997).

Armed conflict in Colombia is also connected to high levels of homicide rates, a form of collective violence perpetrated by actors of the armed conflict that takes a toll on the lives of women across lines of class, race and gender identity, and the communities living in multi-dimensionally impoverished rural and urban zones of the country are disproportionately affected by it (Franco, 2003; Guerrero, 2006; Hawthorne, 2006). Additionally, gender-based violence in marginalised urban areas occurs at the intersection of multiple historical structures consolidated by patriarchal societal norms and social relations, which is the systematic discrimination against and mistreatment of women legitimised in public and private spaces, in social welfare entities of the state, and in public and private educational systems (Corda, 2015; Hawthorne, 2006; Heise, 1998).

On occasion, the well-intentioned social programmes designed to reach out to and provide services to the most marginalised women in society are implicated in and perpetuate structural and institutional violence against the same women they strive to protect (Corda, 2015). If we understand violence as a health issue (Guerrero, 2002), it is paramount to inform it through a gender perspective that targets risks and harm to women's bodies and lives.

Drug-related violence within the armed-conflict framework has paved the way for repressive drug policies affecting women (Zierler & Krieger, 1997). Multiple studies denounce repressive drug policies in Latin America that tend toward criminalisation and incarceration of drug-related offenders and drug users rather than framing the issue as a public health dilemma (Giacomello, 2013; Uprimmy et al., 2016). These policies disproportionately affect women as they are typically implicated at low and susceptible levels in the chains of production and trafficking and are subjected to social programmes that incarcerate the most marginalised users, including pregnant women and women from racial and ethnic minority groups (Del Olmo, 1998; Ferguson & Kaplan, 1993; Giacomello, 2013; Werb et al., 2011; Zierler and Krieger, 1997). These policies are part of the larger political, racial and social welfare mechanism of the so called 'War on Drugs' (Broadhead et al., 2006). Systematic reviews suggest, however, that increased policing, drug-related law enforcement and the use of military and other state forces against street-connected drug users and drug zones contributes to drug market violence and increased homicide rates, consequently increasing levels of violence (Broadhead et al., 2006). Given this context, we propose a feminist, radical harm reduction framework that repels patriarchy with acts of care and struggles against the carceral state in the urban spaces where communities are most often criminalised and incarcerated. In the following section, we outline the key components of harm reduction initiatives in multiple contexts. We argue that these programmes, although seldomly intersecting in the worlds of high-level philanthropy and community-serving organisations, have much to learn from one another and urge scholars to think through the support of drug using and violence-affected women.

1.2. Key elements of harm reduction initiatives in urban drug-affected communities

Over the last four decades, harm reduction interventions have focused on providing drug paraphernalia to drug users to reduce HIV and Hepatitis C transmission (Kerr et al., 2010), infection and epidemic (Campbell & Mzaidume, 2001; Kerr et al., 2005), safe injection facilities (SIFs) which often go by different names (Jardine et al., 2012; Potier et al., 2014; Watson et al., 2013) to avoid police violence and prevent overdoses (Hawk et al., 2015; Wilson et al., 2015), and substitution therapies (Cusick, 2006; Zamudio-Haas et al., 2016). For women specifically, these interventions have also focused on sex work and pregnancy; so mainly on their sexual and reproductive health rather than their general overall health (Collins et al., 2012; Janssen et al., 2009; Rekart, 2005; Rossi et al., 2000). Often times these efforts combine approaches including harm reduction services for alcohol dependent sex workers (Farthinga & Kohl, 2012; Parcesepe et al., 2016) and operate in alliance with community-based organisations that provide harm reduction services (Rekart, 2005). However, these individual-level initiatives fail to address the structural precarity of women in

relation to their health needs and their conceptualisation of health as rather a collective practice that relates also to the health of their families and those near them.

Within the programmatic framework of traditional harm reduction services, ‘harm’ is defined as the adverse health, social and economic consequences of drug or alcohol use and drug-related law enforcement and other mechanisms of social control (Carruthers, 2007; Wright et al., 2012). As described in previous studies, harm reduction practices consist of nutritional support, clinical support for reducing drug and other substance use and the encouragement of wellness activities including exercise, access to prenatal services and increasing connections to support groups within the individual’s support network (Carruthers, 2007). Thus, there is a mismatch between the strategies to address harm and the structural factors that weigh down on the lives and well-being of drug users and drug-affected populations in general, and, we argue, women, in particular. Gendered relations affect women’s autonomy in practicing options for harm reduction like accessing needle exchange services, drug treatment programmes and seeking treatment for drug addiction (Zierler & Krieger, 1997). There is evidence to suggest that women’s low attendance to drug programmes is affected by violence (being harassed in the waiting line of services, being asked for sex) or stigma (traditionally women carry more stigma for using drugs than men do) (Zierler & Krieger, 1997).

We urge scholars to situate harm reduction practice in a wider context that includes a broad range of social, cultural, and economic factors in the conceptualisation of harm (Farthinga & Kohl, 2012; Wright et al., 2012) and to assess risk through a gender perspective that considers how and why women feel vulnerable and violated when seeking support and treatment. For this reason, our definition and approach to harm reduction prioritises the community-driven definition of ‘harm’ and ‘risk’, consistent with peer-driven harm reduction frameworks (Campbell & Mzaidume, 2001; Kerr et al., 2010; Londoño Toro, 2004; Potier et al., 2014).

2. Methodology

2.1. Study site description: Harm reduction in sites of housing injustice in the urban global south

The feminist harm-reduction initiative took place in *Villas del Progreso*,³ located in Ciudad Bolívar in southeastern Bogotá. Historically, Ciudad Bolívar is a recipient of internally displaced persons (IDPs), or victims of the armed conflict who have been forcibly displaced from their rural towns and cities of origin by illegally armed groups, both on the political left and right (Brofenbrenner, 1977; Brookings-LSE Project, 2011). The south of Bogotá is disproportionately affected by armed-conflict migration patterns and a large portion of Bogotá’s urban landscape is occupied by informal settlements such as *Villas del Progreso*. In addition to the high levels of multidimensional poverty and absence of the state in this zone of the city, *Villas del Progreso* is a community that has been historically affected by the presence of paramilitary actors⁴ who control the urban territory and are linked to drug-related violence within the community spaces and broader drug trafficking networks. Participants at many times expressed their fear of these actors and mentioned that our team activities could not create much public commotion in order to avoid possible retaliation or targeting of the family and children involved [Figure 1](#).

The working group consisted of two professors in the Psychology and School of Government departments at Universidad de los Andes in Bogotá and five students at varying levels of undergraduate and postgraduate studies in both departments including two recently graduated community psychologists, one community psychology student, one MPH student and two public affairs undergraduate interns. The working group conducted weekly workshops that included data analysis, grounded theory revisions, inter-coder reliability sessions, analysis and discussion of findings and intervention planning both in university – and community-based settings. The sessions also involved harm reduction activities and research design and modification based on community feedback and experiences in the field. This working group designed and implemented the harm reduction initiative and associated research described in this paper.



Figure 1. Photograph taken by project team: *Villas del Progreso*.

2.2. Data collection techniques

Our qualitative inquiry aimed to understand the social risks to these women’s health and well-being on individual, interpersonal and community levels and to identify potential pathways for health empowerment in their daily lives across these three socio-ecological levels.

Our methodological approach triangulates qualitative methods (interview and focus group techniques), cartographic methods (social mapping) and critical community psychology exercises. The project phases included qualitative baseline data collection, intervention design and implementation and post-intervention data collection. Participants include four women representing four generations within the same family group and their children who remain dependent on them, both in financial and care labour terms ($N = 14$). The intervention phase also included participants’ dependent children (ages ranging from 4–26 years old, including one child with visual and cognitive disabilities). The sampling technique followed a snowball approach employed through long-term advocacy relationships with the research community. The following figure summarises the data collection phases with these four women and their children [Table 1](#):

As part of the pre – and post-intervention data collection, we conducted a total of 17 semi-structured interviews, including 13 interviews with the four principal female participants and other key family members in the household and 4 exit interviews post-intervention with principal participants in the household willing to comment on the process.⁵

The thematic structure of the interview instrument was organised according to the social ecology (Krieger, 2001) of violence exposure, health risk and perceptions of health services for women

Table 1. Phases.

Project phases	Pre-intervention data collection to inform intervention Intervention design and implementation Post-intervention data collection, assessment and exit
----------------	---

(Heise, 1998). At the individual scale, questions explored participant exposure to violence, health risks and health services. At the interpersonal scale, questions explored participant experiences of interpersonal violence, health risks associated with interactions with other individuals in her social and familial network, and any interactions between participant and individuals in her social and familial network regarding health services. At the community scale, questions explored participant experiences of violence, health risks and health services in her community context and what the participant considers to be the principal health dilemmas in her community. At the institutional scale, questions explored participant experiences of institutional violence in the healthcare system and her perceptions of health services provided by different state institutions. This section also included discussions of structural violence related to the armed conflict violence in Colombia. The interview instrument contained questions across levels such as the following: Individual: How do you define violence? Interpersonal: Have you witnessed an act of violence perpetuated by police or other public officials against someone in your community? Community: What are the major health dilemmas in your community? Institutional: What has your experience been in state health centers?

Secondly, informed by preliminary analysis of the pre-intervention semi-structured interviews, we designed a series of interventions at the individual, interpersonal and community levels to create a space of self – and collective care in the living spaces of project participants. Our team led individual sessions with the women leading each household and also included group sessions involving multiple individuals in the household, including children. The individual level of our intervention sessions consisted of individual therapy sessions, self-care activities, life history narrative work. The interpersonal level of our intervention sessions consisted of self-care sessions among family members, workshops on healthy parenting practices, on intra-family communication strategies and conflict resolution. The community level of our intervention sessions consisted of a *sancocho comunitario* to strengthen the team building experience and connect with the household's community space in the neighbourhood, re-appropriation of violent and drug-affected urban spaces, emotional regulation skills for managing relationships between siblings and child–parent relationships, structured play sessions with developmental purposes. Finally, the institutional and structural level intervention sessions consisted of connection of family members with state resources for victims of the armed conflict, with disability rights institutions and child welfare services.

3. Results

In the following results sections, violence against women across generations is presented at the individual, interpersonal and structural levels, as aligned with the analytical structure guiding the coding process.

We present the intergenerational experiences of violence affecting women in urban drug-affected contexts according to their lived and *embodied* experiences (Krieger, 2001). These qualitative data shed light on the public health implications and community-based challenges the team faced during project implementation. Additionally, the results illuminate how forced migration and armed-conflict survival is played out within the household and connected to larger societal structures producing a feedback loop between individual agency and institutions (Nawyn et al., 2009).

By drawing from the life histories of the four women at the centre of this feminist harm reduction initiative, we illustrate the challenges of growing up as a woman in the rural context of armed conflict in Colombia and, upon experiencing forced displacement, subsequently surviving in drug-affected zones of conflict and violence in the city.

As identified in our initial risk assessment of the experiences of women in this family, the family dynamics and daily context of violence include the following dilemmas: living with a disability, child labour, sex work, forced displacement, interpersonal violence within the household, poverty associated triggers of violence, alcohol and inhalant dependence, micro-trafficking-related violence within the community and state violence involving the national police, educational and healthcare institutions. This context of adversity in participants' daily lives should be considered while reviewing

the results on violence, which are organised below in a social ecology framework to present the experiences of these four women at the individual, interpersonal and structural levels [Figure 2](#).

3.1. Individual experiences of violence

There are two main themes related to women's experience of violence and health risk at the individual level. Both examples illustrate the importance of moving harm reduction to the intimate spaces of the home and familial spaces. The first theme includes behaviours of self-harm and suicidal ideation experienced by the participants. Drug consumption emerges as a coping mechanism for navigating stress and psychological symptoms of anxiety and depression.

... I would like to work individually ... on me. Because in reality, I feel that as a person, woman ... I have so many voids ... like that something is missing that will fulfill me ... although you can feel like you have it all, but I feel something emotional or internal, I don't know, that is missing ... sometimes I feel like I can't find myself ... my head hurts ... I stay frozen far away thinking about what I shouldn't be thinking about, many times that's why I can't work, because I'm [feeling] like that ... and this affects me at home, my children, because obviously I get home in a bad mood, for any little thing I punish them. (Marianna, Semi-Structured Interview, 25/09/17)

Intimately connected to the first theme of self-harm, the second theme relates to women's conceptualisation of their health. To participants, their health extends beyond their individual experiences to encompass their family members. According to the data gathered in this project, women's identities are intimately intertwined with being a mother and grandmother and how this role evolves in everyday life. This identity is visualised in the body mapping excerpt above (see [Figure 2](#)). Thus, through careful methodological reflection, we urge scholars to support health empowerment interventions targeting women's individual health by conceptualising embodied gendered experiences (Fandino-Losada et al., 2017) as inextricably related to their context and their social and familial networks. In these scenarios, women do not perceive their individual 'identities' as separate from the characteristics of their family groups.

On the individual level, drug behaviours are not directly linked to personal identity but are rather considered 'past experiences' that have no real bearing on family life for women. Thus, risk is represented as external from household dynamics. Likewise, family and intimate partner dynamics are not a part of household life, given work or 'risk behaviors' are not shared or communicated.

I told her that I would like ... the help of a psychologist, given that we are displaced, the relationship with the father of my children also wasn't very good, I have another partner now, well my work isn't the best in the world, because, truthfully, I work there in La Mariposa [Plaza San Victorino], but my partner doesn't know. (Marianna, Semi-Structured Interview, 01/10/1)



Figure 2. Body mapping reflection. Note: "[name] I feel responsible with myself and my kids." The body mapping exercise draws from the subfield of feminist geography as a form of counter-mapping health narratives at the intimate scale of the body.

In this context in which self-harm and silence are coping and adaptive mechanisms for women, we argue for the need to de-pathologize top-down definitions of violence and harm and ground these concepts in women's everyday emotional geographies:

Sometimes I feel as though I don't have anyone ... as if I am all alone with my children ... I'm distracted, I'm not consistent, as if I were drowning. I just want to run away to a place where no one knows me. (Marianna, Semi-Structured Interview, 25/09/17)

Similarly, María Inés, describes experiences of having to survive without a support network and be the sole provider for her children:

when I had Camilo and Marianna, I lived alone with them ... when I arrived here to Bogotá I arrived alone with them ... and alone ... I defended us, alone I found a room to rent, alone I went out to work, I even learned how to work here in Bogotá, because I never had the help of anyone. (María Inés, Semi-Structured Interview, 10/11/17)

These experiences of lacking a community and interpersonal context to manage experiences of violence and institutional abandonment present a public health challenge to programmatic efforts targeting harm reduction in the lives of women. Thus, the household as a realm targeted by harm reduction initiatives should be conceptualised in terms of the individual health of women and the structural risk factors that affect women's health as linked to their relationships of care and responsibility. In these contexts, women are oftentimes the sole providers for their children as heads of households, which imposes a burden on their mental and physical health.

Furthermore, psychological symptoms intertwine with women's health as they are mediated by contexts of urban drug-related violence. A harm reduction model for women should consider interpersonal kinds of vulnerability related to sexual violence within households. These results show how violence is imposed on women at different levels and why it is paramount to address risk and harm in the intimate spaces of women's daily lives. Multiple forms of oppression related to gender, socio-economic conditions, displacement status, educational history and class coincide to isolate women surviving in the urban margins, leaving them with no social resources or networks to deal with violence. Marianna's mother expresses the following regarding sexual violence and abuse exerted against her children by a family member:

I have noticed the girls have been very sad ... really tired and I [starts to cry] ... so at night when I got home from work my son told me, the little one, Mom I have to tell you something ... Mom what happened was I went up to the second floor and my Uncle was touching their private parts [referring to his sisters] ... of course I was surprised ... my sister's husband, but I don't want her to know anything because I just want to leave without anyone knowing anything ... [after talking with the girls] "why didn't you tell me right then?" ... "Mom, I thought you would beat me" ... (María Inés, Semi-Structured Interview, 10/11/17)

Moreover, Inés mentions:

It is sad to see what these children are ... it makes me so sad to see Marianna's routine, Marianna, those two kids and mixed up in drugs ... Marianna lives a very miserable life. (Inés, Semi-Structured Interview, 09/10/17)

These experiences of violence across generations should be contemplated in definitions of risk and harm in an intervention in this particular family context, that mirrors the experiences of millions of families in IDP receptor sites in Colombian cities. Harm and risk, in the lives of these families, should be defined as inextricably interconnected with the dynamics of intimate partner violence, drug-related violence and structural violence that keeps these families in the urban margins. As discussed in the following section, participants refer to intergenerational trauma and gendered experiences of care labour distributions. These scenarios engender a sense of hopelessness that impacts women's mental health and limits their seeking of social resources.

3.2. Interpersonal experiences of violence

Interpersonal aspects of health risks in the lives of participants relate to the struggles of single parenting, the absence of a partner and the additional pressure thereof on the household:

my children's Dad doesn't visit the kids, he also doesn't help us financially. (Marianna, Semi-Structured Interview, 01/10/17).

... I was six years old when I started working in the streets ... because I only studied until 6th grade, that's like nothing in those times, so it's difficult to get a job ... because you don't have experience and they wouldn't hire someone [like me] ... so for this reason I also haven't focused on finding stable work. (Marianna, Semi-Structured Interview, 01/10/17)

None of the women in this family consider or include men in the decisions regarding their children because of the lack of presence and support provided by them. Even when men live within the household, they are perceived as violent or feared members of the network. Women assume all the reproductive and care labour work. The lack of education and economic power of women in different family generations further deepens this situation, making intimate partner violence an issue across generations and an additional risk factor for drug use and exposure to violence in other areas of their lives:

... He [referring to her exhusband] was too jealous, I couldn't go anywhere, I couldn't visit my Mom, I couldn't go out with my children anywhere, the daycare for my children had to be the closest daycare possible, we ended up living in a place where the daycare was in front [of our house] and the supermarket on the corner. (Marianna, Semi-Structured Interview, 01/10/17)

'... he [former husband] has been living with a girl, who was my friend, for a year and since he went to live with her, he hasn't come back to see the kids, he hasn't given money for them, nothing, so we lost communication ... this year he saw me, he saw me working there in the center [of the city] and he grabbed me by my hair and he dragged me to the San Victorino park, there in *La Mariposa*, he dragged me there and treated me badly. I had to call the police on him. Yes, he hit me ... I have had to take legal action two times. The first time was because he didn't want to leave me be, for anything he would beat me in the streets if he saw me. (Marianna, Semi-Structured Interview, 01/10/17)

Marianna's grandmother provides further context regarding intergenerational physical violence between family members:

I grab the belt and I go and hit him/her with the belt, now I can't do it ... eee now I can't do it, because if she sees me with the belt, right away she's on top of me. (LE, Semi-Structured Interview, 25/10/17)

'... he arrived ... what he came across he threw, he screamed ... it was a situation of complete despair ... he has moments when his neurosis is heightened ... one day I threw hot coffee on him ... I was bringing him coffee and I told him, don't mess with me, and I threw the coffee on him and that was what brought him down. (Inés, Semi-Structured Interview, 25/09/17)

Additionally, María Inés describes the intergenerational legacies of violence in her former husband's family, as a means of contextualising the violent behaviours and daily contexts of her children. Moreover, these descriptions can be understood as intergenerational trauma interfering with mental health:

... their family [her children] is a family that has always lived this way ... they [physically] fight between brothers and sisters, sisters with the Mom ... the children hit their Mom. So they have inherited their aggressive behavior ... because this is hereditary ... in their family, on the father's side, cousins killed one another, brothers and sisters killed one another, aunts [physically] fought with their nieces, pulling knives on one another as if they were strangers, so they have inherited this. (María Inés, Semi-Structured Interview, 10/11/17)

These examples demonstrate how the household context becomes unbearable for women and how they take to the streets, and to drugs, seeking comfort and relief: 'The truth is, I feel safer in the streets than at home' (María Inés, Semi-Structured Interview, 25/09/17). This counterintuitive realisation contrary to traditional harm reduction practice delineates how personal intimate spaces of shared relationships impose a burden on women's mental and physical health related to care labour and economic vulnerability. One of the objectives of our harm reduction initiative was to create positive place memories associated with 'home' in order to reduce street-associated risk behaviours. Interpersonal-level violence is pervasive in women's lives and is transmitted through family networks to,

ironically, deal with iatrogenic effects of contextual armed – and drug-related violence, as described in the next section.

3.3. Structural violence across generations

In this section, we present intergenerational institutional and structural experiences of violence across the four generations of the family. Given the nature of intergenerational trauma, trauma reported here was experienced by participants in their childhood; some of them surviving armed-conflict violence and forced displacement as children. The group specifically tailored the harm reduction initiative to these needs.

Marianna's grandmother describes her family's experience of forced displacement by paramilitary actors from their small rural hometown and land in Salamina, Caldas. This displacement included family members from three generations including Marianna and her brother when they were children.

We had to throw him out that same night ... we sent him to Manizales to my Mom's house ... he went to the [military] battalion of Manizales, reported the case and they sent him here [to Bogotá] ... the next day we had to leave ... we had to talk to them [right wing illegally armed militants] so that they would give us until 6 am the next day when the bus to Manizales passed ... we arrived [to Bogotá] paying for a room near El Cartucho [a drug consumption zone in the city center that was eliminated by the Peñalosa administration in the early 2000s] ... that's where we arrived ... I can't really remember well ... what the house was like ... we arrived there [to the area of El Cartucho] paying for a room and from there we started making our way up, until we could get better organized, where there aren't so many bad things ... until we landed in the [pay-per-day] motel/apartment building on third avenue. (Inés, Semi-Structured Interview, 09/10/17)

Marianna's grandmother also describes her family's struggles with urban displacement and paramilitary social and territorial control in their neighbourhood in the South of Bogotá.

It was a Thursday, they arrived at 3 pm ... asking for the owners of the motel ... the [para]militants told them directly the name of my husband ... my whole body went cold ... when I saw their faces ... my husband went out and there they told him 'you have until tomorrow morning to get out, there is nothing else to discuss' ... they told us to pack up and take our things to the motel on third street ... it was then that my husband started to get sick ... and my mother died because of the problem, the displacement, after a year she died. (Inés, Semi-Structured Interview, 09/10/17)

... when we arrived here to Bogotá we arrived directly to El Cartucho neighborhood, where they didn't see anything but drugs, we saw delinquency, thugs, all of it ... we were seeing so much aggression against others [referring to drug users] ... so even though they are not well dressed they are human beings, they feel like everybody else. (Marianna, Semi-Structured Interview, 25/09/17)

Beyond the failure of the state to provide basic survival support to displaced rural communities landing in the most violent spaces of Colombian cities, violence in and around the household becomes naturalised as a part of survival in the city:

Then we went to live in Las Cruces neighborhood and there is was the same, every day there were dead bodies by our house, we would here gun shots over there, over here, just like at the farm [where they were displaced from in rural Caldas] ... So, that was now becoming normal for us, now that [violence] is just the way it is. (Marianna, Semi-Structured Interview, 25/09/17)

Our feminist harm reduction initiative specifically targeted conflict resolution, communication strategies and emotional self-regulation to moderate violent reactions in the household, normalised through everyday familial dynamics. Additional access barriers in the educational and healthcare system exacerbates the family's socio-economic marginalisation:

You had to go at the crack of dawn to sign up, so that he could get in [to where?] ... They let him in but they didn't fill out the admissions paperwork ... the only thing they did was give him a piece of paper that I still have stored over there. And he came home crying and said "Mom, because I'm poor, nobody wants to help me". (María Inés, Semi-Structured Interview, 25/09/17)

These structural limitations can imply, at times, even physical, psychological and emotional violence expressed in interpersonal behaviours:

Camilo started getting worse ... when he arrived home he looked tired ... I went to the store and when I got back I found Marianna on crying hysterically ... [she said] 'Mom look at my brother's feet' ... AY!! When I took his shoes off I almost died ... his feet were completely hurt ... [he said] ... 'Mom, I don't ever want to go back to school' ... 'that BITCH, that BITCH that takes care of us ... she sent me to get the bathroom keys ... and I couldn't find it ... she threw me out and pushed me from the door ... she told me that I shouldn't tell anyone, that a man had no business gossiping ... and when I went to tell [the administration], no one believed me [repeats] no one believed [my story]. (Maria Ines, Semi-Structured Interview, 25/09/17)

Learned helplessness, disappointment and resentment experienced by historically abandoned urban populations relate to mistrust in institutional support and reluctance to participate in society at large. Marianna describes her reluctance to seek support from the government for fear of losing her children:

... I will not see a psychologist from the government ... because my children are in danger ... [of being stolen by the state or in their communities? This isn't clear] ... they can take them from me, they are really beautiful, so they can take them away and give them up for adoption, so no, because of that I don't do it [seek mental health support]. (Marianna, Semi-Structured Interview, 01/10/17)

These experiences of structural violence further support our claim for a shift in harm reduction practice in the absence of trusted state resources that support women and their children. We therefore argue that moving harm reduction initiatives to women's intimate spaces in the urban margins merits further research and dialogue among practitioners.

4. Discussion

These results illuminate women's health as a multidimensional construct that is affected by embodied gender roles (Fandino-Losada et al., 2017) and socio-ecological determinants of health that include risk factors (Guerrero, 2006) and intersecting, oppressed intergenerational identities. Through the characterisation of health in different levels of the socioecological model (Heise, 1998; Krieger, 2001; WHO, 2002), we show how women in a household that has been displaced by violence, understand and practice health in relation to others in their family networks. Gender, as a restrictive social construct that is intertwined with women's self-concept, self-esteem and identity (Bowleg, 2019), confines these women to limited spaces in the city and further isolates them as they struggle to hold onto their role as caretakers. We argue here that particular gendered identities of women in the city silence the risks they are exposed to as victims of the armed conflict. This is coherent with claims of feminist scholars arguing that gender-based violence is rarely considered as an act of structural violence because it relates to the 'intimacies of the women', thus leaving women outside of the reach of state institutions created for their protection and 'empowerment' (Nawyn et al., 2009).

As previously mentioned, although harm reduction services in the past have addressed sexual health and harm reduction in programming (Collins et al., 2012; Janssen et al., 2009; Rossi et al., 2000), it is paramount to have an overarching framework that tailors service delivery to the multi-level factors and risks embodied in women's lives (Krieger, 2001; Zierler & Krieger, 1997), instead of siloed efforts where sexual and reproductive health and drug use, for example, are treated as separate dilemmas; and violence is understood as separate from intimate gendered dynamics. As conceptualised here, intimate spaces where personal relations are negotiated and modelled are the tenets of women's self-empowerment. We argue that the same work that has been done in urban contexts like these to prevent high homicide rates and interpersonal violence (Concha-Eastman et al., 2002; Guerrero, 2002, 2006; Open Society Foundations, 2018; Tsemberis, 2011) need to be framed within a gender perspective that targets risk and violence as informed by women's experiences. Otherwise, harm reduction efforts, be it state-instituted or civil-society-driven, will continue to fall short in granting women individual, interpersonal, community and institutional-level

resources to protect themselves against violence and to break through the barriers to health empowerment.

Individual level challenges and risks relate to the lack of support networks, the stressors of living in drug-affected environments and the feelings of isolation, depression and anxiety striving from interpersonal violence, intimate partner violence and couple dynamics. These factors can be conceptualised within a harm reduction perspective to target strategies that serve women in their health needs, rather than focusing on individual-level behaviours that do not relate to their understanding of health, harm and risk; or consider women's freedom of mobility within urban spaces. Moreover, these factors compose a picture of determinants of health for women in marginalised urban communities that has not yet received the necessary attention.

At the interpersonal level, participants discussed the effects violence in their daily lives and the trends of child abuse and conflict between family members that trickled down from generation to generation. Intergenerational, multi-level forms of violence interact with one another and ultimately prove iatrogenic for women's health, embodying disparities in the lack of material resources and exclusion from state reparation resources for victims of the armed conflict.

Finally, at the institutional and structural level, the generalised lack of trust in the healthcare and victim reparation system constitutes diverse forms of institutional violence that affect health and well-being of the family unit. The failure of the state to protect the rights of victims of the armed conflict and the subsequent criminalisation, punishment and stigmatisation of this population by state health and education services 'available' to them impacts their health and ability to seek justice, as well as their resistance to different forms of oppression. Collective-level interventions should target care labour gendered dynamics to improve health conditions and mental health symptoms for women and their children. A conceptualisation of violence as a gendered phenomenon in programmatic efforts and policies is paramount to effecting change in these communities given its *intimate* grounding; as well as to the initiation of historical and social reparations for victims.

As Inés expresses feeling safer in the streets than at home, we call for a transformative public health praxis that addresses the issues experienced by women in the urban margins and the actual risk factors that detrimentally impact their health. Through our harm reduction work in intimate spaces of urban marginality, we challenge the very forces that make life unlivable for women in the home. This challenge to the patriarchal structures affecting street-connected women are essential for ensuring that harm reduction initiatives take hold in male-controlled households. Our feminist turn in harm reduction practice was successful for our participants, so much so that when power balances negotiated in the household started to change, male members of the family reacted with violence and eventually prohibited our entry into the household space.

The reaction of husbands, fathers and brothers is coherent with feminist literature that presents the household as social space in which power differentials are constantly being affirmed, challenged, and renegotiated (Nawyn et al., 2009). Our feminist health empowerment initiative that challenged oppression and patriarchal power in the household was ultimately compromised by these very structures. The empowerment of women is met with resistance because it implies change. However, there is a lack of institutional frameworks and programmatic initiatives to support these transformations in the long-term.

Addressing women's physical, psychological, sexual and community health requires harm reduction initiatives that are intersectional, intergenerational and multi-level. Social justice aims in harm reduction efforts will remain out-of-reach if both intimate and structural oppressions are not addressed in programme design.

5. Conclusions

Harm reduction frameworks addressing multi-level violence in urban drug-affected contexts should tailor implementation strategies to household dynamics where women's health is materialised and embodied in daily practices of care and relationships with loved ones. Broadening the constructs

of risk and harm would push harm-reduction rationale from the patriarchal stigmatisation of street-based drug users to a feminist stand-point approach that considers the barriers, intersecting oppressions, stigma and violence affecting women's health (Zierler & Krieger, 1997). The focus of this research was to take public health and community psychology practice back into women's spaces of harm and care. This shift has been called for by feminist scholars for decades but continues to be neglected by public health practitioners.

We argue that harm reduction efforts need to conceptualise the everyday, intimate space as a determinant of preventive and protective strategies for women's health empowerment (Mohanty, 2019). Violence and risk within households are spaces where structural forces also shape health. Without targeting multi-level violence in drug-related public health interventions, women's health in marginal urban contexts will continue to be excluded from large scale harm reduction models propelled by state agencies and large non-governmental organisations.

Notes

1. Drawing from Krieger's (2004) conceptualisation, we define embodiment as the stories our bodies hold and how they interact with the urban environment.
2. By activist-academic gaze, we refer to the oft-times extractivist, voyeuristic practices of activists and academics, and those who identify with or vacillate between both worlds. We imagine an activist-scholarship that survives beyond the violent confines of the NGO Industrial Complex and the commodification of knowledge production in the neoliberal academy.
3. "Villas of Progress".
4. Illegally armed actors historically connected to right-wing ideologies.
5. Male household members were against both the research and intervention process.

Disclosure statement

No potential conflict of interest was reported by the author(s).

References

- Bowleg, L. (2019). Intersectionality Matters [Epilogue]. In P. R. Grzanka (Ed.), *Intersectionality: Foundations and Frontiers* (pp. 413–420). Routledge.
- Broadhead, R. S., Volkanevsky, V. L., Rydanova, T., Ryabkova, M., Borch, C., van Hulst, Y., Fullerton, A., Sergeyev, B., & Heckathorn, D. D. (2006). Peer-driven HIV interventions for drug injectors in Russia: First year impact results of a field experiment. *International Journal of Drug Policy*, 17(5), 379–392. <https://doi.org/10.1016/j.drugpo.2006.06.001>
- Brofenbrenner, U. (1977). Toward an experimental ecology of human development. *American Psychologist*, 32, 513–531. Retrieved August 30, 2018, from <http://maft.dept.uncg.edu/hdf/facultystaff/Tudge/Brofenbrenner%201977.pdf>. <https://doi.org/10.1037/0003-066X.32.7.513>
- Brookings-LSE Project Proyecto del Instituto Brookings-London School of Economics. (2011). Efectos del desplazamiento interno en las comunidades de las zonas de recepción estudio de caso en Bogotá, dc Colombia, en las localidades de Cuba y Ciudad Bolívar. Retrieved September 15, 2018, from <http://www.acnur.org/fileadmin/Documentos/Publicaciones/2012/8470.pdf>.
- Browne, A., Bennouna, C., Asghar, K., Correa, C., Harker-Roa, A., & Stark, L. (2019). Risk and refuge: Adolescent boys' experiences of violence in "post-conflict" Colombia. *Journal of Interpersonal Violence*, 1–23. <https://doi.org/10.1177/0886260519867150>.
- Campbell, C., & Mzaidume, Z. (2001). Grass roots participation, peer-education, and HIV prevention by sex workers in South Africa. *American Journal of Public Health*, 91(12), 1978–1986. <https://doi.org/10.2105/AJPH.91.12.1978>
- Carruthers, S. (2007). The organization of a community: Community-based prevention of injecting drug-use related harm. *Substance Use and Misuse*, 42(12–13), 1971–1977. <https://doi.org/10.1080/10826080701533302>
- Cho, S., Crenshaw, K. W., & McCall, L. (2013). Toward a field of intersectionality studies: Theory, applications, and praxis. *Signs: The Journal of Women in Culture and Society*, 38(4), 785–810. <https://doi.org/10.1086/669608>
- Collins, S. M., Clifasefi, S. L., Dana, E. A., Andrasik, M. P., Stahl, N., Kirouac, M., Welbaum, C., King, M., & Malone, D. K. (2012). Where harm reduction meets housing first: Exploring alcohol's role in a project-based housing first setting. *International Journal of Drug Policy*, 23(2), 111–119. <https://doi.org/10.1016/j.drugpo.2011.07.010>

- Concha-Eastman, A., Espitia, V. E., Espinosa, R., & Guerrero, R. (2002). La epidemiología de los homicidios en Cali, 1993–1998: Seis años de un modelo poblacional. *Revista Panamericana de Salud Pública*, 12(4), 230–239. <https://www.scielo.org/article/rpsp/2002.v12n4/230-239/>.
- Cordeiro, A. (2015). Reforma a las políticas de drogas en Latinoamérica: Discurso y realidad. Colectivo de Estudios Drogas y Derecho, CEDD. Retrieved August 30, 2018, from http://fileserv.idpc.net/library/Alejandro_v09.pdf.
- Crenshaw, K. W. (1991). Mapping the margins: Intersectionality, identity, politics and violence against women of color. *Stanford Law Review*, 43(6), 1241–1299. <https://doi.org/10.2307/1229039>
- Cusick, L. (2006). Widening the harm reduction agenda: From drug use to sex work [Commentary]. *International Journal of Drug Policy*, 17(1), 3–11. <https://doi.org/10.1016/j.drugpo.2005.12.002>
- Del Olmo, R. (1998). Reclusión de mujeres por delitos de drogas: Reflexiones iniciales. *Revista Española de Drogodependencias*, 31(1), 5–24. <https://dialnet.unirioja.es/servlet/articulo?codigo=5440050>.
- Dutton, M. A., James, L., Langhorne, A., & Kelley, M. (2015). Coordinated public health initiatives to address violence against women and adolescents. *Journal of Women's Health*, 24(1), 80–85. <https://doi.org/10.1089/jwh.2014.4884>
- Fals Borda, O., & Anisur Rahman, M. (2001). *Acción y Conocimiento Como Romper El Monopolio Con Investigación-Acción Participativa*. CINEP.
- Fandino-Losada, A., Guerrero-Velasco, R., Mena-Munoz, J. H., & Gutierrez-Martinez, M. I. (2017). Efecto del control del crimen organizado sobre la violencia homicida en Cali (Colombia). *Revista CIDOB D'Afers Internacionals*, 116 (116), 159–178. <https://doi.org/10.24241/rcai.2017.116.2.159>
- Farthing, L., & Kohl, B. (2012). Supply-side harm reduction strategies: Bolivia's experiment with social control. *International Journal of Drug Policy*, 23(6), 488–494. <https://doi.org/10.1016/j.drugpo.2012.06.004>
- Ferguson, S., & Kaplan, M. S. (1993). Women and drug policy: Implications of normalization. *Affilia*, 129–144. <https://doi.org/10.1177/088610999400900203>
- Franco, S. A. (2003). Social-medical approach to violence in Colombia. *Latin American Social Medicine*, 93(12), 2032–2036. <https://doi.org/10.2105/ajph.93.12.2032>
- Freire, P. (2000). *Pedagogy of the oppressed*. Continuum International Publishing Group (Original work published 1970).
- Giacomello, C. (2013). Mujeres, delitos de drogas y sistemas penitenciarios en América Latina. Consorcio Internacional sobre políticas de drogas. Retrieved September 1, 2018, from https://www.unodc.org/documents/congress/background-information/NGO/IDPC/IDPC-Briefing-Paper_Women-in-Latin-America_SPANISH.pdf.
- Guerrero, R. (2002). Violence is a health issue (Editorial). *Bulletin of the World Health Organization*, 80(10), 767. <https://apps.who.int/iris/handle/10665/71646Journal>
- Guerrero, R. (2006). Violence prevention through multi-sectoral partnerships: The cases of Cali and Bogota. *Colombia. African Safety Promotion*, 4(2), 88–98. <https://doi.org/10.4314/asp.v4i2.31595>.
- Hawk, K. F., Vaca, F., & D'Onofrio, G. (2015). Reducing fatal opioid overdose: Prevention, treatment and harm reduction strategies. *Yale Journal of Biology & Medicine*, 88, 235–245. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4553643/>
- Hawthorne, S. (2006). Men's patriotic wars against women's intimate lives: Patriarchy, the institution of heterosexuality and patriotism. *African Safety Promotion*, 4(2), 20–32. <https://www.ajol.info/index.php/asp/article/view/31590>
- Heise, L. (1998). Violence against women: An integrated, ecological framework. *Violence Against Women*, 4(3), 262–290. <https://doi.org/10.1177/1077801298004003002>
- Janssen, P. A., Gibson, K., Bowen, R., Spittal, P. M., & Petersen, K. L. (2009). Peer support using a mobile access van promotes safety and harm reduction strategies among sex trade workers in Vancouver's Downtown eastside. *Journal of Urban Health*, 86(5), 804–809. <https://doi.org/10.1007/s11524-009-9376-1>
- Jardine, M., Crofts, N., Monaghan, G., & Morrow, M. (2012). Harm reduction and law enforcement in Vietnam: Influences on street policing. *Harm Reduction Journal*, 9(1), 27. <https://doi.org/10.1186/1477-7517-9-27>
- Kerr, T., Hayashi, K., Fairbairn, N., Kaplanc, K., Suwannawong, P., Zhanga, R., & Wood, E. (2010). Expanding the reach of harm reduction in Thailand: Experiences with a drug user-run drop-in centre. *International Journal of Drug Policy*, 21(3), 255–258. <https://doi.org/10.1016/j.drugpo.2009.08.002>
- Kerr, T., Oleson, M., Tyndall, M. W., Montaner, J., & Wood, E. (2005). A description of a peer-run supervised injection site for injection drug users. *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, 82(2). <https://doi.org/10.1093/jurban/jti050>.
- Krieger, N. (2001). Theories for social epidemiology in the 21st century: An ecosocial perspective. *International Journal of Epidemiology*, 30(4), 668–677. <https://doi.org/10.1093/ije/30.4.668>
- Krieger, N. (2005). Embodiment: A conceptual glossary for epidemiology. *Journal of Epidemiology & Community Health*, 59(5), 350–355. <https://doi.org/10.1136/jech.2004.024562>
- LeGrand, C., Isschot, L., & Riaño-Alcalá, P. (2017). Land, justice, and memory: Challenges for peace in Colombia. *Canadian Journal of Latin American and Caribbean Studies/Revue Canadienne des études Latino-Américaines et Caraïbes*, 42(3), 259–276. <https://doi.org/10.1080/08263663.2017.1378381>
- Londoño Toro, B. (2004). Bogotá: Una ciudad receptora de migrantes y desplazados con graves carencias en materia de recursos y de institucionalidad para garantizarles sus derechos. *Estudios Socio-Jurídicos*, 6(1), Retrieved September 1, 2018, from http://www.scielo.org.co/scielo.php?script=sci_arttext&pid=S0124-05792004000100011.

- Maheer, D., & Thomson, A. (2018). A precarious peace? The threat of paramilitary violence to the peace process in Colombia. *Third World Quarterly*, 39(11), 2142–2172. <https://doi.org/10.1080/01436597.2018.1508992>
- Mohanty, C. T. (2019). The “home” question. In P. R. Grzanka (Ed.), *Intersectionality: Foundations and frontiers* (pp. 413–420). Routledge.
- Montero, M. (2010). Crítica, autocrítica y construcción de teoría en la psicología social latinoamericana [Criticism, self-critique and the construction of a Latin American social psychology]. *Revista Colombiana de Psicología*, 19(2), 177–191. http://www.scielo.org.co/scielo.php?pid=S0121-54692010000200003&script=sci_abstract&lng=es
- Montero, M. (2012). El Concepto de Intervención Social desde una Perspectiva Psicológico-Comunitaria [The concept of social intervention from a community psychology perspective]. *Revista MEC-EDUPAZ*, 54–76. <http://www.journals.unam.mx/index.php/mecedupaz/article/view/30702>.
- Nawyn, S. J., Reosti, A., & Linda Gjokaj, L. (2009). Gender in motion: How gender precipitates international migration. *Advances in Gender Research*, 13, 175–202. <https://www.scopus.com/record/display.uri?eid=2-s2.0-77950744138&origin=inward&txGid=8b9f7a9949b06f944167de8444bee7fd>
- Open Society Foundations. (2018). *Police & harm reduction: How law enforcement can advance public safety, public health, and public confidence*. Retrieved March 20, 2019, from <https://www.opensocietyfoundations.org/sites/default/files/police-harm-reduction-20180720.pdf>.
- Parcesepe, A. M., L’Engle, K. L., Martin, S. L., Green, S., Sinkele, W., Suchindran, C., Speizer, I., Mwarogo, P., & Kingola, N. (2016). The impact of an alcohol harm reduction intervention on interpersonal violence and engagement in sex work among female sex workers in Mombasa, Kenya: Results from a randomized controlled trial. *Drug and Alcohol Dependence*, 161(1), 21–28. <https://doi.org/10.1016/j.drugalcdep.2015.12.037>.
- Phelan, A. (2019). Engaging insurgency: The impact of the 2016 Colombian peace agreement on FARC’s political participation. *Studies in Conflict and Terrorism*, 42(9), 836–852. <https://doi.org/10.1080/1057610X.2018.1432027>
- Potter, C., Laprévot, V., Dubois-Arber, F., Cottencina, O., & Rollanda, B. (2014). Supervised injection services: What has been demonstrated? A systematic literature review. *Drug and Alcohol Dependence*, 145, 48–68. <https://doi.org/10.1016/j.drugalcdep.2014.10.012>
- Rekart, M. L. (2005). Sex-work harm reduction. *The Lancet*, 366(9503), 2123–2134. [https://doi.org/10.1016/S0140-6736\(05\)67732-X](https://doi.org/10.1016/S0140-6736(05)67732-X)
- Ritterbusch, A. (2016). Mobilities at gunpoint: The geographies of (im)mobility of transgender sex workers in Colombia. *Annals of the American Association of Geographers*, 106(2), 422–433. <https://doi.org/10.1080/00045608.2015.1113112>.
- Rossi, D., Touzé, G., Goltzman, P., Cymerman, P., Lasala, G., & Sánchez, A. (2000). Drug use and sex in abstentionist treatment programs. *International Journal of Drug Policy*, 10(6), 427–430. [https://doi.org/10.1016/S0955-3959\(99\)00020-1](https://doi.org/10.1016/S0955-3959(99)00020-1)
- Tsemberis, S. (2011). Housing first: The pathways model to end homelessness for people with mental illness and addiction manual. *European Journal of Homelessness*, 5(2), 235–240.
- United Nations General Assembly. (1948). Universal declaration of human rights. Retrieved May 21, 2019 from <https://www.un.org/en/universal-declaration-human-rights/>.
- Uprimny, R., Martínez, M., Cruz, L., Chaparro, S., & Chaparro, N. (2016). Mujeres, políticas de drogas y encarcelamiento: una guía para la reforma de políticas en Colombia. *Dejusticia*. Retrieved September 3, 2018, from <https://www.dejusticia.org/publication/mujeres-politicas-de-drogas-y-encarcelamiento-una-guia-para-la-reforma-de-politicas-en-colombia/>.
- Watson, T. M., Strike, C., Kolla, G., Penn, R., Jairam, J., Hopkins, S., Lucee, J., Degani, N., Millson, P., & Bayoumi, A. M. (2013). Design considerations for supervised consumption facilities (SCFs): Preferences for facilities where people can inject and smoke drugs. *International Journal of Drug Policy*, 24(2), 156–163. <https://doi.org/10.1016/j.drugpo.2012.09.003>
- Werb, D., Rowell, G., Guyatt, G., Kerr, T., Montaner, J., & Wood, E. (2011). Effect of drug law enforcement on drug market violence: A systematic review. *International Journal of Drug Policy*, 22(2), 87–94. <https://doi.org/10.1016/j.drugpo.2011.02.002>. 2011
- Wilson, D. P., Donald, B., Shattock, A. J., Wilson, D., & Fraser-Hurt, N. (2015). The cost-effectiveness of harm reduction. *International Journal of Drug Policy*, 26, S5–S11. <https://doi.org/10.1016/j.drugpo.2014.11.007>
- Winton, A. (2004). Urban violence: A guide to the literature. *Environment and Urbanization*, 16(2), 165–184. <https://doi.org/10.1630/0956247042309874>
- The World Bank. (2017). Intentional homicides, female (per 100,000 female) – Colombia. <https://data.worldbank.org/indicator/VC.IHR.PSRC.FE.P5?locations=CO>.
- World Health organization [WHO]. (2002). *World report on violence and health: Summary*. Retrieved March 24, 2019, from https://www.who.int/violence_injury_prevention/world_report/en/summary_en.pdf.
- Wright, T. E., Schuett, R., Fombonne, E., Stephenson, J., & Haning, W. F. (2012). Implementation and evaluation of a harm-reduction model for clinical care of substance using pregnant women. *Harm Reduction Journal*, 9(5), 1–10. <https://doi.org/10.1186/1477-7517-9-5>.

- Zamudio-Haas, S., Mahenge, B., Saleem, H., Mbwapbo, J., & Lambdin, B. H. (2016). Generating trust: Programmatic strategies to reach women who inject drugs with harm reduction services in Dar es Salaam, Tanzania. *International Journal of Drug Policy*, 30, 43–51. <https://doi.org/10.1016/j.drugpo.2016.01.012>
- Zea, M. Cecilia, Reisen, C. A., Bianchi, F. T., Gonzales, F. A., Betancourt, F., Aguilar, M., & Poppen, P. J. (2013). Armed conflict, homonegativity and forced internal displacement: implications for HIV among Colombian gay, bisexual and transgender individuals. *Culture, Health & Sexuality*, 15(7), 788–803. <https://doi.org/10.1080/13691058.2013.779028>
- Zierler, S., & Krieger, N. (1997). Reframing women's risk: Social inequalities and HIV infection. *Annual Review of Public Health*, 18(1), 401–436. <https://doi.org/10.1146/annurev.publhealth.18.1.401>