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"He Will Still Know Where I Live": Harm Reduction for Women Who Use Drugs and Experience Gender-Based Violence

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Abstract

Background: Treatment for substance use disorders in Spain has traditionally been abstinence-focused and developed from an androcentric perspective, failing to address the specific needs of women who use drugs. Although abstinence-based models continue to predominate, cities such as Madrid and Barcelona now offer a broader range of services, including harm reduction approaches. The intersection between substance use and gender-based violence remains largely overlooked, especially in research and service provision, thereby reinforcing systemic inequalities and limiting access to appropriate resources. This article explores the intersection between drug use and gender-based violence among women, emphasizing harm reduction as a gender-sensitive approach.

Method: A qualitative study was conducted based on seventeen semi-structured interviews with women who have used or are currently using psychoactive substances in two major Spanish cities. The sample included women of diverse ages, nationalities, socio-economic backgrounds, and substance use profiles. Recruitment was carried out through a combination of strategies, including social media, snowball sampling, and engagement with a harm reduction center. Data were analyzed thematically using NVivo 14 to identify the types of gender-based violence experienced and the strategies employed to confront it.

Results: All participants experienced gender-based violence, including institutional, familial, intimate partner, and sexual violence. Structural violence and stigma further restrict their access to health, social, and legal resources, thereby increasing their vulnerability. Many women used substances as a coping mechanism in response to gender-based violence.

Conclusions: The study highlights the complex intersection between substance use and gender-based violence among women, emphasizing the need for tailored, intersectional harm reduction interventions and strategies to support women in safely and effectively reporting violence.

Keywords: women who use drugs; gender-based violence (GBV); harm reduction; intersectionality.

1. Introduction

Historically, treatment for substance use disorders in Spain has been primarily abstinence-focused, driven by charitable, religious institutions, or framed within a medical-assistance approach (1,2). In the mid-1980s, efforts to develop innovative interventions emerged in response to Spain's most severe drug crisis—centered on intravenous heroin use—which had devastating consequences on morbidity and mortality among people who used drugs (3). From that point onward, a public health-based addiction care model was established, promoting harm reduction programs, including Opioid Antagonist Treatments, needle exchange programs, social and healthcare services for people actively using drugs, and resources to meet basic needs (1,2,4).

However, despite its innovative nature and its break from previous interventions for people who inject drugs, public, social, and healthcare strategies in this field have been developed from an androcentric perspective since their inception. These strategies have focused on the substance, men, and the route of administration, generally being insensitive to the harm derived from the broader context in which drug use occurs (5,6).

Scientific research on women who use drugs has traditionally adopted a medicalized perspective, focusing on issues such as injection drug use, Human Immunodeficiency Virus (HIV) prevalence, overdose, Opioid Antagonist Treatments, and drug use during pregnancy (7–12). However, other lines of research have increasingly drawn attention to additional needs and challenges faced by women who use drugs, including barriers to accessing harm reduction services, the burden of caregiving responsibilities, and the demand for gender-specific resources, such as women-only services (13,14).

Furthermore, there is increasing recognition of the need to improve harm reduction services for women who use drugs by also addressing gender-based violence (GBV), as defined in Article 3 of the Istanbul Convention: *"violence that is directed against a woman because she is a woman or that affects women disproportionately."* (15–19). Women who use drugs are five times more likely to experience violence compared to non-drug-using women (6,20–22). Despite this, addiction research has only minimally addressed this issue, focusing primarily on intimate partner violence (IPV) (23–25) while overlooking other forms of GBV that women—particularly those who use drugs—experience (26–28).

Research has consistently shown that the relationship between substance use and GBV among women is complex, bidirectional, and reciprocal, with each potentially reinforcing the other over time. A substantial body of research indicates that many women initiate or escalate substance use as a coping strategy in the context of trauma, particularly experiences of childhood abuse, IPV, and sexual assault (29–32). Several studies consistently find that women who have experienced interpersonal violence often resort to using drugs as a coping mechanism to manage trauma, particularly post-traumatic stress disorder (PTSD) symptoms. This self-medication pattern has been observed across multiple contexts: survivors of IPV, adult sexual assault victims, and women with histories of childhood abuse (33–38)

Beyond the growing recognition of women who use drugs exposed to IPV, evidence underscores that drug use can be both a consequence and a trigger for various forms of GBV. Stigma, economic dependence, and the erosion of self-protective capacities all contribute to increased vulnerability. While many women use substances to cope with trauma, women who use drugs also develop strategies of resistance and survival—such as seeking shelter, accessing legal assistance, or connecting with community-based services—although these are often fragmented or inaccessible due to overlapping stigmas (18,29,39,40).

Mainstream drug policy continues to neglect women's specific realities, reinforcing structural violence —legitimized by social frameworks—. Women who use drugs often face criminalization and institutional violence rather than support, especially if they are homeless, racialized, sex workers, pregnant, or have children (41). Moreover, their experiences of trauma are frequently medicalized and pathologized, with little attention paid to the structural inequalities that shape their substance use. This context reinforces the need for harm reduction and support services that are not only trauma-

informed and gender-responsive but also grounded in intersectional and feminist approaches (25,42,43).

Currently, in Spain, there is a significant lack of services that address the intersection of drug use and experiences of GBV. Most existing services are not designed to respond to these interrelated realities, even though they mutually reinforce each other in the lives of women who use drugs (42,44,45). When gender, age, ethnicity, race, or sexual identity are also considered, these gaps become even more pronounced. The absence of a gender, intersectional, and interdisciplinary perspective in addressing the specific needs of women in these programs results in low female participation, further hiding women who use drugs and perpetuating structural inequalities (5,46,47).

Nonetheless, a limited number of pioneering initiatives illustrate how more inclusive harm reduction models tailored to the needs of women can be effectively implemented. Initiatives such as *Metzineres* (Barcelona) provide harm reduction services and safe spaces for womxn—cis, trans, and gender-diverse individuals—who experience gender oppression, substance use, and structural violence. Grounded in intersectional feminism, its approach addresses drug use while actively responding to interconnected vulnerabilities such as violence, housing insecurity, and social exclusion. In Madrid, the *Beatriz Galindo shelter* offers specialized support to women experiencing GBV, substance use disorders (including alcohol and other drugs), and severe or persistent mental health conditions. (22,42,48–51).

However, the lack of similar services across other regions of Spain significantly constrains the ability to provide comprehensive and context-sensitive responses to the complex and intersecting needs of women who use drugs, rendering current efforts insufficient at the national level.

Considering the above, we have asked ourselves: a) What types of GBV do women who use drugs face? b) What strategies do women who use drugs use to address GBV? c) How can incorporating GBV care into harm reduction for women who use drugs be beneficial?

2. Method

This research presents a qualitative study based on seventeen semi-structured interviews conducted between January and June 2024 with women who have used any psychoactive substance for at least two years, either currently using or abstinent, in two major Spanish cities

(Madrid and Barcelona). In this study, women who use drugs with diverse characteristics and circumstances were included: ethnicity, nationality, socioeconomic status, age, experiences of violence, and health conditions, which shaped their lived experiences (52).

Participants were recruited through multiple strategies, including the dissemination of an informational poster on social media platforms (LinkedIn, WhatsApp, Instagram, and Telegram), snowball sampling, harm reduction centres (Beatriz Galindo), and through professionals working in treatment services for substance use disorders. This approach facilitated the inclusion of participants with diverse backgrounds and experiences, providing valuable insights into structural forms of violence—such as housing instability—while capturing a broad range of experiences related to psychoactive substance use and GBV, and ensuring diversity in nationality, age, socioeconomic status, and housing conditions.

Prior to the commencement of fieldwork, women were excluded if they presented severe mental health conditions or psychological states that impeded participation, exhibited only sporadic or non-sustained substance use, or lacked sufficient Spanish fluency to engage in an interview. Inclusion criteria for women in treatment for substance use disorders required daily substance use for at least two years before entering treatment. In contrast, for women with active use, daily consumption for at least two years at the time of contact was required. No transgender women participated, as none proactively contacted the research team or were referred during the recruitment period.

Of the 20 women who initially made contact, three were excluded for not meeting the inclusion criteria. The remaining seventeen women participated in the study; fifteen interviews were conducted in person at locations chosen by the participants—mostly cafés or bars—while two were conducted online. All interviews were conducted individually. The interview guide began with general questions to build rapport, gradually progressing to more specific topics. Interviews lasted approximately one hour and were audio-recorded and transcribed. One interview was repeated to clarify certain points that had not been fully addressed in the first. During and immediately after the interviews, field notes were taken to capture additional observations and contextual information, including emotional expressions such as crying. Data collection continued until data saturation was reached, meaning that no new themes or information emerged from subsequent interviews. Transcripts were not returned to participants for comment or correction; however, participants will be provided with full study findings. Although a detailed coding tree

is not included in this manuscript, all themes and codes were systematically organized using NVivo 14.

2.1. Sample

Seventeen women participated, aged 21 to 55 years (*mean* = 38, *SD* = 11.28). Thirteen participants were from Spain, while four were migrants from Sweden, Morocco, Colombia, and Argentina. Participants reported diverse experiences of intimate partner, family, sexual, and institutional violence, often overlapping.

Psychoactive substance use histories were heterogeneous, including long-term use of cannabis, alcohol, benzodiazepines, opioids, and cocaine, with most engaging in polydrug use. Four participants had used psychoactive substances: three were in treatment for substance use disorder, and one had ceased use through self-initiated cessation.

Participants' life circumstances varied: eight were employed, three were students, three received a non-contributory pension, and one was on sick leave; monthly income ranged from €500 to €2,000. Education levels included vocational training (n = 6), university studies (n = 6), high school (n = 4), and primary education only (n = 1). Thirteen participants were single, two were married, and two were divorced, and nearly half (n = 8) were mothers. Housing conditions ranged from stable accommodation to sheltered or precarious housing.

2.2. Data Analysis

Once the women were contacted, they were asked screening questions: the principal psychoactive substance they used and its frequency, or the principal psychoactive substance for which they were currently receiving treatment for substance use disorder.

The interview guide had two dimensions: (1) psychoactive substance use and (2) experiences of GBV — family, partner or ex-partner, and institutional. All interviews were recorded, transcribed verbatim, and anonymized by removing all identifying information. The transcripts were analysed using thematic analysis (53) to identify patterns and capture participants' experiences. The coding team consisted of three researchers with relevant expertise: Researcher A, an anthropologist specializing in gender and drug use with extensive experience in this field; Researcher B, a social and cultural anthropologist with expertise in gender, drug use, and social exclusion; and Researcher C—the interviewer—a PhD candidate focusing on women, psychoactive

substances, and violence, with practical experience in social research and interventions. While some codes were agreed upon from the outset, others led to discrepancies, which were resolved collaboratively until consensus was reached. This approach ensured that diverse perspectives were systematically considered, and investigator triangulation minimized individual bias and enhanced reliability. NVivo 14 software was used to support consistency and coordination in coding.

The research was conducted in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ) to ensure rigor and validity. Attention was given to sample selection, using purposive sampling to include diverse perspectives and achieve data saturation. Before data collection, the interviewer's characteristics, such as potential biases, assumptions, and specific interests in the research topic, were acknowledged to ensure transparency and reflexivity. To enhance credibility, representative quotes from participants have been included (54).

2.3. Ethical Considerations

Approved by the Ethics Committee of Comillas Pontifical University, all participants provided informed consent to take part in the research and to have their interviews recorded after being fully briefed on the study and its confidentiality commitments. Their participation was formally documented through the signing of an informed consent form. Confidentiality and anonymity were strictly maintained throughout the process. As a token of appreciation, participants received a small gift for their involvement in the research.

3. Results

The results of this study address GBV faced by women who use drugs. First, institutional violence by public resources and services is discussed. Secondly, the experiences of family and partner violence are presented, where women describe situations of physical, psychological, and sexual abuse. Finally, the impact and coping strategies developed by the interviewed women in response to the GBV are outlined.

3.1. Institutional and structural violence

Women who use drugs face significant barriers to accessing basic services such as healthcare and social protection—both legal and police protection. These barriers are not incidental; they are deeply

embedded in institutional dynamics that reproduce patterns of exclusion. As a result, these dynamics lead to the invisibility of their own needs and the concealment of drug use, significantly limiting social support.

In the legal realm, institutional violence is evident in the way women are treated when reporting the GBV they have experienced, both at the time of filing a report and throughout the judicial process. Many women report experiencing mistrust from authorities.

> *"I felt like they were downplaying it, that they minimized it a lot, especially at the courthouse"* (37-year-old woman who uses cannabis)

Facing the constant doubt about the truthfulness of their accounts, *"the judge, when they talk to you, interrogates you as if you were lying"* (27-year-old woman who uses benzodiazepines), invalidating their testimonies due to drug use: *"They don't take us seriously [...] they think you're making it up, saying you're high, or something like that [...] They believe everything is because of the drugs"* (44-year-old woman who uses cocaine).

Law enforcement agencies, such as the police, may, at times, inadvertently contribute to the perpetuation of violence through insufficient attention, perceived indifference, or inappropriate treatment, as reported by several participants. Such responses may be influenced by the perceived nonconformity of women who use drugs with traditional gender roles, potentially leading to inadequate or inappropriate actions.

> *"The police are not a resource in any way. They laugh at you after they've beaten you up, they laugh, they treat you like shit"* (54-year-old woman who uses cocaine)

This type of behavior generates feelings of frustration and undervaluation in women due to the lack of support and protection from the authorities

> *"It's a strange feeling of helplessness"* (37-year-old woman who used cannabis).

This revictimization and lack of protection within the judicial system constitute the second level of violence that women survivors must face. These dynamics perpetuate power structures in which women's

testimonies are distrusted and their credibility questioned throughout the process (55).

In some cases, measures such as restraining orders were insufficient and had the opposite effect of what was intended, generating feelings of insecurity in the women.

> *"Although I had a restraining order [against him] [...] he was always at my house, he was in the neighborhood [...] I went months without being able to relax on the terrace"* (37-year-old woman who uses cannabis).

Another form of institutional violence documented in the testimonies occurs within social and healthcare services. Women's right to care is often restricted and diminished, leading to the deprivation of essential resources. This issue is particularly evident during maternity, where treatment for substance use disorders facilities and healthcare services frequently adopt medicalized, depersonalized, and coercive approaches. One testimony illustrates this dynamic, describing how a pregnant woman sought to discontinue Opioid Agonist Treatment, yet her wishes were disregarded by healthcare staff at the Addiction Care Centre.

> *“I had a big problem at an Addiction Care Center. I told him [referring to the doctor], I said, look, I want to get pregnant and I don’t want to medicate during pregnancy [referring to the opioid substitution treatment] [...] the nurse told me no, that I was like a diabetic and that I would have to medicate for life [...] and that I should start with methadone, I said, look, I’ve never taken methadone in my life, it’s super addictive, I’m going to get pregnant while taking methadone, and she said: maybe the baby will be born with a little withdrawal syndrome, but that passes. I said, but, I mean, is that true? And of course, I had a huge argument with her [...] I started arguing with her. Tears came to my eyes. Suddenly, it was like everything fell to the ground."* (38-year-old woman who used heroin)

These dynamics not only ignore the decisions made by women but also perpetuate a form of institutional violence by downplaying the complex issues they face.

> *"They didn’t take me seriously, because of course, since they knew I used, they did whatever they wanted with me"* (54-year-old woman who used alcohol and cocaine)

and reinforce social exclusion,

> *"Social services, for example, don't take you seriously, they don't help you because you use drugs, they don't help you with anything"* (44 years old, woman who uses cocaine).

Furthermore, services tend to oscillate between exaggerating or downplaying the needs of women who use drugs without giving an appropriate assessment of the severity of their situations and without considering the intersections between trauma, health, and substance use, key factors that affect the health and well-being of women (52).

> *"I've been to the CAID [Addiction Care Centers], and I didn't like the care because it seemed like they minimized my problem"* (29-year-old woman who used alcohol and cocaine).

Some of the women interviewed found support and protection through specific programs for survivors of violence, highlighting the diversity of profiles and needs that can be met by the services available. However, the judicial system's responses do not reach all women who use drugs and have experienced violence, as evidenced by the experiences shared by the participants in this research.

> *"I entered an anti-violence program [Comprehensive Monitoring System for Gender-Based Violence Cases – VioGén System]. They issued a restraining order […] and, well, I am grateful."* (54-year-old woman who uses cannabis)

3.2. Family violence and intimate partner violence

According to the Council of Europe (56), there is a relationship between experienced violence and the use of psychoactive substances, particularly among women. However, this link is not deterministic and should not be viewed in isolation, as social factors such as environment, support, and socioeconomic conditions intersect with these two dynamics. The narratives collected reveal various experiences of family violence, particularly perpetrated by fathers, and IPV, which serve as common threads in the life stories of the women interviewed.

> *"When we were kids, he always lost control […] I often went to school wearing makeup to hide it […] He is an abuser"* (46-year-old woman who uses cannabis)

> *"I was married for 14 years, and the abuse began almost from the very first moment [...] It was all terrible, I have never been more afraid in my life"* (55-year-old woman who uses cannabis)

These forms of violence manifest in various forms, ranging from psychological abuse to physical aggression.

> *"The guy was a man, a violent person, very possessive, very controlling, and violent both verbally and physically"* (41-year-old woman who used alcohol).

The testimonies of the interviewed women reflect the violence they have survived. In many cases, violence begins in childhood, when the father figure exerts some form of abuse—whether physical or psychological. These early experiences shaped women's socialization, fostering feelings of fear and shame. The accounts highlight how women who have survived violence face additional forms of violence that exacerbate their situation. Many of them experience continuous cycles of abuse, both within their family unit and in their romantic relationships.

> *"It's just that all the relationships have been bad, they've all treated me badly [...] I thought it wasn't, but what they tell you about daddy issues and all that because it all connects, everything"* (27-year-old woman who uses benzodiazepines).

3.3. Sexual violence

Another form of violence that emerged in the women's testimonies was sexual violence. This type of violence was reported at multiple stages of life—from childhood through adolescence, adulthood, and into older age—significantly impacting the personal and sexual development of many participants.

> *"I suffered abuse in childhood, when I was about 5 or 6 years old [...] child sexual abuse*" (38-year-old woman who used heroin)

> *"I went through many years of sexual abuse when I was little. When I was pre-adolescent, and the last one was when I was already a teenager*" (46-year-old woman who uses cannabis).

This type of violence occurred in various contexts, including the family sphere, relationships with partners or ex-partners, as well as with acquaintances and strangers.

Partner or ex-partner violence.

> *"Before the girl I was with, I was with another one who did force me sexually"* (37-year-old woman who uses benzodiazepines).

> *"It started by isolating me from people [...] and well, it ended up isolating me from everyone. Every time I talked to someone or went out with someone, he would go crazy, start crying [...] there was a strong emotional blackmail, and it even got to sexual and physical abuse"* (27-year-old woman who uses alcohol)

Acquaintance violence.

> *"My trainer sexually abused me"* (21-year-old woman who uses cannabis)

Known non-partner male violence.

> *"He made me enter his room, I lay down, and about an hour later, he was already in the room and forced me to have sex with him"* (54-year-old woman who used alcohol and cocaine)

> *"This man [the landlord] approached me and abused me. He touched me inappropriately"* (29-year-old woman who uses cannabis)

Stranger-perpetrated violence.

> *"A guy who abused me forced his penis into me without my consent"* (29-year-old woman who used alcohol and cocaine).

The various accounts collected in this research illustrate the complexity of GBV experienced by women who use drugs. This violence intersects throughout their lives, takes multiple forms, and profoundly shapes their social and familial relationships. Addressing such violence requires a sensitive harm reduction approach when implementing support measures.

3.4. Women's strategies in risk and harm reduction related to violence

3.4.1. The Use of Psychoactive Substances as a Coping Mechanism for Violence

Violence and drug use are interconnected experiences in the lives of women who use drugs. The strategies they employ to confront violence

vary. When violence precedes the use of psychoactive substances, drug use becomes a coping strategy. However, in other cases among the interviewees, drug dependence precedes violence, making it more difficult for women to confront, which leads to cycles of both violence and drug use. The women's narratives explicitly reveal that drug use served as a means of escape.

> *"I always wanted to use a lot, but that was because I wanted to escape from everything that was happening with him [...] when he abused me, I would go buy drugs and use them to escape, to block out reality [...] It's connected because when someone is violent towards you, your way of escaping, your way of softening things, is through drug use."* (54-year-old woman who used alcohol and cocaine).

Some women increased their substance use as a way to cope with the violence.

> *"I increased my alcohol and speed [amphetamine] use to avoid the situation I was experiencing"* (41-year-old woman who used alcohol).

Other women used psychoactive substances to hide situations that caused distress, as stated by a 46-year-old woman who uses cannabis:

> *"Trying to find something that calms me down [...] is probably what made me smoke, to hide many things."*

Confronting violence led some women to modify their patterns of psychoactive substance use, turning to substances other than their usual ones. For example, a 23-year-old woman whose primary substance was cannabis reported using alcohol to cope with episodes of violence. In this case, the context of violence influenced her choice of substance, as her goal was to escape, and alcohol served that purpose.

> *"At home, I would get drunk alone; it was my way of letting it all out [...] I feel like it takes me away from reality."*

In this context, harm reduction emerges as a crucial approach to addressing substance use among women who have experienced violence. This approach recognizes that, although substance use can have negative consequences, it also plays an important role for those women who adopt it as a strategy to cope with violence (57).

3.4.2. Individual Mechanisms for Coping with Violence

Other ways in which the interviewed women confronted violence included personal mechanisms such as minimizing the violence, where women downplayed the situation to continue their lives without letting it condition essential aspects, as reflected in this narrative:

> *"I didn't feel like I was justifying him at all, but I did take a lot of weight off it [...] I didn't give it more importance because I wasn't going to let that shit haunt me for the rest of my fucking life."* (21-year-old woman who used cannabis).

In addition to minimizing violence, forgetting, memory blocking, and dissociation were defence mechanisms against traumatic situations. Although these might seem like protective strategies at the moment, they can lead to long-term psychological issues such as anxiety, depression, or difficulties in interpersonal relationships (58). Firstly, narratives reveal mental blocking, where this strategy acts as a form of protection.

> *"Your mind just blocks it out, like [...] That mechanism my brain has learned to do without me even wanting it to"* (44-year-old woman who used cocaine).

Secondly, dissociation, a consequence of trauma, occurs when a woman disconnects from reality or her emotions, as if the experiences were not part of her. This allows her to endure the emotional pain caused by the traumatic situation.

> *"I have it completely dissociated [...] one of the effects of abuse is dissociation"* (38-year-old woman who used heroin).

Thirdly, selective forgetting, where memories of traumatic experiences are erased as a form of self-protection.

> *"These are things I erase, and I don't want to remember, but there are many things I've erased because my mind just deletes them"* (27-year-old woman who uses benzodiazepines).

Lastly, memory fragmentation occurs when the traumatic situation appears in a partial or disordered manner.

> *"I've tried to remember many times, but I just can't, and I only recover the memory when I'm getting out of the car [after the sexual assault]"* (21-year-old woman who used cannabis).

The narratives of these women demonstrate how self-protection becomes an adaptive response to experiences of violence. A constant state of hypervigilance is reflected, with permanent alertness acting as a defence mechanism to avoid situations that could lead to

revictimization and protect them from additional risks and harms, as observed in this narrative.

> *"I am not capable of having a casual [sexual] encounter with someone [...] I have no sexual freedom [...] I've always been alert"* (29-year-old woman who used cannabis*).*

Other forms of self-protection arise from fear of possible negative consequences for their physical and emotional integrity.

> "*He will still know where I live, so I'll have to move*" (37-year-old woman who used cannabis).

The analyses of the interviews showed that women who use drugs experience various situations of violence, some of which are additional to the violence faced by women in the general population, and they develop strategies to combat them. These coping mechanisms limit their freedom, primarily due to fear and mistrust. Thus, self-protection becomes a means of survival aimed at avoiding revictimization, which can lead to isolation and difficulties in personal, relational, and social autonomy.

3.4.3. Formal Mechanisms for Confronting Violence: Reporting

Reporting serves as a formal mechanism to address various instances of GBV; however, the experiences of the interviewed women reveal that this process does not guarantee a reduction in personal or social risk. The limitations of the Spanish judicial system —such as how these crimes are adjudicated (59) and the available protection measures for victims (60) —combined with long waiting periods, lack of adequate protection after filing a report, and even fear of legal repercussions— make reporting neither accessible nor safe for women (61,62).

Women interviewed who were survivors of violence decided not to report as a form of self-protection against the unknown—wanting to avoid revictimization—and due to the potential negative consequences of the judicial process.

> *"Because for me, it was like a friend had stolen from me"* (21-year-old woman who uses cannabis)

Or they did not consider reporting a viable option.

> *"I had no examples around me, no role models for that kind of thing. No, I didn't see it as a possibility"* (38 years old, woman who used heroin)

This decision serves to minimize further harm in a context where the legal system can be revictimizing and burdensome. Therefore,

choosing not to report may be seen as a strategy to protect their physical and emotional well-being, avoiding a process perceived as both hostile and ineffective.

> *"It would probably have been much more unpleasant for me than the results that [reporting] could have had... If I reported it, it would be his word against mine"* (29-year-old woman who uses cannabis)

Fear, one of the most frequently mentioned emotions, becomes an emotional barrier to reporting. It is an instinctive response to danger that paralyzes action.

> *"I know I didn't do it because of fear... fear takes over me"* (41-year-old woman who uses alcohol)

Far from being irrational, this fear can be seen as a self-protection strategy, both against the aggressor and a system that often fails to provide guarantees to women who report violence.

> *"It would be a difficult process for me at this moment, and it would be a heavy burden"* (27-year-old woman who uses alcohol)

Additionally, when a woman who uses drugs decides to file a report, she often faces a lack of credibility regarding her testimony, particularly if there are no physical injuries. The reference to drug use further exacerbates her vulnerability and makes access to justice more difficult.

> *"You file a report at the police station, and they ignore you. Like, they don't care because I'm a junkie, so they don't treat you the same."* (44-year-old woman who uses cocaine)

The women's accounts show that formal mechanisms—such as filing a report—are not perceived as viable options. Reporting is not viewed by women who use drugs as a positive step in confronting the violence they have survived, and the fear of both legal and personal consequences paralyzes them. Moreover, when women do decide to report, their drug use is frequently used to discredit their testimonies, undermining their credibility. This institutional distrust further increases their vulnerability and limits women who use drugs' access to justice and to a gender sensitive treatment service.

4. Discussion

The findings of this research highlight the multiple forms of GBV experienced by women who use drugs, as well as the coping strategies they adopt to confront such violence. These results underscore the

importance of integrating GBV considerations into harm reduction interventions to provide more comprehensive and context-sensitive care for women who use drugs.

International research highlights how women who use drugs experience multiple, intersecting forms of violence—ranging from childhood trauma, such as maltreatment, sexual abuse, family violence, and institutional abuse, to structural and social violence—that accumulate over the life course and exacerbate their vulnerability, as reflected in the findings of this study. These overlapping experiences contribute to complex health inequalities —such as risks of infectious diseases— mental health disorders —such as PTSD, depression, and anxiety—emotional well-being, and socioeconomic stability (20,23,42,52,56,63–67).

In this study, this accumulation was evident: participants with long histories of substance use often reported lifelong exposure to violence, both within families and intimate partnerships, while others described sexual and institutional violence, highlighting the diversity and complexity of violence experienced by women who use drugs. These patterns mirror findings from prior European and Spanish studies, which have documented that women who use drugs experience multiple forms of violence, ranging from psychological and physical to sexual abuse, across both childhood and adulthood (17,18,68). This evidence reinforces the need for harm reduction strategies to adopt a comprehensive approach to GBV—one that accounts for all forms of violence, not just IPV—and recognizes the intersecting and cumulative effects of the multiple forms of violence faced by women who use drugs, to minimize all associated risks and harms (17,69).

According to the findings of this research, the violence experienced by women who use drugs throughout their lives is not only pervasive but also shapes the coping strategies they adopt in response. Among these, participants described the use of psychoactive substances as a means of both managing and enduring the consequences of such violence, as a mechanism for regulating emotional distress, and as a strategy of escape. These findings align with existing literature, highlighting those women exposed to interpersonal violence often experience urgent needs that necessitate timely harm reduction interventions (33,35–37).

Although coping mechanisms differ, reporting incidents of violence—an essential component in addressing GBV and ensuring the protection of women who use drugs—is often not an option they pursue. The experiences of the interviewed women reveal that formal

reporting frequently fails to reduce either personal risks or social harms. Factors such as fear of legal repercussions, potential revictimization, and the burdens of judicial procedures, alongside institutional distrust and the stigmatization of drug use, discourage women who use drugs from reporting. These findings align with broader evidence suggesting that fear is a primary barrier to reporting IPV, but they further highlight that for women who use drugs, additional structural and social vulnerabilities exacerbate this reluctance (70).

This research confirms that GBV is prevalent among all interviewed women. Therefore, the recommendations outlined in the Spanish national guide for a comprehensive approach to GBV and substance use in women (51) should be considered. Within the country's gender-based violence response system, when a woman actively uses substances, she is typically required to attend a treatment for substance use disorders (71). Drug use is perceived as a disruptive factor in intervention processes and is treated as a barrier to effective care. This abstinence-focused approach disregards women’s right to self-determination and often results in the denial of access to comprehensive services. As a result, the current system fails to address the intersecting realities of substance use and violence. It is therefore essential that harm reduction services explicitly integrate GBV support and that coordinated interventions between GBV services and drug services become standard practice.

To develop innovative harm reduction models that prioritize individuals and address structural inequalities rather than solely focusing on substance use, interventions should adopt a comprehensive, multidisciplinary, trauma-informed, and feminist approach (57,72,73). The lack of adequate services—including sexual and reproductive health care, childcare support, consideration of cultural and language barriers, and tailored support for incarcerated women or sex workers—reinforces the inequalities these women face. However, suppose women who use drugs support services incorporate a gender perspective, a multidisciplinary approach, trauma-informed, and intersectionality. In that case, they will acknowledge that women's life experiences and needs are diverse and shaped by their social, economic, and cultural contexts (43,74,75).

In practical terms, the Women and Harm Reduction International Network report (76) confirms that most harm reduction programs worldwide still fail to implement gender-transformative models, despite the availability of tools and frameworks to guide such

approaches. Although such initiatives remain limited in number, innovative interventions demonstrate a positive shift by integrating harm reduction and GBV support services, thereby challenging traditional models. For instance, *SisterSpace* in Vancouver (Canada), the world's first overdose prevention site exclusively for women, showed that peer support workers increased engagement, participation, and safety (77). In Tehran (Iran), the NGO Khaneh Khorshid supports underprivileged women facing drug use, homelessness, and family violence, with internal monitoring indicating improved service engagement, though formal evaluations are lacking (78).

In Europe, gender-responsive services such as *MANAS-GAT* (Lisbon, Portugal) and the *Beatriz Galindo Shelter* (Madrid, Spain) address the intersection of substance use, gender-based violence, and social exclusion. The Beatriz Galindo Shelter operates as an active resource implementing multiple support and harm reduction initiatives with a gender perspective, as outlined in its operational plans (79). However, formal evaluations of the effectiveness of these programs have not yet been published.

By contrast, *Metzineres* (Barcelona, Spain) has been documented as an innovative, gender-responsive harm reduction initiative that provides a safe environment fostering solidarity, personalised care, and empowerment, while also engaging in advocacy—such as the Barcelona Declaration—to address structural inequalities. Existing publications (42) describe its functioning and the perceived benefits for participants, yet formal scientific assessments are still lacking. Although these services can be transformative for participants, broader policy and societal changes are needed to ensure equitable access and fulfil states' human rights obligations for women who use drugs (48–50,80).

The use of psychoactive substances among women cannot be conceptualized as a homogeneous experience, as it is shaped by intersecting factors that affect both vulnerability and barriers to accessing support and care. The findings of this study indicate that, although GBV is widespread among women who use drugs, experiences vary according to substance type, life stage, social context, and intersecting factors such as ethnicity, socioeconomic status, migration status, age, and social support. This variability underscores the need for harm reduction interventions to be carefully tailored to each woman's unique circumstances (29,81,82).

4.1. Limitations

The sample was primarily drawn from two large urban areas, which may limit the representation of other contexts, particularly rural and mid-sized settings. Women living in smaller or rural communities may experience distinct forms of stigma related to psychoactive substance use and gender-based violence, which warrants further investigation. The absence of transgender women who use drugs further underscores the need for future studies to incorporate gender identity and sexual orientation better to fully understand these women's experiences and coping strategies, particularly considering that they often develop mechanisms to manage violence within care systems that do not adequately address their specific needs.

Although this study included women with varied substance use patterns and profiles, future research should aim to achieve saturation across key analytical categories and examine additional intersectional axes of inequality. Longitudinal and mixed-method approaches are crucial to capture the evolution of these experiences, the role of substance use as a coping strategy on women's health trajectories, and the integration of harm reduction perspectives into judicial and social interventions to more effectively support and protect women who report violence.

5. Conclusions

This study highlights the multiple forms of GBV experienced by women who use drugs and the coping strategies they employ to confront such violence. The findings emphasize the importance of integrating GBV considerations into harm reduction interventions and adopting feminist and intersectional approaches in policymaking, as well as providing safe, specialized, and multidisciplinary services that respond to the diverse needs of this population. Moreover, the lack of confidence in the judicial system underscores a critical gap that calls for the development of rights-based interventions to address barriers related to credibility, fear of institutional repercussions, and stigma among women who use drugs (42,47,52,83,84).

Abbreviations

GBV: Gender-Based Violence

IPV: Intimate Partner Violence

PTSD: Post-Traumatic Stress Disorder

6. Declarations

Ethics approval and consent to participate

The study was approved by the Ethics Committee of Comillas Pontifical University (Opinion 39/22-23; April 25th, 2023).

All participants provided written informed consent.

Consent for publication

Not applicable.

Availability of data and materials

The data are available from the corresponding author upon reasonable request.

Competing interests

The authors declare that they have no competing interests.

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Authors' contributions

AR designed the study and analyzed the data. CM and NR supervised the data and triangulated the analyzed information. All authors reviewed the manuscript and approved the final version.

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7. References

1. Colom J. Análisis de las intervenciones en drogodependencias en España desde sus orígenes hasta la reducción de daños. In: Igia G, editor. Gestionando las drogas Conferencia de consenso sobre reducción de daños relacionados con las drogas: cooperación e interdisciplinaridad. Barcelona; 2001. p. 49–59.

2. Del Río M. Reducción de daños, situación actual y perspectivas de futuro. In: Igia Grup, editor. Gestionando las drogas: Conferencia de consenso sobre reducción de daños relacionados con las drogas: cooperación e interdisciplinaridad. Barcelona; 2001. p. 35–43.

3. Gamella J. Mareas y tormentas: ciclos de policonsumo de drogas en España (1959-1998). Algunas consecuencias estratégicas para el diseño de políticas públicas. *Cuadernos de Psiquiatría Comunitaria.* 2001;1(1):7–18.

4. Rodríguez Aranda E, Altell G, Porredon A, García E. Reducción de daños en el siglo XXI. Madrid; 2023.

5. Karen Mamo. Wo (men) without the 'wo', Women's (in) visibility in addiction studies and drug policy:1–16.

6. United Nations. World Drug Report 2018. United Nations Office on Drugs and Crime; 2018. https://www.unodc.org/wdr2018/. Accessed 20 Jan 2025.

7. Shannon K, Bright V, Allinott S, Alexson D, Gibson K, Tyndall MW. Community-based HIV prevention research among substance-using women in survival sex work: The Maka Project Partnership. *Harm Reduct J.* 2007;4:1–6. doi: 10.1186/1477-7517-4-20

8. Gonzalez-Nieto P, Salimian A, Arredondo J, Angulo L, García de Loera A, Slim S, et al. Intersections between syndemic conditions and stages along the continuum of overdose risk among women who inject drugs in Mexicali, Mexico. *Harm Reduct J.* 2023;20(1):1–11. doi: https://doi.org/10.1186/s12954-023-00815-9

9. Wright TE, Schuetter R, Fombonne E, Stephenson J, Haning WF. Implementation and evaluation of a harm-reduction model for clinical care of substance using pregnant women. *Harm Reduct J.* 2012;9:1–10. doi: 10.1186/1477-7517-9-5

10. Bardwell G, Austin T, Maher L, Boyd J. Hoots and harm reduction: a qualitative study identifying gaps in overdose prevention among women who smoke drugs. *Harm Reduct J.*

2021;18(1):1–10. doi: https://doi.org/10.1186/s12954-021-00479-3

11. Ly S, Shannon K, Braschel M, Zhou H, Krüsi A, Deering K. Prevalence, correlates, and quality-of-life outcomes of major or persistent pain among women living with HIV in Metro Vancouver, Canada. *Harm Reduct J.* 2024;21(1):1–12. Available from: https://doi.org/10.1186/s12954-023-00859-x

12. Khuat OTH, Morrow M, Nguyen TNN, Armstrong G. Social context, diversity and risk among women who inject drugs in Vietnam: Descriptive findings from a cross-sectional survey. *Harm Reduct J.* 2015;12(1):1–6. doi: http://dx.doi.org/10.1186/s12954-015-0067-9

13. Beaugard CA, Khudairi F, Yesufu O, Farina A, Laks J. "I don't think of it as a shelter. I say I'm going home": a qualitative evaluation of a low-threshold shelter for women who use drugs. *Harm Reduct J.* 2024;21(1):1–11. doi: https://doi.org/10.1186/s12954-024-00930-1

14. Coppel A, Perrin S. Women, gender and drugs: between research and action. *Harm Reduct J.* 2024;21(1). doi:10.1186/s12954-024-01106-7

15. Elms N, Link K, Newman A, Brogly SB. Need for women-centered treatment for substance use disorders: Results from focus group discussions. *Harm Reduct J.* 2018;15(1):1–8. doi: 10.1186/s12954-018-0247-5

16. Austin T, Lavalley J, Parusel S, Collins AB, Olding M, Boyd J. Women who use drugs: engagement in practices of harm reduction care. *Harm Reduct J.* 2023;20(1):1–12. doi: https://doi.org/10.1186/s12954-023-00775-0

17. Folch C, Casabona J, Majó X, Meroño M, González V, Colom J, et al. Women who inject drugs and violence: Need for an integrated response Mujeres que usan drogas inyectadas y violencia: Necesidad de una respuesta integrada. *Adicciones*. 2021; 33(4):299-306. doi: 10.20882/adicciones.1322

18. Valencia J, Alvaro-Meca A, Troya J, Gutiérrez J, Ramón C, Rodríguez A, et al. Gender-based vulnerability in women who inject drugs in a harm reduction setting. *PLoS One*. 2020;15(3). doi: 10.1371/journal.pone.0230886

19. World Health Organization. Violence against women prevalence estimates, 2018: global, regional and national prevalence estimates for intimate partner violence against women and

global and regional prevalence estimates for non-partner sexual violence against women. 2021. https://www.who.int/publications/i/item/9789240022256. Accessed 4 Feb 2025

20. Logan TK, Cole J, Leukefeld C. Women, sex, and HIV: Social and contextual factors, meta-analysis of published interventions, and implications for practice and research. *Psychol Bull*. 2002;128(6):851–85. doi: 10.1037/0033-2909.128.6.851

21. Choo, E. K., Benz, M., Rybarczyk, M., Broderick, K., Linden, J., Boudreaux, E. D., & Ranney MLT. The Intersecting Roles of Violence, Gender, and Substance Use in the Emergency Department: A Research Agenda. *Physiol Behav.* 2016;176(1):139–48. doi: 10.1111/acem.12525

22. Plaza-Hernández L, Hansen RG, Bedoya CE, Ferrer PX, Ramos RJ. Gender-Based Violence among Women who Use Drugs: A Quantitative and Qualitative Study in 6 EU Countries. *Addictology.* 2023;23(2):107–21. doi: /10.35198/01-2023-001-0004

23. Mason R, O'Rinn SE. Co-occurring intimate partner violence, mental health, and substance use problems: A scoping review. *Glob Health Action*. 2014;7(1). doi: 10.3402/gha.v7.24815

24. 24. Cafferky BM, Mendez M, Anderson JR, Stith SM. Substance use and intimate partner violence: A meta-analytic review. *Psychol Violence*. 2018;8(1):110–31. doi: 10.1037/vio0000074

25. Romo-Avilés N, Tarriño-Concejero L, Pavón-Benítez L, Marín-Torres J. Addressing Gender-Based Violence in Drug Addiction Treatment: a Systematic Mapping Review. *Int J Ment Health Addict*. 2023; doi: 10.1007/s11469-023-01072-4

26. Council of Europe. Convention on preventing and combating violence against women and domestic violence. Istanbul; 2011. https://www.coe.int/en/web/gender-matters/council-of-europe-convention-on-preventing-and-combating-violence-against-women-and-domestic-violence. Accessed 1 Mar 2025.

27. United Nations. Convention on the Elimination of All Forms of Discrimination against Women. New York: United Nations; 1979. https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-elimination-all-forms-discrimination-against-women. Accessed 1 Mar 2025.

28. Davide Barbieri, Antonio García Cazorla, Blandine Mollard, Julia Ochmann, Vytautas Peciukonis, Jolanta Reingardė, et al. Gender

Equality Index 2021 Health Lithuania;2021. https://op.europa.eu/et/publication-detail/-/publication/c747d746-564c-11ec-91ac-01aa75ed71a1/language-en. Accessed 1 Mar 2025.

29. Kitson C & O'Byrne P. The Experience of Violence Against Women Who Use Injection Drugs: An Exploratory Qualitative Study. *Canadian Journal of Nursing Research*. 2021 Dec 1;53(4):340–52.

30. Soccol KLS, Terra MG, Silveira A da, Tisott ZL, Ferreira CL de L, Dutra PC da C, et al. Vivências de violência no quotidiano de mulheres consumidoras de drogas. *Rev. Enf. Ref*. 2025.6(1):1-7. https://revistas.rcaap.pt/referencia/article/view/28688

31. Zhong S, Yu R, Fazel S. Drug Use Disorders and Violence: Associations With Individual Drug Categories. *Epidemiol Rev*. 2020;42(1):103-116. doi:10.1093/epirev/mxaa006

32. Logan T, Walker R, Cole J, Leukefeld C. Victimization and Substance Abuse among Women: Contributing Factors, Interventions, and Implications. *Review of General Psychology*. 2002;6(4):325–97. doi:https://doi.org/10.1037/1089-2680.6.4.325

33. Ogden SN, Dichter ME, Bazzi AR. Intimate partner violence as a predictor of substance use outcomes among women: A systematic review. *Addict Behav*. 2022;127:107214. doi:10.1016/j.addbeh.2021.107214

34. Goodrum NM, Bernard DL, Moreland AD. Interpersonal Violence, PTSD, and Substance Use Types among Women Receiving Substance Use Treatment. *J Dual Diagn*. 2022;18(3):123-134. doi:10.1080/15504263.2022.2090649

35. Flanagan JC, Jaquier V, Overstreet N, Swan SC, Sullivan TP. The mediating role of avoidance coping between intimate partner violence (IPV) victimization, mental health, and substance abuse among women experiencing bidirectional IPV. *Psychiatry Res*. 2014;220(1-2):391-396. doi:10.1016/j.psychres.2014.07.065

36. Ullman SE, Relyea M, Peter-Hagene L, Vasquez AL. Trauma histories, substance use coping, PTSD, and problem substance use among sexual assault victims. *Addict Behav*. 2013;38(6):2219-2223. doi:10.1016/j.addbeh.2013.01.027

37. Gezinski LB, Gonzalez-Pons KM, Rogers MM. Substance Use as a Coping Mechanism for Survivors of Intimate Partner Violence: Implications for Safety and Service Accessibility. *Violence*

Against Women. 2021;27(2):108-123. doi:10.1177/1077801219882496.

38. Montanari M. Women, Drugs, Prison. Profile and pathways of women incarcerated in Italy and Portugal. [Lisboa]: Universidade de Lisboa; 2025.

39. Tirado-Muñoz J, Gilchrist G, Lligoña E, Gilbert L, Torrens M. A group intervention to reduce intimate partner violence among female drug users. Results from a randomized controlled pilot trial in a community substance-abuse center. *Adicciones*. 2015;27(3):168-178. doi:https://doi.org/10.20882/adicciones.703

40. Tirado-Muñoz J, Gilchrist G, Fischer G, et al. Psychiatric comorbidity and intimate partner violence among women who inject drugs in Europe: a cross-sectional study. *Arch Womens Ment Health*. 2018;21(3):259-269. doi:10.1007/s00737-017-0800-3

41. Ettorre E. (2004). Revisioning women and drug use: Gender sensitivity, embodiment and reducing harm. *International Journal of Drug Policy*, 15(5–6), 327–335. doi: 10.1016/j.drugpo.2004.06.009

42. Shirley-Beavan S, Roig A, Burke-Shyne N, Daniels C, Csak R. Women and barriers to harm reduction services: a literature review and initial findings from a qualitative study in Barcelona, Spain. *Harm Reduct J.* 2020;17(1):1–13. doi: 10.1186/s12954-020-00429-5

43. European Union Drugs Agency. Women and drugs: health and social responses. 2023;1–11. https://www.euda.europa.eu/publications/mini-guides/women-and-drugs-health-and-social-responses_en. Accessed 28 Mar 2025.

44. Bungay V, Dewar L, Schoening M, Guta A, Leiper W, Jiao S. Co-designing an Outreach Intervention for Women Experiencing Street-Involvement and Gender-Based Violence: Community–Academic Partnerships in Action. *Violence Against Women*. 2024;30(8):1760–82. doi: 10.1177/10778012241233004

45. El-Bassel N, Strathdee SA. Women who use or inject drugs: An action agenda for women-specific, multilevel, and combination HIV prevention and research. *J Acquir Immune Defic Syndr*.2015;69:182–90. doi: 10.1097/QAI.0000000000000628

46. Värmå Falk M, Strömdahl S, Ekström AM, Kåberg M, Karlsson N, Dahlborn H, et al. A qualitative study of facilitators and barriers to participate in a needle exchange program for women

who inject drugs. *Harm Reduct J.* 2020;17(1):1–10. doi: 10.1186/s12954-020-00425-9

47. United Nations Office on Drugs and Crime. World Drug Report 2020. Socioeconomic characteristics and drug use disorders. World Drug Report Booklet 5. 2020. 1–33 p. https://wdr.unodc.org/wdr2020/en/socioeconomic.html. Accessed 28 Mar 2025.

48. Correlation – European Harm Reduction Network. *Gender-transformative harm reduction services*. 2025. https://correlation-net.org/2025/02/11/gender-transformative-harm-reduction-services/

49. Metzineres. Metzineres – Sheltered environments for womxn who use drugs surviving violence. Available from: https://metzineres.org/en/

50. Fundación Salud y Comunidad. Centro de acogida y centro de día para mujeres en situación de grave exclusión "Beatriz Galindo" (Madrid). 2021. Available from: https://www.fsyc.org/proyectos/centro-de-acogida-y-centro-de-dia-para-mujeres-en-situacion-de-grave-exclusion-beatriz-galindo-madrid/

51. Martínez-Redondo P, Santamaría EA. Inventario institucional de recursos asistenciales (ambulatorios y residenciales) que realizan un abordaje conjunto de la violencia de género y adicciones. Federación Española de Municipios y Provincias y Delegación del Gobierno para el Plan Nacional sobre Drogas. Madrid. 2024. 78 p. https://www.drogasgenero.info/documento/inventario-institucional-violencia-de-genero-y-adicciones/. Accessed 28 Mar 2025.

52. Morton S, Gallagher B, McLoughlin E. *'You can't fix this in six months': The intersectionality of women's substance use in the Irish context*. Dublin; 2023 http://hdl.handle.net/10197/24235. Accessed 28 Mar 2025

53. Braun V, Clarke V. Thematic Analysis. A Practical Guide. In: Cooper P, Camic D, Long A, Panter D, Rindskopf K, Sher J, editors. APA Handbook of Research Methods in Psychology, Vol 2: Research Designs: Quantitative, Qualitative, Neuropsychological, and Biological. Washington, DC.: American Psychological Association; 2012. p. 57–71.

54. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews

and focus groups. *International Journal for Quality in Health Care*. 2007 Dec;19(6):349–57. doi: 10.1093/intqhc/mzm042

55. United Nations. Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power. Adopted by General Assembly resolution 40/34 of 29 November 1985. New York: United Nations; 1985. https://www.ohchr.org/en/instruments-mechanisms/instruments/declaration-basic-principles-justice-victims-crime-and-abuse. Accessed 28 Mar 2025.

56. Benoit T, Jauffret-Roustide M. "Improving the management of violence experienced by women who use psychoactive substances." 2016. https://www.drugsandalcohol.ie/25383/. Accessed 28 Mar 2025.

57. Robinson K, Ickowicz S. Research with Women Who Use Drugs: Applying a Trauma-informed Framework. *J Addict Med.* 2022;16(6):627–9. doi: 10.1097/ADM.0000000000000998

58. Goodman R. Contemporary Trauma Theory and Trauma-Informed Care in Substance Use Disorders: A Conceptual Model for Integrating Coping and Resilience. *Adv Soc Work*. 2017;18(1):186–201. doi: 10.18060/21312

59. Real Decreto Legislativo 10/1995, de 23 de noviembre. Boletín Oficial del Estado, nº 281, 24 noviembre 1995. https://www.boe.es/buscar/act.php?id=BOE-A-1995-25444. Accessed 28 Mar 2025.

60. Ley orgánica 1/2004, de 28 de diciembre, de Medidas de Protección Integral contra la Violencia de Género. Boletín Oficial del Estado, nº 313, 29 diciembre 2004. https://www.boe.es/eli/es/lo/2004/12/28/1. Accessed 28 Mar 2025.

61. Singh D, Anandan A, Narayanan S, Athirah Daud NA, Azman A, Vicknasingam B. Factors associated with intimate partner violence and barriers to reporting it, among female who use drugs in Malaysia. *Drugs: Education, Prevention and Policy*. 2022;29(5):614–24. doi: 10.1080/09687637.2021.1941777

62. Muñoz-Rivas MJ, Ronzón-Tirado R, López-Ossorio JJ, Redondo N. Beyond the Initial Assault: Characterizing Revictimization in Intimate Partner Violence and Its Implications for Women's Health. *Psychosocial Intervention*. 2024;33(2):65–72. doi: 10.5093/pi2024a4

63. Boyd J, Collins AB, Mayer S, Maher L, Kerr T, McNeil R. Gendered violence and overdose prevention sites: a rapid ethnographic study during an overdose epidemic in Vancouver,

Canada. *Addiction*. 2018;113(12):2261-2270. doi:10.1111/add.14417

64. Stoicescu C, Richer A, Gilbert L. Nexus of Risk: The Co-occurring Problems of Gender-based Violence, HIV and Drug Use Among Women and Adolescent Girls. In: The Impact of Global Drug Policy on Women: Shifting the Needle. *Emerald Group Publishing Ltd.;* 2020:49–57. doi: 10.1108/978-1-83982-882-920200008

65. Silberg C, Likindikoki S, Mbwambo J, Mmari K, Saleem HT. Housing instability and violence among women who use drugs in Dar es Salaam, Tanzania. *Harm Reduct J*. 2022;19(1):1–10. doi: 10.1186/s12954-022-00649-x

66. Campbell JC. Health consequences of intimate partner violence. *Lancet*. 2002;359(9314):1331-1336. doi:10.1016/S0140-6736(02)08336-8

67. El-Bassel N, Gilbert L, Wu E, Go H, Hill J. HIV and intimate partner violence among methadone-maintained women in New York City. *Soc Sci Med*. 2005;61(1):171-183. doi:10.1016/j.socscimed.2004.11.035

68. Caldentey C, Tirado Muñoz J, Ferrer T, et al. Intimate partner violence among female drug users admitted to a general hospital: screening and prevalence. *Adicciones*. 2017;29(3):171-179. doi:10.20882/adicciones.738.

69. Torchalla I, Linden IA, Strehlau V, Neilson EK, Krausz M. "Like a lots happened with my whole childhood": violence, trauma, and addiction in pregnant and postpartum women from Vancouver's Downtown Eastside. *Harm Reduct J*. 2015;12:1. doi:10.1186/1477-7517-12-1

70. Gómez Plaza A, Villajos Pozuelo S, Candeira de Andrés L, Hernández Gómez A. Estudio sobre el tiempo que tardan las mujeres víctimas de violencia de género en verbalizar su situación 2019. https://violenciagenero.igualdad.gob.es/violenciaencifras/estudios/investigaciones/tiempo-tardan-verbalizar-situacion/. Accessed 01 Apr 2025.

71. Martínez-Redondo P, Arostegui Santamaría E. Situación en España de la violencia de género y el abuso de sustancias: revisión de la evidencia y propuestas para el abordaje conjunto de la violencia de género y el abuso de sustancias en los servicios de atención. Madrid: Ministerio de Sanidad, Delegación del Gobierno para el Plan Nacional sobre Drogas; 2021.

72. Levenson J. Trauma-informed social work practice. Social Work (United States). 2017;62(2):105–13. doi: doi.org/10.1093/sw/swx001

73. Killeen TK, Brewerton TD. Women with PTSD and Substance Use Disorders in a Research Treatment Study: A Comparison of those with and without the Dissociative Subtype of PTSD. *J Trauma Dissociation*. 2023;24(2):229-240. doi:10.1080/15299732.2022.2136327

74. Arpa S. Women who use drugs Issues, needs, responses, challenges and implications for policy and practice. 2017. https://www.euda.europa.eu/document-library/women-who-use-drugs-issues-needs-responses-challenges-and-implications-policy-and-practice_en. Accessed 01 Apr 2025.

75. Mutatayi C, Morton S, Soto NR, Pálsdóttir KI, Pires CV. Implementing a gender approach in drug policies: prevention, treatment and criminal justice A handbook for practitioners and decision makers. https://book.coe.int/en/drugs-and-addictions/11036-pdf-implementing-a-gender-approach-in-drug-policies-prevention-treatment-and-criminal-justice.html. Accessed 01 Apr 2025.

76. Women and Harm Reduction International Network. Global Mapping of Harm Reduction Services for Women and Gender Diverse People Who Use Drugs. 2024;42. https://idpc.net/publications/2024/12/global-mapping-of-harm-reduction-services-for-women-and-gender-diverse-people-who-use-drugs. Accessed 28 Mar 2025.

77. Atira Women's Resource Society. SisterSpace: shared using rooms — women-only overdose prevention site: three-month developmental evaluation [Internet]. Available from: https://www.atira.bc.ca/sites/default/files/SisterSpace_Report_August2017.pdf

78. Alam-mehrjerdi, Zahra et al. "Women-only drug treatment services and needs in Iran: the first review of current literature." *Daru: Journal of Faculty of Pharmacy, Tehran University of Medical Sciences*. 2016; 24(3). doi:10.1186/s40199-016-0141-1

79. Área de Políticas Sociales, Familia e Igualdad. Plan operativo anual 2024: Estrategia Municipal sobre Prevención y Atención a las personas en situación de sinhogarismo 2022-2027. Madrid: Ayuntamiento de Madrid; 2024. Available in: https://www.madrid.es/UnidadesDescentralizadas/Integraciony

EmergenciaSocial/PersonasSinHogar/EspecialInformativos/Ficheros/POA_2024_EstrategiaDignitas.pdf

80. Stone K, Shirley-Beavan S. The Global State of Harm Reduction 2018. London: Harm Reduction International; 2018. ISBN: 978-0-9935434-7-0

81. Harm Reduction International. Impact of service disruptions on women, ethnic minorities and Indigenous people - Harm Reduction International. 2022. https://hri.global/publications/impact-of-harm-reduction-services-disruption-on-women-ethnic-minority-groups-and-indigenous-people-who-use-drugs/. Accessed 01 Apr 2025.

82. Mereish EH, Bradford JB. Intersecting identities and substance use problems: Sexual orientation, gender, race, and lifetime substance use problems. *J Stud Alcohol Drugs.* 2014;75(1):179–88. Doi: 10.15288/jsad.2014.75.179

83. Shields SA. Gender: An Intersectionality Perspective. *Sex Roles*;2008 18;59(5):301–11. doi: 10.1007/s11199-008-9501-8

84. Vu, M., Li, J., Haardörfer, R. *et al.* Mental health and substance use among women and men at the intersections of identities and experiences of discrimination: insights from the intersectionality framework. *BMC Public Health* 19, 108 (2019). https://doi.org/10.1186/s12889-019-6430-0