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COMMENT

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Women, gender and drugs: between research and action

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Abstract

This article is part of Harm Reduction Journal's special issue on harm reduction research in the francophone context and specifically the Harm Reduction Network (HARENE). After highlighting the history and current context of harm reduction for women in France, we present the results of four research studies addressing the links between gender and drugs which were presented in the book *Espaces genrés des drogues. Parcours dans la fête, l'intimité et la réduction des risques* ('Gendered Spaces of Drugs. A journey of intimacy, party and harm reduction'). This article is divided into three parts, each addressing a specific space: the space of institutional care, the intimate marital space, and the urban festive space. We begin by describing gender inequalities within harm reduction and care structures, by demonstrating how single-sex spaces facilitate the care of women, and how care professionals can perpetuate unequal gender norms in their relationship with a woman in a situation of addiction expressing a desire for pregnancy. Concerning the marital space, we highlight the reproduction of gender norms within socially included heterosexual couples who use drugs and are socially included, particularly concerning the choice of the intimate partner, the distribution of tasks linked to the purchase and sale of drugs, and parenthood. Finally, concerning the festive space, the article highlights the differentiated strategies of men and women in urban festive places, and the maintenance of a gendered order of festive places and drug consumption. This leads us to discuss the current issues of stigmatization of women drug users, and the initiatives put in place in the French context to promote harm reduction for women who use drugs.

Introduction

A long-time invisible issue in France, an increasing number of studies are investigating the use of licit and illicit drugs by women; moreover, care services are beginning to take this specific context into account. Over the last two decades, a new generation of researchers have made gender and drugs their chosen field of research [1–9]. This mobilization parallels that of professionals and activists in harm reduction for drug users and for the treatment of addictions. Despite the fact that research on gender in the field of addictions is still relatively scarce, and that gender-specific services are still far from adequately responding to the scale and diversity of women's needs, these first steps are decisive: after years of polemic, the specific consideration of women has finally acquired legitimacy.

In France, as in other European countries, these advancements are part of the development of the feminist movement. However, drug prevention and care services in France have been slower than other countries in Northern Europe to take into account the specific situations experienced by women using drugs as many articles

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point this out, starting with the special issue on Women and Addiction of the special issue of the *Bulletin Epidémiologique Hebdomadaire* (Weekly Epidemiological Bulletin) edited by *Santé publique France* (the national public health agency) which opens up the mobilization of research on this theme in 2009 [10, 11]. This delay is partly due to the fact that any consideration of specific needs runs against the principle of universalism which governs French society in the name of human rights. This principle opposes offering specific services for particular social groups out of a fear that doing so might lead to further exclusion and stigma of these same groups [12]. In France, a dominant opinion is persuaded that the visibility of a problem reinforces exclusion and stigma. Beyond women, this fear has been invoked to refuse any specific measure for all drug users in the name of the principle of universality (see the introduction of this special issue). As the fight against AIDS has shown, the fight against stereotypes and prejudices requires an awareness that is unthinkable if the problem is ignored or hidden. During the 90s, the first harm reduction experiments had to demonstrate the exclusion of health services and the possibility of overcoming its catastrophic consequences. But we had to wait the public law of 2004 to obtain legal status for harm reduction policy. Once the institutional system was created, the issue of stigmatization was forgotten in the public debate. In the meantime, those involved in harm reduction, whether drug users, caregivers or researchers, have been able to become aware of the need for a collective fight against stigmatization and exclusion.

Awareness of the stigmatization that weighs on women who use drugs is even slower, having to overcome a double stigma, whose consequences are ignored or denied. Indeed, drug users are stigmatized in general [13], but women even more so [14], because they go against gender norms associated with femininity, such as obedience, passivity and conformism. This juxtaposition of stigmas, linked to gender and drug use, makes it necessary to mobilize an intersectional approach, “a transdisciplinary theory aimed at understanding the complexity of identities and social inequalities through an integrated approach” [15]. Researchers today recommend analyzing drug use as an axis of inequality integrating into an intersectional analysis [13, 16–18], in the same way as gender and social class, age, sexual orientation, disability, etc. This intersectional approach also makes it possible to consider the category “woman” in a more complex and less homogeneous way, taking into account the differences in stigmatization of women drug users according to their race, their level of income, their housing situation, their professional activity - sex worker who use drugs being, for example, very stigmatized [19] -, their parenting - mothers using drugs also being very stigmatized [2, 20] -, their sexual orientation, etc.

In the field of addiction, it was not until the beginning of the 21st century that the question of women’s use of psychotropic substances - defined as “any product acting on the psyche, leading to a modification of the state of consciousness and/or behavior” [21] - began to arouse researchers’ and practitioners’ interest. In social representations, the world of drugs is a man’s world; this echoes what field-based researchers and institution-based practitioners observe, and what existing statistical data highlight in the law enforcement and health systems [22]. The ‘revelation’ that women using heroin could be pregnant or mothers came in 1985 with AIDS testing of women in maternity wards, but at that time, everything was done to ensure that information about mother-to-child transmission of HIV did not circulate, in order to protect HIV-positive women from stigmatization but also to prevent the threat of AIDS from causing panic in the general public [12]. Therefore, with few exceptions, there were no specific addiction or HIV services for pregnant women or mothers who use drugs at that time.

In the end of the 80s and especially at the beginning of the 90s, a number of research studies focused on developing medical research to protect mothers and children [1]. At the end of the 1990s, women experiencing severe social and economic exclusion started to frequent low-threshold services where professionals became aware of the violence these women suffered in the street. Despite this, very few specific services for women were put in place, and no sociological or anthropological research focusing specifically on this population was conducted. A turning point came in 2006 after the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) highlighted the insufficient provision of health services for women who used drugs in Europe. Experts, researchers and practitioners became aware of the lack of such services in France and started to mobilize. For example, the special issue of *Bulletin Epidémiologique Hebdomadaire* Weekly Epidemiological Bulletin) [10] was in part devoted to international research on women and addiction while, given the absence of specific research, researchers of the *Observatoire français des drogues et des tendances addictives* (French Observatory for Drugs and Drug Addiction, or OFDT) must have limited themselves to extracting and analysing data on drug use by women from French epidemiological surveys [23, 24]. Results from that quantitative gender-based comparison made by the OFDT highlighted that more men consumed psychotropic substances than women and that drug abuse by men was more frequent. The only exceptions were tobacco, where the prevalence of women smokers was similar to that of men and psychotropic medications, where women consumed more frequently than men [11, 24].

The first surveys focusing on women who used drugs were conducted in institutional services for harm reduction called CAARUD (*Centre d'Accueil et d'Accompagnement à la Reduction des Risques pour les Usagers de Drogues*) (reception and support centres for harm reduction for drug users) [25]. These centers were created in application of the public health law passed in 2004 which gave legal status to the harm reduction policy. With the objective of combating infectious diseases and limiting overdoses, these centers provide access to harm reduction equipment such as sterile syringes or condom. Intended for drug users with severe exclusion, these centers also offer a range of services meeting immediate health needs, such as the possibility of taking showers and washing clothes. To evaluate the effectiveness of harm reduction policy, regular surveys are carried out on users' risky behavior. It is withing this framework that a special survey on women was carried out, with a qualitative investigation added to the epidemiologic survey which leads to the following conclusions : " women consume more crack-free-base than men, and report more at-risk practices. Interviews highlight the central place of the sexual partner during the initiation of drug use and during the path of consumption of women" [23].

This apparently confirms the prejudices and stereotypes that weigh on these women. How can we be surprised? The women who use the harm reduction services are very marginalized, often homeless and exposed to street violence. Due to their double stigmatization, they resort less to health care. Due to these later female consultations, women who use drugs present more physical and psychological problems than men at the time of treatment [26]. Women also suffer more physical and symbolic violence in the drug world than men, notably sexual violence during sales and use [27], where a link sometimes occurs in representations between drug use, sexual availability and desire [7, 28]. Women also suffer a greater risk of fraud when purchasing drugs, because they are judged as not having the 'business personality' [29] allowing them to know the price and quality criteria, to negotiate with dealers and to defend themselves [30].

They seem to embody the inevitable decline of women who use drugs but during the 90s and especially in the following decade, new profiles of women appeared within the framework of the party scene, reaching with then current social representations of heroin consumption, consumers, women or men, are adopting new patterns of drug use, endeavoured to avoid harm and to restrain addictive behaviour. Starting in the mid-1990s, self-support associations started to disseminate and implement strategies to help users regulate their drug use at parties without distinguishing between women and men uses. The same is true of the first field research which noted the presence of women in the festive environment but did not seek to identify specific behaviors according to gender. The first research dedicated to women in the context of the party scene was carried out by Emmanuelle Hoareau in 2012. Conducted in Marseille, her research found a diversity of profiles of women who consumed drugs according to the choice of drugs and how to consumed it (e.g. drug injected, snorted or swallowed, regular or occasional use), the context of use (e.g., in party space, in public urban space or in private life) and the social status (e.g.;, socially included women, women living in social precarity). Women who are multiple users and who inject often belong to working-class backgrounds. They are often very marginalized and in poor health [31]. Some of them, previously heroin users, stabilized by opioid substitution treatment, were able to have access to housing and their health improved. Women frequenting the techno party scene were often better socially included than men frequenting the same festive spaces. Social inclusion is defined here as having permanent housing, being in employment or studying, and not experiencing financial difficulties, these criteria being inspired by measures established by the Council of Europe [32] to establish a minimum degree of social inclusion. These socially included women wanted to maintain their social integration by controlling their consumption. In the context of the techno party, there are also women on the margins of society, living in squats or on the move. Finally, cannabis is the most widely used drug, even though the women who use it remain largely invisible and rarely attend specialist services [33]. According to Hoareau, this diversity was associated with three factors: "the implementation of opioid substitution treatments (OST), the spread of techno parties, and the expansion of cannabis use" [33].

Since the 1990s, drug use had not been hidden in the party scene; it is so readily on display that researchers can easily enter into contact with users. However, "investment by the social sciences on the issue [of women who use drugs] remains weak", as Maïa Neff notes [4, p. 573]. The growing awareness of the lack of research on women's use of drugs is linked to the intersection of advancement in the feminist movement and new modes of consumption, with more women being able to justify their choice to consume psychotropic substances, if not in public, then at least in their own eyes. The relatively recent development of research on women who use drugs is also thanks to the capacity of a new generation of researchers to situate themselves at the intersection of several fields of research. These include not only feminism and addiction (the primary fields) but other fields depending on the social and cultural affiliations of women using drugs, but which also depend on the practices that can be associated with the use as sex work or sexual relations, or even specific situations such as like pregnancy or parenting. It remains to be explored how

women invest in these different contexts, the problems they encounter and the strategies they develop to deal with them.

In this context, the ‘Drugs, Genders and Cities’ project, led by Mélina Germes, Jenny Künkel, Emmanuel Langlois, Roxane Scavo and Sarah Perrin (co-author of this article), who are members of two laboratories[1] of the National Centre for Scientific Research (CNRS) organized a series of three conferences in 2020 and 2021 aimed at analysing the intersections between gender, drug use and sales, and spatiality, focusing mostly on the French context. The first conference was entitled “Sex, Drugs and the City”, and the second “The genders of urban drug policies”. Despite the titles being in English, the conference language was French. The third conference was entitled “Festive Drugs: Gender, Mobilities and Space” and was conducted in English[2].

At the end of these three conferences, we published *Espaces genrés des drogues. Parcours dans la fête, l’intimité et la réduction des risques* (Gendered Spaces of Drugs. A journey through Partying, Intimacy and Harm reduction), which is a collection of articles from members of the organizing committee of the three conferences, and researchers and doctoral students who participated in them. Published in 2022 by *Editions Le Bord de l’Eau* [34], the objective of the collection was to analyse how spaces are occupied according to gender in the context of the world of drugs, and to reveal the spatialities of gender issues within alcohol and drug consumption practices. The present article is based on the collection. As in that publication, we examined three different types of space: institutional framework spaces (including addiction treatments and harm reduction services), spaces dedicated to intimacy, and urban party scene spaces. We discuss these three types of spaces in the context of women who use drugs in the following Sects. (1, 2 and 3). The objective of this article is to highlight the way in which gender conditions access and support in care and harm reduction structures, marital dynamics and festive practices of women who use drugs, in a context of questioning traditional gender norms and the development of research on gender in the world of drugs. These three spaces were chosen because they are the sites of important mobilizations and transformations (with significant developments in the consideration of gender in the medico-social field, challenges to gender norms in the marital space and the development of strategies to reduce sexual risks in festive spaces), and therefore have deep political relevance for harm reduction. Also, there is already initial research carried out in these three spaces and bringing them together in this article allows us to progress in taking into consideration the different profiles of women who use drugs, the obstacles they face and the strategies they develop to cope with it. The discussion section focuses on the fight against gendered stigmatization of the use of psychoactive substances.

The care provided to women who use drugs in institutional harm reduction (HR) and treatment spaces

In 2013, as part of a framework created by the government to prioritize services for women suffering from addiction (2013–2017), the French addiction association network *Fédération Addiction* organized a working group on the issue of women with addiction [31]. The objective was to develop guidelines to improve care and support provided to women in various services (e.g., Addiction treatment clinics, called CSAPA) and HR services (e.g., CAARUD) [35]. An inventory taken at the time highlighted that approximately one in four persons provided care in CAARUD were women. The ratio was only slightly better for CSAPA. These figures are concerning given that an estimated one in three women consume drugs (depending on the drug used, these variations differ significantly) [11].

What can this underrepresentation of women be attributed to? For both CAARUD and CSAPA, this question arises in a context where specific services for women are infrequent and are mostly limited to a small number of tools such as female condoms, discussion groups and gynaecological consultations. Some CAARUD also offer women-only hours in mixed spaces; however, most male and female care providers question the need for this: does the use of gender-specific spaces not simply risk reinforcing the marginalization of women?

This was the context of a field-based research study conducted by Florent Schmitt between 2015 and 2018 in two CAARUD, in which he carried out an ethnographic immersion based on observations and semi-structured interviews with professionals and drug users [35]. One provided mixed-gender support, while the other offered support entirely reserved for women, something which was extremely unusual in the French context at that time. The study aimed to answer two questions: i) How can we understand inequality in access to CAARUD when the care and support offered by these services is based on a principle of unconditional access, without requiring a request for addiction treatment which is the case in CSAPAs ? To what extent can single-gender care services compensate for this structural inequality in access? One of the first answers to both questions was the non-use of the services by women. For Schmitt, this lack of use was linked to gender violence which weighs on women not

[1] Passages and Center Emile Durkheim.

[2] Researchers who spoke at the conferences included Anne Coppel (co-author of this article), sociologist, Gemma Block (University of Netherlands), Emily Nicholls (University of Portsmouth), Maïa Neff (Université de Laval/ENS Lyon), Florent Schmitt (Université Paris 1 Sorbonne) and Laurent Gaissad (Paris Nanterre University).

only in places where drugs are sold and consumed, but also in their private lives. Interviews with women who went to the mixed-gender CAARUD demonstrated this; specifically, respondents reported that they avoided going to the CAARUD out of fear of meeting other drug users who frequented spaces for dealing and consumption (the CAARUD being located near such places) because they did not want to be robbed or solicited for sex. Furthermore, they declared that they might avoid going to the CAARUD if there was a risk that they would meet men whom they already knew and who had already been violent with them in their private lives.

However, the under-representation of women was not only due to their decision not to seek care; as Schmitt noted, “It is also the result of an undeclared gendered targeting which does not say its name” [19, p. 73]. Professionals are persuaded to offer universal services without distinction of gender, but this principle hides what actually happens in the centre which offers privileged access to men [6, 35]. More specifically, in convivial spaces, men tended to appropriate the furniture, chairs, tables and sofas, while women stood on the periphery and limited their use of services offered by the CAARUD to drinking the beverages offered. Social exchanges linked to drug use took place here among men inter se, with discussions about ‘good deals’ for supplying, reselling, donating or swapping drug products, or about recipes for preparing a rock of crack. Virility was asserted with sexist remarks, attitudes, and gestures; women were returned to naturalized functions associated with their gender. They were supposed to be sexually available and had to pay attention to their appearance.

Another gender norm highlighted in Schmitt’s research was that women must be providers of care; this justified an unequivocal moral condemnation of pregnant women or mothers who continued to consume. Consequently, the CAARUD providing women-only support was used by women to discuss the violence they experienced. This contributed to increase their awareness of the gender norms that weighed on them all and provided them with the means to develop strategies to resist these norms. Violence was therefore “the first gateway to women’s space” [19, p. 83], something observed by a woman educator in the CAARUD providing women-only support; it was only then that she became aware of the frequency of violence and rape, an issue left silent in mixed-gender spaces.

Moreover, women in the single-gender CAARUD – escaping male pressure – sat around a table, eating and chatting among themselves in the same way as men in the mixed-gender CAARUD did. They asked for and received harm reduction tools, including condoms, which in the mixed-gender CAARUD marked them as being sexually available. They also took advantage of the basic services offered; they took showers, washed their clothes, moved around the CAARUD – sometimes in their underwear – and, if they wished, they could also sleep on the floor, a behaviour also tolerated for men in the mixed-gender CAARUD, given the precariousness of this often-homeless population. Schmitt’s research comparing single-gender spaces to mixed-gender spaces therefore highlighted “a form of negative discrimination against women”, a gendered division of roles that was almost invisible, so much so that it seemed to be taken for granted, and something against which the mixed-gender CAARUD’s care providers could do very little to fight against, their mission being to welcome everyone without making any moral judgment on consumption practices or deviant behaviour. Indeed, the only limits in place were the prohibition of alcohol or drug consumption and physical violence within the centre.

Schmitt’s research did not focus on the professional practices of the team providing care in the women-only CAARUD, but it is clear that they were committed to this experiment; they were very attentive to users’ needs and provided adapted support services, something highlighted by the friendly atmosphere. The latter is far from being a general rule in France’s CAARUD and CSAPA; indeed, the relationships between drug users - who are most often very marginalized - and healthcare professionals are complex to say the least. The social exclusion associated with addiction arouses a range of emotions in professionals from compassion to rejection, from fear to anger in the face of violent or immoral behaviour, and from involvement to detachment when a care project appears doomed to failure.

Another study, conducted by Maïa Neff, focused on the emotions of care providers in a CSAPA dedicated to parenting [36]. Initially intended for pregnant women and mothers of children under 3 years old, the service was extended to include parenting, the aim being to offer to help better balance the responsibilities of each person in the couple, and therefore to reduce stigmatization of women. However, more than 70% of the patient[3] population in that CSAPA were women and monitoring focused on specificities identified as feminine: vulnerability, traumatic and violent experiences, the relationship to one’s body and self-representations. Neff found that drug consumption by a mother is very often sanctioned by losing custody over her child(ren), despite the fact that motherhood can be seen as an opportunity to change one’s social role and to break away from the confines of the ‘polluted’ identity of a drug addict as Laurence Simmat-Durand pointed out in a research published in 2007 [2]. Her work

[3] CSAPA are not harm reduction services, they are centers specialized in the treatment of addictions. This is why we use the term patient to talk about people attending CSAPA, and the term drug user to talk about people attending CAARUD.

highlighted the four sets of standards that weigh on pregnant women or mothers who use drugs, namely (i) criminal norms punishing drug use, (ii) social norms of 'good' mothers, (iii) medical norms governing the monitoring of high-risk pregnancies, and finally (iv) gender norms. These norms do not consider the role of the father, who may be absent, violent, or even obstruct his partner's access to care, particularly when he himself is a drug user.

In her study of the CSAPA, Neff found that care providers – who were mainly women – had a dual mission: to support women and to protect the child. However, while non-judgment is a requisite with regard to the mother, care providers must assess the quality of the bond between the mother and the child, and take the necessary measures to guarantee good living conditions for the latter. Indeed, the interests of the mother do not always converge with those of the child. There is no systematic training for qualified professionals, but voluntary training courses are offered which may relate either to the monitoring of pregnant women either on the management of personal emotions which is supposed to be sufficient to become aware of the weight of prejudices and constraints that weigh on pregnant women or mothers. Accordingly, care providers, particularly when they themselves are mothers, are encouraged to implement 'emotional work', which consists of trying to become aware of their own emotions and ensuring they do not interfere with the decisions they make.

In Neff's work, the case of Sonia, a patient followed by two women – one a gynaecologist, and the other an educator – illustrates the tensions between representations of the 'good' mother and respect for this patient's choices regarding at-risk behaviours. Sonia wanted to remove her contraceptive implant, which required the gynaecologist's approval. However, according to the two care providers, Sonia's support was "complicated"; she required an emotional investment from them that "went beyond the [established] framework". She was followed during her pregnancy, with medical treatments, consultations to reduce her drug consumption, and her progress was initially judged "meteoric" by a nurse. But the hope of a happy motherhood suddenly collapsed after she gave birth; she was sent to mother-and-child accommodation in another city. Sonia abruptly left that structure, leaving her child alone there, returned to the city she had left, began squatting and started using drugs again.

The child was immediately placed in social care, as were her three previous children. Sonia's request to remove the contraceptive implant aroused incomprehension and even indignation in the two professional care providers. They could not agree to a fifth pregnancy, which could only repeat previous mistakes. Sonia was described by "her fragility" and "her deficiencies", something highlighted by "her strong emotional dependence" on her sexual partners, who followed one after another in rapid succession, and who often turned out to be violent. The lack of autonomy seemed obvious; according to the care providers, it reflected a psychiatric pathology.

Exacerbated by her fourth pregnancy, the salient features of Sonia's personality exemplify the gender-related representations of drug users provided support in CAARUD and CSAPA: women "experiencing a great deal of suffering", with "low self-esteem" as Carine Mutatayi also noted [37]. Professionals who use their own experience as a basis to define what a desirable motherhood is, are not aware that they are imposing a model which is specific to their own social environment, and which does not take into account the material conditions of existence. The emotions circulating in the CSAPA in question indicated to Sonia how unacceptable her request was, something which she perceived as a definitive disqualification from becoming a mother again in the future. This led her to flee the CSAPA where "emotional work is strongly intertwined with power relations such as those of gender, class and age" [36]. Neff also pointed out that the tension between what professionals perceived to be a desirable motherhood and the reality experienced by socially excluded female users, was so violent for care providers, that the CSAPA suffered from significant staff turnover, more than half the team changing their workplace over a one-year period.

In principle, relationships of support must be based on non-judgment, which implies a caring attitude. The 'emotional work' described by Neff calls on "the intimate experience of motherhood to be mobilized as professional knowledge"; this results in positive evaluations if care providers identify with the patient, or negative evaluations if the latter's behaviour does not conform to the standards that define "acceptable maternity wards". The patient's behaviour is interpreted with regard to personality, without taking living conditions into account or indeed the burden of the stigma that weighs on drug users, a burden that is all the heavier in women who become mothers.

The clinical picture described by Neff confirms the stereotypical diagnosis made by men and women practitioners that weighs on women who use drugs, victims not only of violence by men, but also of their own deficiencies, their lack of autonomy, their emotional dependence, and the absence of self-esteem. This diagnosis neglects the particular moment when women using drugs request help. No wonder then that they report how difficult it is for them to talk to care providers about their problems linked to drug use. This is a time when women who use drugs tend to have low self-esteem. Does this mean that they have no autonomy, that they are irremediably condemned to a life of chaos? "Women? They're worse than men", clinicians sometimes said of their heroin-addicted

patients before the arrival of OST at the end of the 1990s [38]. These clinicians were not aware that women who were better socially included and had sufficient control over their consumption avoided treatment services to protect themselves from value judgments. Published in recent years, guidelines dedicated to women using drugs now recommend fighting against stereotypes and stigmatizing representations, nevertheless, the emphasis placed on deficiencies, lack of self-esteem and associated mental disorders is often resented by women [27, 31, 37, 39].

The self-monitoring of drug consumption that women using drugs practice is invisible in healthcare institutions. As much as possible, they keep their consumption secret, which allows them to frequent non-specialized services, hospitals and general practitioners, but which implies a certain control over their drug use. Those who lose their ability to control this consumption find themselves on the street; they are then unanimously despised, described by their deficiencies, their traumas and are locked into chronicity. And yet no one – be it a man or woman – can live on the street without a survival strategy, something which "requires know-how, tactics and strategies, far from the image of people without autonomy, without control over their existence" [40].

Men, more than women, can resort to coping strategies, including illicit activities such as theft or drug resale. Given that women are a priori more marginalized than men in sociability networks, they find it more difficult to use coping strategies than men, so the last resource becomes their body. Whether or not they resort to sex work, women must protect themselves, which makes them true warriors, who can be proud of "their survival strategies in a hostile environment" to use Mathieu Lovera's phrase [40, p. 89]. The experience they acquire on the street can become part of their resources. Breaking with their 'imprisonment' in chronicity means calling on their experience, their skills, their know-how. These empowerment strategies are now advocated in guides and training courses. It remains to be seen how professional practices evolve in the field of addiction, an under-explored research question.

Intimate and marital relationships of women who use drugs

To date, few scientific studies have addressed the intimate and marital experiences of women who use drugs. Most of the relatively small number of studies on couples who use drugs concern people in socially precarious situations, and highlight the frequent domestic violence and control-based marital relationships which women who use drugs are victims of [27, 31, 37]. There are very little data on the marital relationships of socially included women who consume and sell drugs. This population, with a double invisibility (because they are women and because they are socially included) constituted the study population that Sarah Perrin studied during her sociology doctorate thesis [30]. Specifically, she conducted a total of 65 interviews: 45 with socially included women who used and sold drugs (26 in Bordeaux, France and 12 in Montreal, Canada) and 20 with socially included men who used and sold drugs (12 in Bordeaux, 8 in Montreal), between 2018 and 2022. Most of the interviewees were heterosexual, and the mean age was 26 years. Most consumed cannabis daily, and used stimulants (cocaine, MDMA/ecstasy) and sometimes hallucinogens (LSD) in party contexts.

Her analyses corroborate the classic findings of the sociology of conjugal roles, in particular the idea that "like attracts like" [41] in terms of place of residence, social environment of origin, educational level, income, religion, and substance use. Specifically, participants reported that they preferred to date partners who also used illicit drugs, because otherwise it could create a feeling of mismatch [42]. Moreover, it was not enough that partners were also consumers; the uses within the couple also had to be similar. Participants therefore preferred to be in a relationship with someone who used the same drugs as them with similar frequencies and in similar contexts. Note that male and female partners can influence each other in their consumption (by increasing or decreasing it), and that in the sample studied, women were not introduced to drugs by their romantic partners. Both men and women started their drug use with friends.

Although individuals in general look for partners similar to themselves, men and women do not look for exactly the same thing in heterosexual relationships [41]. Expectations of partners are always shaped by gender norms. The drug users interviewed by Perrin were no exception to the rule. Men who used drugs were more likely to declare that they preferred to date a woman who consumed less than them, or who did not consume. This trend is not specific to the area studied; for example, in a study by Barrault, alcoholic men looked for partners without substance use disorders [42]. Men often look for female partners who consume less, in the hope that the latter will act as a barrier to the former's consumption [43]. For these men, their partners must embody a maternal, reassuring, and even authoritarian role, which protects and restricts them in order to help them take care of themselves; this brings us back to the idea developed in Neff's research of the 'providing care' role imposed on women.

During her research, Perrin only met one mother, called Louane. Her story is indicative of the gendered double standard that governs parenthood in men and women who use drugs, something revealed in the large number of public policies targeting mothers who use drugs, but which leave fathers unscathed. Examples of

these policies are drug testing during pregnancy without the mother's consent, and encouraging pregnant women who use drugs to have abortions [44]. Louane was 30 years old. She was an educational consultant in Montreal. Her doctor prescribed her with medical cannabis following health problems related to her anxiety. She had two children, aged 9 and 7. When they were born, she stopped using cannabis completely for several years because she wanted everything "*to be very well supervised*". Her husband, who smoked cannabis recreationally every day, "*reduced [his consumption] a lot*" after the birth of the children, although Louane suspected he "*smoked [...] in secret when he went out with his friends*".

We can already see two very distinct behaviours here: Louane completely stopped smoking because she felt that it was the best thing to do at this time in her life, while her husband reduced but did not interrupt his smoking; moreover, he admitted to his wife that he had secretly smoked cannabis with friends. Louane reported that when she used cannabis in the family home, she was discreet about it: *"I wait until the children are asleep or until they are really out of my sight before going outside to smoke my joint."* Instead, her husband, was "*less careful*", which Louane justified by the fact that he smoked *"a little more regularly"*. Generally speaking, the father wanted cannabis consumption to be discussed in a very open manner with the children, for example by smoking their first joint with them, while Louane described herself as "*more closed*".

This "*closure*" may be linked to Louane's fear of being stigmatized if those around her learned that she was a mother who used cannabis. She feared that people would say that she was "*not a good mother*", and sometimes felt guilty about the fact that she smoked joints despite having children: "*I ask myself questions*, [...] *I asked myself if I was doing the right thing*." Louane already felt judged by her own mother, whom she had confided in about her therapeutic use of cannabis, and who replied to her that she had to "*be careful*", out of concern about Louane's ability to perform her maternal role correctly. In contrast, Louane's partner was not afraid of other people's judgement, and was comfortable talking about his consumption in public. Louane directly correlated this contrast between her husband's attitude and her own with the "*patriarchal*" context of our society:

> *A man has the right to drink, a man has the right to go out; a woman is judged more; and women, among us, we judge [...] too. Society [...] does not yet have, I find, the same openness in relation to what a man can do versus a woman.*

Louane's case reveals gender inequalities in parental roles. As in many couples, it is considered normal for the mother to abandon part of her individual identity for her children and for the father to maintain his autonomy and individuality without being judged.

In couples, the collective system of daily management is reflected through a distribution of household work that is often very gendered, automated and perceived as obvious by both partners [45]. The purchase and sale of drugs comes under the umbrella of the domestic tasks which the man performs. This gendered distribution in the work of buying and selling drugs within the couple is a direct consequence of the specific vulnerabilities of women, who are often the subject of various stereotypes, including that they lack credibility, that they have an incapacity for violence, and that they are lecherous [6, 7]. In Perrin's work, participants explained that it was almost always the male partner who was responsible for purchasing the drugs used by the couple and that the reported reason for this was to spare women the task of buying substances from a potentially dangerous dealer who would try to defraud them or try to hit on them. Indeed, women are the subject of sexist stereotypes when they buy drugs [7, 28, 46, 47], which justifies in the couple's eyes the fact that it is the man who is in charge of the purchases. Women, who are much more discreet in the face of police and security agents, transported drugs by hiding them in their underwear or handbags, whether in party spaces or in the street. Men, when carrying drugs, hide them in their socks or underwear, but they know that they are more at risk of being body searched than women, since most security agents and police officers are men, and that only a female agent can carry out a body search on a woman.

Again, this highlights the pervasiveness of gender norms, and how illegal practices were almost normalized in the domestic context. Negotiations, protection and risk-taking were for men, while women kept an eye on the spouse. This does not mean that women were incapable of selling without their partners. Most women interviewed who sold drugs had already done so alone, independently, without the support of a man; however, their sales practices did not fit into a marital management model. When the purchasing and selling tasks are divided between a heterosexual couple, it seems that a gendered distribution of tasks is put in place, for the sake of comfort and safety, with a view to having an element of routine in their daily life.

When partners stop having similar drug use patterns – because one increases, decreases or stops his/her use – tension can follow in the couple. In another study by Barrault, couples whose drug consumption patterns differed expressed less marital satisfaction, and drug use often lay at the heart of negative interactions between spouses [48]. In Perrin's survey, conflicts were reported linked to the fact that the drug use patterns of the two

partners were no longer similar. A form of romantic disenchantment could also occur when women tired of having to serve as a safeguard for their companions' habits. Finally, the theme of violence - central in the literature on women and drugs - was also predominant in Perrin's interviews of drug users about their marital experiences. Several women reported cases of violence within the couple, most often manifested through insults, controlling their private life (monitoring of social networks, bans on going out, etc.), threats, and more rarely physical violence.

Gender and drug use in urban party spaces

Since the creation of the "*Balance ton bar*" ("grass on your bar") movement in Europe in 2021, the vulnerabilities of women in partying contexts has been made increasingly visible, particularly at the sexual level [49]. One of the consequences of this is that persons providing assistance at party spaces are developing harm reduction practices which including providing care for victims, distancing perpetrators of violence from the event location, distributing protective drink covers for glasses (to prevent spiking of drinks), development of devices such as "Ask Angela" in festive space (which allow people who are victims of harassment or assault to discreetly request bar or club staff by "ask Angela", a coded message to ask for help), raising awareness of gender-based and sexual violence, as well as awareness as to what consent is.

With the diversification of the nightlife offer in city centres, women are increasingly present in party spaces, and some of them are demanding access to night-time partying spaces in cities as a tool of emancipation and empowerment [50]. This demand to appropriate spaces is one of several contemporary feminist challenges, especially as substance use is more stigmatized in women than in men, including in party settings. For several decades, feminist studies have shown to what extent women are required to control their bodies, that is to say their clothes, their gestures, their behaviours, their position in space [51], and of course their drug consumption. For their part, men can indulge in excessive consumption without a second thought, something which can be interpreted as the privilege of enjoying hegemonic masculinities [52].

Roxane Scavo conducted a qualitative survey in Bordeaux using the emotional mapping method [53] with socially included, heterosexual, cisgender, white people, aged between 19 and 48, who regularly consumed alcohol and occasionally other drugs, mainly MDMA and cocaine, in party settings. This research took place between 2019 and 2020. The emotional mapping method aims to understand relationships with urban space, by visualizing the emotions of the interviewees in relation to places, contexts and practices, and appealing to a spectrum of diverse emotions [54]. Each emotion is associated with a color (green for relaxation, yellow for pleasure, orange for happiness and desire, blue for worry, purple for disgust, red for hostility). During the interviews, participants are encouraged to map their own life space and situate themselves in the creative space of a blank page; each person takes ownership of the mapping process in a unique, valid, and meaningful way.

Scavo demonstrated that women regulated their habits depending on the places where they partied. Specifically, the geography of their consumption depended on whether loved ones were present, the proximity of a place of refuge, and their perception of a place as being safe. They viewed the use of psychoactive substances as a form of vulnerabilisation [28], and made their drug use a determining factor in their choices about which spaces they went to party. In contrast, men felt authorized to consume everywhere in the urban space: not only at parties or at home, but also in the streets, stairwells, and in poorly lit squares. Accordingly, drug consumption and the capacity to endure the consumption of drugs while walking straight or vomiting, or to tell a virile account of one's nocturnal misfortunes not only participates in masculinity, but is a condition of masculinity [55].

Moreover, Scavo's work highlights that women thought about which outfit they would wear depending on where they went out, with the idea of making sure they would be able to walk quickly, or run if necessary; this was not the case for men. Women also used other strategies to protect themselves, such as bringing pepper spray with them, not going home alone, and staying on the phone when they walked alone at night. The women Scavo interviewed faced the typical paradox of what we call post-feminism [50]: the search for emancipation through the pleasure of partying, consumption and being together with other women on the one hand, and almost constant self-control as soon as a male presence emerges on the other.

Discussion

This article highlights that irrespective of the context of drug consumption by women - whether in spaces for harm reduction and care, or in intimate and marital relationships, or in urban party spaces - the issue of gendered stigma systematically comes up. This stigma paints women who use drugs in terms of decadence and sexual debauchery, in terms of the figure of a 'bad' mother and of a 'bad' partner. It acts as an obstacle to health care and as a means of social control over consumption behaviours [8]. This stigmatization is institutional, political, medical, and media-related; it even operates in the world of drugs, where women who buy drugs are discredited, scammed, intimidated, threatened and harassed by their dealers [6, 56].

In the light of these findings, the fight against the stigmatization of women who use drugs therefore appears essential. This fight requires collective mobilization which begins with the mobilization of the people directly concerned, just as in the fight against AIDS. This involves taking up the slogan "Nothing about us without us" of the International Network of People who Use Drugs (INPUD), an international self-support network whose executive director, Judy Chang, is a woman who is very active on the issue of narcofeminism [57]. It also involves taking gender into account in harm reduction practices, as an element of social systems and structures, and not just as an individual attribute, with the objective of gender transformative health [58]. This means that gender should be considered by health professionals as an element of social systems and structures, and not just as an individual attribute, with the aim of gender transformative health.

Gender-transformative approaches to health, collaborative and relational, "actively work to examine, challenge and modify rigid gender norms and power imbalances in order to achieve health and equity goals of gender" [59, p. 9]. Promoting gender transformative health requires that professionals who work with drug users in the broad sense be trained on gender issues [60]. In the French context, a training offer on gender and drugs is developing; we can mention the training offered by the organization IREMA, "Women, gender and use of psychotropic drugs". However, participation in these training courses is based on the voluntary participation of professionals, and on the capacity of their structures to finance them. Social workers and health professionals can benefit from courses on gender during their university curse, but this depends on the establishments and the content of the programs is diversified, not currently making it possible to establish a common and homogeneous base of knowledge.

In France, the mobilization of those directly concerned (i.e., women who use drugs) must be developed even further. On the PsychoActif forum, which is dedicated to substance users, one can find discussions between women addressing issues specific to gender and consumption. Historically in France, women played a key role in harm reduction implementation. For example, the first syringe exchange programme in Seine Sait Denis was experimented by Nelly Boullenger. The first street team in Paris was set up by Malika Tagounit, who was also project manager of a "Boutique", programme which provided support to non-abstinent people, as well as the *Sleep-In* programme which provides shelter to non-abstinent people living in extreme social vulnerability, a project that Anna Fradet designated and managed [61]. The community health approach was adopted by these pioneers, under different modalities such as the action research carried out by Anne Coppel [38], or in neighborhood adopted by Lia Cavalcanti in a community health service. Beyond Paris and the Ile de France, other women like Beatrice Stamboul in Marseille or Danièle Ledit in Strasbourg are among these pioneers. At *Limiter la casse* (*Limit Breakage)*, a collective of associations created in 1993, as many women as men promoted harm reduction, irrespective of their background (association-based or professional activists, doctors, nurses or social workers). Women were also at the origin of the first harm reduction services specifically intended for women drug users; initially very marginal initiatives, these services are now legitimized.

Unfortunately, supply still cannot meet demand, especially for women-specific services. This lack of services dedicated to women is largely the legacy of a healthcare system that was intended to be universal and which refused to take specific needs into account until very recently [62]. In the field of drugs as elsewhere, the gender transformative approach to health promotion requires thinking about actions centered on women, and therefore potentially the establishment of single-sex spaces [58]. Numerous studies report that single-sex spaces and devices encourages the arrival of women by providing them with a feeling of security, by giving them the opportunity to appropriate the space and to speak out about the violence they have suffered, particularly sexual [6, 35, 63, 64]. Ultimately, the universalist model continues to show its limits when we focus on women who use drugs, and even more so when we consider the intersection of different axes of discrimination to which they may be subject. Developing specific actions appears essential, in harm reduction structures, in festive and urban spaces, and in any other space where people who use drugs are likely to go.

Conclusion

Although few in number, research on women who use drugs has nevertheless acquired legitimacy in the field of addictions. This field is however dominated by a medical logic, which is essential for maternity, HIV-HCV infectious pathologies and risk-taking studied in epidemiological surveys in terms of prevalence and incidence. All these approaches are based on sex but social science researchers and harm reduction activists, the fight against HIV, or feminists) seem to be the only ones to understand behaviors and identities based on gender. Harm reduction has inherited from the fight against AIDS the need to fight exclusion and stigma. Of course, collective mobilization against AIDS dates to the 20th century, but activists in the fight against AIDS remain active in the festive context, an environment which resists the medicalization of institutional services. From now on, the fight against stigma has become a public health issue for the World

Health Organization [65] as well as for the United Nation Organization [66]. Beyond public health, advances in the feminist movement contribute to questioning the hierarchy of sexual roles traditionally justified by the biological characteristics of women and men. Changing relations between men and women faces increased obstacles when women belong to stigmatized minorities, the stigmatization of drug users can be increased by other stigmatized affiliations such as migrants, sex workers, great exclusion. This justifies, once again, the need for an intersectional approach. The deconstruction of these stigmatized affiliations requires collective work; otherwise, women develop different strategies to protect themselves, either by keeping a distance from the most threatening men, or by hiding certain affiliations or practices.

Concerning the institutional care space, Florent Schmitt's research focuses on access to women in CAARUD and on an innovative experimentation of a single-sex space dedicated to women. His research begins with an observation of mixed spaces, where women are the subject of "negative discrimination" which is not perceived by the hosts or users or which is naturalized as being a matter of gender difference. The women who attend this CAARUD must accept the marginal portion of the reception space allocated to them, but their behavior changes radically when they were able to access the single-sex service. Feeling at home, they use without restriction the services monopolized by men in the mixed space. It is also a means of resistance to the violence they experience and of which they become aware by interacting with each other. Breaking with the "neutral masculine" of the institution, the single-sex space contributes to the empowerment of these women who are very excluded, which also opens new practices of welcoming and supporting these women. The research carried out by Maïa Neff leads to a more pessimistic conclusion. Dedicated to the follow-up of Sonia, a pregnant user, her research deconstructs the mechanism which results in the repetition of the placement of the newborn, which follows the previous placements of the first three children. For the gynecologist and the educator responsible for monitoring Sonia, this woman is "a complex case", marked by her vulnerability, her dependence on her sexual partners who follow one another in rapid succession, and suffering from mental disorders. These caregivers disqualify Sonia as a future mother by seeking to impose a model of mother-child relationship specific to their environment, without taking into account Sonia's living conditions. Obviously, the training of these caregivers on pregnancy monitoring is lacking. The turnover of caregivers in this department bears witness to this. It is to be hoped that services dedicated to parenthood will be equipped with training tools and support for professionals to better take into account what pregnant women or mothers experience, the relationship between mother and father as well as weight. of stigma.

Concerning the intimate space, Sarah Perrin's research highlights the weight of gender norms in the marital dynamics of heterosexual and socially included women who use drugs. The researcher highlights the influence of substance use on the choice of partners, and the fact that men seem to favor female partners who consume less drugs than them. Partners influence each other in their consumptions. A gendered division of drug purchases and sales operates within couples, with men taking charge of tasks deemed dangerous such as relationships and negotiations with dealers, and women carrying more drugs due to their discretion with the police. Sarah met only one mother, Louane, and her case illustrates how a man and a woman who use drugs adapt their uses differently to parenthood. Ultimately, drug use can also create tensions within couples, with several women interviewed mentioning violence linked to drug use.

Finally, regarding the festive space, Roxane Scavo's study retraces, using the method of emotional mapping, the trajectories and strategies of Marie, a 27-year-old drug user, and her friendly network. This research highlights the empowerment that women can derive from their urban festive practices and their drug use, empowerment which is sometimes paradoxically mixed with a feeling of vulnerability in the face of the risks of physical and sexual violence. The women interviewed all put in place strategies to reduce these risks, unlike the men interviewed. There is therefore a gendered order of festive roles and practices, marked by strategies of self-control and avoidance of certain neighborhoods and festive places. This research also highlights the current renewal of sexual harm reduction practices in festive spaces. This research also sheds light on the current renewal of sexual harm reduction practices in festive spaces, a theme addressed in the German context by Künkel [67] and in the Anglo-Saxon context by Nicholls [68].

The situation of women who use drugs in France remains problematic: they use treatment facilities less often than men and are subject to specific vulnerabilities in intimate and party spaces. They are at greater risk of experiencing violence and are constantly faced with stigmatization; this reduces them to fragile beings without any agency, or to persons of ill repute who are socially discredited. It is therefore essential to develop research that consider the complexity of women's drug use trajectories, with a view to proposing harm reduction measures adapted to the diversity of their profiles and their needs. We have already underlined, in the introduction, the interest of focusing on the three spaces investigated in this article. If research on health care, intimacy and festive practices of women who use drugs must continue, it is essential to extend the fields of investigation to other

spaces and situations. With an intersectional aim, being more interested in the trajectories of migrant, incarcerated, homeless, racialized, LGBTQIA+women who use drugs seems essential to fight against their stigmatization and promote their access to harm reduction.

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Sarah Perrin and Anne Coppel drafted this article and all authors revised the manuscript. All authors read and approved the final manuscript.

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