IN THE 2024/25 ESSD BOOK

TOPIC: Engaging PWUD in harm reduction initiatives. E.g., chapters exploring/reflecting on what does or doesn't improve user engagement with harm reduction initiatives

CHAPTER: Drugs and Harm Reduction Initiatives in Belgium: Women's Perspectives on Overcoming Barriers to Care

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Abstract

Harm reduction should be a key aim of all drug policy, interventions and support. Treatment should be available for those who seek it. Research should bring the voices and experiences of people who use drugs (PWUD) into the evidential base which (ideally, at least) underpins policy. To do this, the analysis is based on qualitative data collected from participants in three Belgian cities, Liège, Charleroi and Brussels, thus providing a nuanced understanding of how these factors combine and impact their access to addiction treatment and risk reduction services. The scope of this research is not limited to illicit substances, but also extends to alcohol, prescription drugs and new psychoactive substances.

Fifteen semi-directive interviews were conducted in three Belgian cities: Liège, Charleroi and Brussels. The present article engages with a set of testimonies and is distinguished by its approach, which focuses on the intimate and subjective experiences of the women concerned. Using a grounded theory methodology, we analyse how people who use drugs (PWUD) construct a subjective interpretation of their care trajectory based on their own lived experiences. More specifically, the analysis examines: (a) how each woman who uses drugs experiences her addiction from a gendered perspective; (b) the meaning she assigns to her situation; (c) the barriers she encounters in accessing services tailored to women's specific needs in terms of prevention, treatment, and harm reduction; and (d) the strategies or alternatives they consider for improving both their drug use situation and their access to care.

Key words: Gender dynamics- Drug use-Access to care- Harm reduction-Grounded theory

1 Introduction

Research on drug use has long overlooked the role of gender, even though studies have shown clear differences between men and women in patterns of use and the prevalence of related psychiatric disorders (Bryant & Treloar, 2007). In addition, the use of illicit drugs remains relatively low, especially among women. In both France and Canada, while cannabis experimentation has increased significantly, regular use remains limited, as does the use of other illegal substances (Rotermann, 2021; Weinberger et al., 2019). Women are consistently less likely than men to use these substances (Bryant & Treloar, 2007), which reinforces their minority status and often increases the social stigma they face. As a result, women's drug use, often overlooked in data and public policy, deserves more attention through gender-sensitive approaches.

The sociology of deviance and drug use has long been shaped around male figures, marginalizing women's experiences and overlooking their specific vulnerabilities and challenges. This exclusion has been evident both in public debates and in the development of policies (Chesney-Lind, 2015; Jauffret-Roustide et al., 2008). In *Outsiders* (1965), Howard Becker makes almost no reference to women among people who use cannabis. When interviewed fifty years later, he explained that, in the sociological context of the time, gender was not considered an important variable for analysis. According to him, women were rarely present in the environments he observed, and their absence did not seem significant at the time (Becker, 1967). This perspective, typical of that era, contributed to the invisibility of women's drug use in early studies on deviance. A similar lack of attention to female experiences can be found in the sociology of delinquency, which often focused on a male world seen as "by definition closed to women" (Mauger, 2009). As sociologist Maïa Neff explains, this invisibility is mainly due to two factors: the limited presence of women in public spaces, which reduced their exposure to institutional scrutiny, and the influence of an academic tradition largely shaped by and for me (Neff, 2018).

Since then, studies focusing on the experiences and practices of women involved in drug use, selling, or purchasing have multiplied, making gender a central issue in current research. In what follows, we will explore some of these dimensions, directly related to our research question.

Harm reduction approaches to women's drug use

In Belgium, drug-related harm reduction policies mainly aim to lessen the negative effects of drug use on people's health, social lives, and safety (Van Huyck, 2019). Rooted in a public health approach, this policy moves away from strictly repressive methods and instead focuses on the well-being of individuals. It includes a range of policies, programs, and practices designed not only to reduce the harms caused by drug use itself, but also those linked to legal and institutional systems. Based on human rights and social justice principles, harm reduction promotes non-judgmental support, respects individual choices, and does not require abstinence as a condition for receiving help (Harm Reduction International).

The idea of "risk" has become a key concept in health policy, especially during the HIV/AIDS epidemic. It played an important role in changing how prevention was approached and how social responses were organized (Calvez, 2010).

In Belgium, harm reduction began to take shape in the late 1980s. It first focused on certain groups considered to be at high risk, such as gay men, migrants, and sex workers. However, this targeted approach was also criticized, as it risked reinforcing the stigma already faced by these communities (Quirion, 2002). At that time, drug policies were mostly based on repression and strict abstinence. But these strategies proved to be ineffective. As the situation worsened, several European countries had to rethink their approach. Authorities began by giving people who inject drugs easier access to sterile syringes, and later to opioid substitution treatments (Morel & Couteron, 2011). These changes led to a sharp drop in HIV infections among people who use injectable drugs. Encouraged by these results and working closely with PWUD communities, harm reduction advocates started to change the way drug use was handled. Over time, harm reduction helped reshape how care and prevention were offered, not just for injection drug use, but for all types of drug use (Chappard et al., 2019).

Women who use drugs: A high-risk group

Women began to be included in public health discussions around drug use in the 1990s, when researchers recognized that they were at higher risk of contracting and transmitting sexually transmitted infections (STIs), including HIV (Durand, 2022). Following these findings, harm reduction policies started to focus mainly on two groups: pregnant women and sex workers. The main goal was to protect the unborn child and to prevent the sexual transmission of HIV (Hoareau, 2012). However, this approach did not consider gender as a social construct. Instead, it focused on the female body, mainly through the lenses of reproduction and sexuality. In this view, women who use drugs were often seen as unfit for reproduction (Coppel & Perrin, 2024,; Murphy & Rosenbaum, 1999). As a result, women's drug use became a public health concern not because of the impact on their own health, but because of the perceived risks it posed to others.

The first social science studies on women's drug use emerged from a public health perspective. They mainly focused on pregnant women and the effects of their drug use on their children. Canadian criminologist Sylvie Frigon notes that in studies of heroin-using women, the figure of the mother is highly prominent, often linked to concerns about child neglect or abuse (Frigon, 1989). Starting in the 1980s, the idea of the "crack baby" spread widely in public discourse, especially in North America (Boyd, 2004). This period saw growing interest in how certain drugs (particularly opiates, crack, and cocaine) affected pregnancy (Sales & Murphy, 2000).

Since the 1990s, several studies, especially in the United States, have explored how women who use drugs experience motherhood in a context marked by heavy stigma. In an environment shaped by the war on drugs, qualitative and ethnographic research has shown that these women still try to fulfill their role as mothers. They often develop strategies to protect their children, such as reducing their use, entering opioid substitution programs, or keeping their children away from risky situations

(Du Rose, 2015; Murphy & Rosenbaum, 1999). In the 2000s, other research in France and Canada continued this work. It shows that motherhood often becomes a key moment that can encourage changes in drug use patterns (De Koninck et al., 2003). Pregnancy is sometimes seen as an opportunity for change, but it can also be a period of intense surveillance. Some women adjust their drug use to match the expectations of healthcare or social institutions (Niccols et al., 2012).

Following this line of research, several other studies have looked more closely at mothers who use drugs, especially during pregnancy (Hoareau, 2012; Jauffret-Roustide et al., 2008; Minnens, 2020; Senn et al., 2005; Simmat-Durand, 2002). These studies point to the many challenges these women face, such as poverty, isolation, social pressure, and demands from institutions. These difficulties have a strong impact, not just on the women's health, but also on their ability to care for their children and on the overall living conditions of their families.

In several countries, programs have been developed to support pregnant women or mothers who use drugs. These services aim to reduce health risks, support parenting, and improve the living conditions of both women and their children. In Canada, various initiatives work toward this goal. In Toronto, the *Breaking the Cycle* program supports women starting in pregnancy. In Quebec, *Main dans la main* helps expectant mothers prepare for the arrival of their child (L'Espérance et al., 2016). In France, mother-child units provide both medical and social support. In Bordeaux, the *Perinatal Addiction Unit*, opened in 2020, cares for pregnant women or young mothers facing hardship. The goal is to ensure a safe pregnancy and support parenting, without the presence of fathers, in order to protect women from violence or exploitation (La Case, 2020).

The Belgian context

In Belgium, there is not yet a national structure equivalent to those found elsewhere. A few local initiatives do include parenting support in their services, particularly within residential centers or harm reduction programs. However, these services remain limited. From a public health perspective, the situation of women who use drugs and engage in sex work is especially concerning. Several studies show that they face a high risk of contracting HIV and other sexually or blood-transmitted infections (Goldsmith & Friedman, 1991; Inciardi & Surratt, 2001; Labbé et al., 2013; Nadeau et al., 2000). They are also exposed to very high levels of physical and psychological violence (Romero-Daza et al., 2003). Despite these risks, their access to substance use treatment services is even more limited than that of other women who use drugs, due to multiple barriers (social, institutional, and related to stigma) (Nuttbrock et al., 2014).

In light of these findings, a relevant study was conducted in 2018 as part of the GEN-STAR project (GENder-Sensitive Treatment and Prevention Services for Alcohol and Drug Users), funded by the Belgian Federal Science Policy Office (BELSPO) and the Federal Public Service for Health. The study aimed to assess the availability of services and the need for gender-sensitive prevention and care approaches in Belgium. It also sought to identify the barriers and challenges that limit women's access to services. The results highlight the need for a holistic approach that addresses both physical and psychological dimensions to ensure effective and appropriate support. Social stigma emerged

as a major barrier, reinforcing shame and guilt, and making it difficult for women to acknowledge their needs (Schamp et al., 2018). In this regard, peer support plays a crucial role by providing a safe, non-judgmental space for listening and acceptance. In addition, safety concerns and daily responsibilities further complicate access to care, limiting women's ability to focus on themselves and engage in a recovery process. This study sheds light on the complexity of the obstacles faced and underscores the urgent need for personalized interventions tailored to the realities and specific needs of these women.

This paper explores the gender dynamics that shape women's access to care and harm reduction services when seeking treatment for substance use. The analysis draws on qualitative data collected from participants in Liège, Charleroi, and Brussels, offering insights into how these factors interact and affect access to care and harm reduction. The research extends beyond illicit substances to include alcohol, prescription medications, and new psychoactive substances.

2 Material and method

Qualitative research stands out for its commitment to understanding social phenomena in context, thus focusing on the daily realities experienced by the individuals involved. It goes beyond numbers and raw data to delve "into the realm of lived experience, feelings, emotions, opinions, and representations, thus revealing the subtleties and intricacies of their personal history.

2.1 A grounded theory analysis method

2.1.1 Grounded in experience

Because it is closely tied to empirical data, grounded theory appeared to be a relevant methodological choice for exploring the experiences of women who use drugs. Originally developed by sociologists Barney Glaser and Anselm Strauss in 1967, this approach allows researchers to build theory from the ground up, by interpreting and connecting qualitative data gathered from the field (Glaser & Strauss, 1967). As Christophe Lejeune (2019) points out, grounded theory combines a commitment to reflecting participants' lived realities with attention to how they interpret and express those experiences (Lejeune, 2019).

This method offers a way to understand the issue through the perspectives of the women involved, by focusing on how they experience drug use in relation to their gender, the meaning they give to their situation, the barriers they encounter when trying to access appropriate support, and the possibilities they imagine for change. The analysis followed the classic steps of open, axial, and selective coding, allowing categories to emerge and be refined throughout (Paillé, 1994). These stages reflect the general logic of grounded theory and can be briefly summarised, as they mostly concern standard analytical procedures.

In line with the aims of the study, this approach sheds light on how gender shapes women's trajectories, influences their relationship with care systems, and contributes to persistent inequalities in access to health and harm reduction services.

2.1.2 An iterative and theoretical sampling approach

This study employed grounded theory as defined by sociologists Paillé and Mucchielli, emphasising a continuous and comparative analysis where data collection and analysis were closely connected. The process followed an iterative and interactive logic, with problematisation, fieldwork, and conceptual development mutually informing one another (Paillé & Mucchielli, 2016). Participant selection and interview sequencing were guided by theoretical sampling, enabling each interview to refine the emerging analysis and direct subsequent inquiry. Priority was given to the depth and diversity of subjective accounts rather than to sample size, aiming to capture the multifaceted nature of the phenomenon. Informal participant feedback on preliminary findings was incorporated into the final recommendations.

2.1.3 Ethical Approval and Ethical Considerations

This study received approval from the Ethics Committee of the University of Liège. Given the vulnerability of the participants, who are women who use drugs, particular care was taken to ensure ethical and respectful engagement at every stage.

Recruitment was conducted through institutions that already support these women (see Table 1). The study was introduced by staff members whom the participants trusted, allowing for a gentle and non-intrusive approach. The researcher then met with interested participants in a calm and familiar environment.

Informed consent was obtained in writing after explaining the study's purpose, procedures, confidentiality measures, and the voluntary nature of participation. A separate form addressed the protection of privacy. Participants were reminded that they could decline or withdraw at any time, without explanation or consequence.

The interview guide avoided overly sensitive or distressing topics. All interviews took place in private, supportive settings, with a focus on comfort and emotional safety. A respectful, non-judgmental, and trauma-informed approach guided the entire process.

2.1.4 Participants

Fifteen semi-structured interviews were conducted in three Belgian cities: Liège, Charleroi, and Brussels. Although this sample was smaller than originally intended, it still allowed for an initial "attempt to make sense" of the findings (Paillé, 2006) on how each woman experiencing drug use lives with her addiction and, against this backdrop, the barriers she faces in accessing services tailored to their specific needs in prevention, treatment, and harm reduction.

People who use drugs (PWUD) were primarily recruited from shelters, psychosocial intervention centres, mental health services, psychosexual information services, as well as women's support organisations for those in precarious situations, specialised drug addiction consultations, and community organisations dedicated to supporting women in difficulty.

3 Results and discussion

Although existing research often suggests that women are less likely than men to seek healthcare services on their own initiative, our study takes a different perspective. Instead of measuring how often care is sought or identifying gender gaps, we focus on understanding the specific conditions that make access to healthcare possible, as revealed through the women's lived experiences. Using grounded theory, our analysis is rooted directly in their personal narratives. It explores how meaning is constructed in their interactions with healthcare institutions and how these perceptions influence their decisions. Rather than being guided by purely rational choices, their engagement with, or avoidance of, healthcare services is shaped by how they interpret and experience the systems around them.

3.1 Structural exclusion from treatment services

3.1.1 Perceived and internalised stigmatisation

For people suffering from drug addiction, stigmatisation is an omnipresent reality, fuelled by stereotypes, prejudice and discrimination. Analysed here as a stereotyped and fundamentally prejudicial process, stigmatisation takes the form of reductive labelling, devaluation of status and discrimination, thereby altering the individual's relationship with his or her identity, social environment and institutional structures (Corrigan & Wassel, 2008).

The way in which society views drug use affects women more than men, making it particularly difficult for them to access harm reduction services . It's not just a question of substances: prejudice on the part of citizens and health professionals, discrimination on the grounds of precariousness, gender, sexual orientation or migratory status, and inequalities of power all contribute to creating an environment where women feel judged and marginalised. Fear of these judgements often deters them from seeking help, perpetuating a vicious circle of vulnerability. Female users spoke of the pervasiveness of stigma in their daily lives, an experience that leads them to downplay the importance of self-care and harm reduction.

A 27-year-old woman living in Charleroi, who uses crack cocaine on the streets on a daily basis, shared her experience after going to hospital with problems related to her drug use and severe anorexia. This user's comments express a social judgement in which her drug use is associated with the figure of the prostitute, perceived as a symbol of marginalisation, excess and moral deviance. In their perceptions, drug use is sometimes associated with a supposed sexual availability and desire. Her story reveals the presence of stigma in care practices, which fuels institutional discrimination.

This reinforces mistrust of the healthcare system, which hampers access to care and harm reduction measures.

'How did you feel when you were admitted to hospital?

'I felt that I was being judged, that I was being looked at sideways. They thought I was a prostitute, just because I smoke crack. Even the doctors spoke badly to me, because they thought I was a 'crackhead'. And if I go elsewhere, I'm never treated well. They make me feel guilty [...]' (Alcohol, cannabis, amphetamines, medication (antidepressants) user, 27, Charleroi)

In addition, the user described demeaning treatment, marked by the attribution of a 'dirty' identity, illustrating a feeling of stigmatisation. This experience is part of the concept of perceived stigmatisation, defined by Livingston and Boyd (2010), in which individuals internalise and feel society's adherence to depreciatory stereotypes about them.

"And on your side, do you see yourself that way?"

"After a while, seeing the way they look at me, they made me feel so guilty. No matter how hard you try not to believe it, you just end up feeling worthless…"
(Alcohol, cannabis, amphetamines, antidepressants user, 27 years old, Charleroi)

The process of internalised stigma results from repeated exposure to judgement and demeaning remarks, gradually leading individuals to absorb these negative perceptions into their self-image. This self-devaluation reflects an identity shift, manifesting through a conscious or unconscious acceptance of the stereotypes associated with a marginalised social condition.

This reality raises questions about the social disqualification experienced by women who use drugs. As drug users, they are often perceived as irresponsible, excluding them from socially accepted roles and identities (Murphy & Rosenbaum, 1999). For those living in precarious conditions, experiencing homelessness, or belonging to ethnic minorities, this dual stigma—linked to drug use and strict gender norms—fuels distrust towards healthcare institutions. Through a process of exclusion, this narrative shapes the perception of these women as deviant individuals, further deepening their marginalisation and social exclusion.

A 23-year-old woman, homeless in Brussels and struggling with alcohol and cocaine use, attempts to access a treatment centre. Confronted with what she perceives as condescending attitudes, she feels deeply uncomfortable with the very structures meant to support her.

"Tell me about your experience seeking help?"

"I tried once to get treatment. The woman at reception pulled a strange face when I told her I was using. She wrote something down on her paper, then spoke to me like I was a child who'd done something wrong. I told myself, never again."
(Alcohol and cannabis user, 23 years old, Brussels)

Prejudices related to drug use, especially against women, hinder the success of harm reduction initiatives. Women experience considerable difficulty speaking openly about their use, as they face a highly demeaning social image. This burden often pushes them to isolate themselves and conceal their situation, which significantly delays their access to support services. To overcome stigma, some women seek support from their peers, creating a form of sisterhood. One user describes her fear of asking for help, fearing judgment as a mother. They fear not only being misunderstood, but also being accused of neglecting their children, which dissuades them from seeking care. Shame and guilt prevented her from entering a support service. However, support between women sometimes helps overcome these barriers.

3.1.2 Specific needs

a) To pregnant and mothering users

As the previous results have shown, women facing alcohol or drug addiction experience a much stronger social stigma than the male (Meyers et al., 2021; Murphy & Rosenbaum, 1999). Pregnancy accentuates this perception, with the well-being of the unborn child becoming a priority. During their pregnancy, women who use drugs are confronted with a double transgression: on the one hand, drug use, considered an illicit practice, and on the other hand, non-compliance with recommendations related to prenatal care. The potential harm caused by the use of toxic substances is then considered, just as the mother's ability to fulfill her role is questioned. The reluctance of some pregnant women who use drugs to undergo prenatal care is often explained by the lack of appropriate care in health services, which distances them from the necessary care. Although more and more maternity wards are interested in supporting them, these women still encounter numerous barriers (El Guendi, 2025). Fear of judgment, shame, or even the fear of attracting the attention of social services often dissuade them from seeking help, making their access to care particularly difficult.

So, when you got pregnant, how did your drug use go?"

"I didn't tell anyone, not even the father directly. I didn't want to be taken away after the shift. So you hide, you miss appointments...

Didn't you consider talking to a doctor?"

"Yes, just a gynecologist. She saw that I was fragile, lost... I was afraid she'd cause me trouble."

What would you have needed to feel good during this pregnancy?

"People to help me manage it all together, you know." (Alcohol, cocaine, prescription medication, stimulant user, 23, Brussels)

The distrust that keeps women away from pregnancy monitoring is interpreted by maternity professionals as a first attack on the well-being of the unborn child. Maternity services care for pregnant women, but few of them actually offer help with dependency. The lack of staff trained in the double burden of maternity and dependency forces users to face this complex situation alone. Often isolated and without a support network, they are also reluctant to engage in care, for fear that it will lead to family breakdown, or worse, the loss of custody of their children.

b) A response to users who are victims of violence

The data collected underscores the severity and chronicity of the violence suffered by women drug users, including incest, domestic violence, and sexual assault, which profoundly mark their lives.

Incest

Many women addicted to drugs have suffered childhood trauma, particularly sexual abuse. These traumatic experiences create emotional fragility and impair their ability to feel safe. Faced with this suffering, they develop coping strategies such as dissociation and emotional detachment. Substance use becomes an extension of these mechanisms, offering immediate yet illusory relief.

"Can you tell me about your childhood?"
"It's not easy... There are things I'd rather not remember."
"Take your time. If you feel comfortable, can you tell me about what you experienced?"
"He had some unclear things, you know." My cousin... I was just an eight-year-old kid, you know. Afterwards, the memories came back. Then I tried to turn off my brain. When I get high, it's to forget, to stop thinking. You know, when you're drunk, there's nothing that moves you anymore? Well, maybe that's what I'm looking for... nothing anymore." (Alcohol, medication (antipsychotics) user, 35 years old, Liège)

The act of speaking about oneself, entering an unfamiliar environment, or being observed by healthcare professionals can reactivate traumatic memories or intensify feelings of shame and vulnerability (Copeland et al., 2007; Viaux, 2022). Women in these situations may fear being judged, misunderstood, or rejected if they talk about their past or their substance use. Some may also perceive medical institutions as rigid, hierarchical, or even unsafe, especially when they have previously experienced control or violence in institutional settings (Goldstein et al., s. d.). In addition, when healthcare professionals are not trained to recognize or respond to the effects of trauma, their interactions can unintentionally recreate dynamics of power, silence, or exclusion. In this context, accessing care is not only a medical or administrative process. It also represents an emotional challenge that requires inner resources these women may not always have at their disposal (Grossman et al., 2021).

Domestic violence

Drug and alcohol use severely impairs judgement, making individuals more vulnerable to impulsive and violent reactions. These behaviours are often heightened by withdrawal or the effects of psychoactive substances (Barnwell, Borders & Earleywine, 2006).

"Has your partner ever been violent with you?"
" Yes. He was using drugs regularly at the time, cocaine and pills. When he was high, he became unpredictable and aggressive. One evening, I asked him to stop using in the house. He shouted at me, accused me of controlling him, and then pushed me against the wall. I remember thinking that the drugs had completely changed who he was."
(Alcohol, cannabis, cocaine, crack, medication (anxiolytics) user, 48 years old, Charleroi)

In these conditions, access to healthcare requires much more than services that are simply available and open. It calls for spaces that are specifically designed to welcome women whose daily lives are shaped by dynamics of domination, sometimes reinforced by male authority figures within institutions themselves (McCloskey et al., 2006). For a healthcare setting to be truly accessible, it must be perceived as safe, understanding, and free from controlling dynamics. Mixed-gender environments that are overcrowded, impersonal, or dominated by male presence can easily trigger fear and discourage these women from even stepping inside (Delage & Lieber, 2019). The issue is fundamentally relational. Providing care for these women means acknowledging the forms of oppression they endure and developing responses that account for the systemic violence embedded in their everyday lives.

Sexual violence

Sexual violence is a deeply traumatic and distressing experience that many women face, often intertwined with other forms of abuse, such as physical and emotional violence (Hamel et al., 2016). Insecurity and violence are major concerns highlighted in the testimonies gathered from the women participating in this study. These experiences reveal a close link between the daily lives of women and the potential dangers inherent in public spaces. Verbal, physical, and sexual assaults are pervasive threats in their perception of the street.

"Have you experienced any violence while living on the street?"

"I had once fallen asleep on a bench, in the middle of the afternoon. When I opened my eyes, a guy was already on top of me. After that, I never managed to sleep anywhere with men around."

(Alcohol and heroin user, 50 years old)

Harm reduction services face significant challenges in supporting these women, whose experiences are particularly complex. Their situation results from the intersection of two major issues: drug addiction, which exposes them to severe stigma, and the violence they endure, often overlooked and insufficiently addressed. This double vulnerability hinders their access to care and support services, as institutions struggle to adapt their interventions to meet their specific needs. Despite efforts to strengthen support, the structure of care and support systems remains compartmentalised, with a marked distinction between addiction management and the care for violence experienced. This separation, often driven by organisational constraints or institutional logics, obstructs access to comprehensive support for these women with unique life paths. For example, a drug user seeking help for violence frequently encounters specialised structures that exclude substance users, while addiction services are inadequate for addressing the psychological trauma caused by violence.

Conclusion

This research does more than describe the experiences of a marginalised group. It highlights how institutions help determine which lives are supported and which remain on the margins. In Belgium, women who use drugs face a number of obstacles that limit their ability to access care. These

obstacles are not only related to service availability or individual behaviour. They are also shaped by broader systems of inequality which affect how women are seen and treated in care settings.

Understanding substance use only as a sign of deviance overlooks the reality of many women's lives. As shown in the interviews, drug use often becomes a way to manage emotional pain, violence, and repeated social exclusion. The strategies women adopt to cope (such as avoidance, silence, or emotional withdrawal) are not always recognised by support systems. When their ways of surviving do not match the expectations of professionals, they may be misunderstood or excluded from care altogether.

These difficulties become even more complex for women who are mothers. Accessing treatment often means making difficult choices between their own recovery and caring for their children. Without practical solutions like childcare integrated into support services, many mothers simply cannot engage with care programs. What may appear as a lack of motivation is often the result of systems that are not designed to meet their everyday needs. Supporting women in this situation requires services that allow them to care for themselves without having to give up their role as parents.

In the same way, many services that support victims of violence are not equipped to respond to the realities of women who also use drugs. When services work in isolation and follow rigid entry criteria, they risk leaving out women whose needs do not fit into one category. As a result, women who are both victims and substance users often remain invisible in the system and cannot access appropriate help.

Moving forward, it is essential to strengthen the links between addiction care and support services for women exposed to violence. Shared training, better coordination, and more flexible approaches would allow professionals to respond in a more holistic way. Some positive examples already exist. For instance, certain maternity wards provide substitution treatment, parenting support, and a safe environment under one roof. These models show how different forms of care can be combined to respond more effectively to the realities women face.

In conclusion, this research calls for a broader understanding of what it means to access care. The barriers these women face are not just personal or psychological. They are part of the way services are organised and the assumptions they are built on. Making care truly accessible means creating systems that take into account the complexity of women's lives, rather than forcing them to adapt to services that were not made for them. This approach is in line with current European goals around gender equality and public health and points to practical ways of building more inclusive and supportive care system.

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