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From Denial to Pregnancy and Motherhood to 'Gender Informed'? Women and Ireland's Alcohol and Drug Strategies, 1996-2025

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Background

Women compose a sizable percentage of individuals who consume alcohol and drugs problematically in the Republic of Ireland, and much research supports the need for gender sensitive drug policies and services. This paper reviews three decades of alcohol and drug policy in the Republic of Ireland to see how strategies have framed women.

Method

We initially conducted a content analysis and then a critical policy analysis of the four national alcohol and drug strategies, and other key documents, published between 1996 and 2025. Carol Bacchi's 'What's the problem represented to be?' approach guided the analysis.

Results

The historical analysis shows Irish alcohol and drug policy moving through a number of non-linear stages, with a consistent theme of concern for women who consume alcohol or drugs during pregnancy. Women-specific recommendations were only included in the most recent strategy (2017-2025). The analysis shows a development from initial denial around women's

drug use to an almost exclusive focus on pregnancy and parenting, to an acknowledgement of the need for 'gender informed approaches'.

Conclusion

The paper concludes by discussing how these problematisations, and silences, can be viewed within the context of wider women's health inequality.

Key words: alcohol policy; drug policy; drug strategies, Ireland; problematisation, women

Introduction

Women compose a sizable percentage of individuals who consume alcohol and drugs problematically in the Republic of Ireland. Roughly one-quarter (27%, N= 3,156) of the 11,488 people who entered treatment for a currently illicit drug[1] in 2022 were women (European Union Drugs Agency, 2024a). This ratio has stayed somewhat consistent over the last decade, and is broadly in-line with the European average (Arpa, 2017). The gender gap is narrower for alcohol. In 2023, 8,163 individuals in treatment reported alcohol as their 'main problem drug'. Of these, 63% (N=5,203) were men, suggesting that close to 40% were women (Health Research Board, 2024). Women also accounted for approximately one-third (34%, N=110) of Irelands drug-induced deaths in 2020 (European Union Drugs Agency, 2024b) and 27.3% (N=162) of alcohol-related deaths in 2022 (Doyle et al., 2024).

Over twenty years ago, Ettorre (2004) proposed the need for 'gender-sensitive' drug policies and services. Gender-sensitivity acknowledges that men's needs and experiences have

[1] In this paper, illicit drug refers to any controlled substance specified in the Schedule of the Misuse of Drugs Regulations 2017. Some of these substances can be legally obtained under prescription.

historically been privileged over women's and, that women experience substances and services differently to men. As such, services should be tailored according to diverse needs.

Much empirical research supports the proposition that women's experiences of alcohol and illicit drugs are physiologically and emotionally differently to men's (see Arpa, 2017; Erol and Karpyak, 2015; Fonseca et al., 2021; Measham, 2002; Tuchman, 2010). Studies have also shown that women who use drugs are more likely than men to be stigmatised (Radcliffe and Stevens, 2008; Mayock and Butler, 2022; Morton et al., 2023) and experience domestic violence (Banka et al., 2022), and less likely to access treatment (Arpa, 2017) and harm reduction services (Bardwell et al., 2021). Women encounter distinct barriers to services, including lack of childcare access (Morton et al., 2023; Stone et al., 2010), fear that children will be taken into care (Banka et al., 2022; Harris et al., 2023; Miller et al., 2025; Morton et al., 2023; Tuchman, 2010) and experiences of sexual harassment within services (Bardwell et al., 2021; Muel et al., 2025; Tuchman, 2010). In Ireland, Banka and colleagues (2022:28) estimated that 'at least' 11,000 women 'who use substances' experienced domestic violence in 2020. Domestic violence presents a barrier to treatment and rehabilitation, including partners preventing women from accessing or engaging in services, through physical, financial and/or emotional abuse (Morton et al., 2015, 2023; Pallatino et al., 2021; Stone et al., 2010). Furthermore, a number of studies have found that men and women interact differently in group treatment settings, with some women unwilling or unable to fully engage and interact in mixed-gender settings (Tuchman, 2010; see Muel et al., 2025).

The research literature is clear that women and men experience drugs and services differently. This paper sought to critically assesses how three decades of Irish alcohol and drug policy has framed the needs of women who use illicit drugs and/or alcohol. Influenced by Bacchi's (2009) 'What's the problem represented to be?' (WPR) approach, it analyses Ireland's four national alcohol and drug strategies, between 1996 and 2025. The key finding is that Irish alcohol and

drug policy initially denied women's drug use to then focus almost exclusive upon pregnancy and motherhood, and only recently begun to promote 'gender informed approaches'. The following section will provide some context on Irish drug policy.

Policy Context

Ireland's drug control laws were 'relatively repressive' until the 1980s (O'Mahony, 2004:5), when the government began promoting more harm reduction measures. This was motivated by concern over the spread of HIV through intravenous drug use (Butler, 1991). Harm reduction has since coexisted within a relatively strict prohibitionist regime (Leonard and Windle, 2020), although the government is moving towards a more 'health-led approach' (Morton et al., 2020). This has included, for example, the recent provision of injectable naloxone formulations (European Union Drugs Agency, 2025), drug testing at festivals (Ivers et al., 2022), and a safe injecting facility in Dublin (Health Service Executive, 2025). This said, while the current government is committed to a health-led approach, many harm reduction and treatment services remain under-resourced (Citizens Assembly, 2024; Leonard and Windle, 2020; Murray, 2023).

Irelands' drug policy, practice and resource allocation have been driven by consecutive national strategies. Alcohol and illicit drugs were dealt with under separate strategies until 2012, when they were merged. The current strategy *Reducing Harm, Supporting Recovery: A Health Led Response to Drug and Alcohol Use in Ireland 2017-2025* seeks:

> To create a healthier and safer Ireland, where public health and safety is protected and the harms caused to individuals, families and communities by substance misuse are reduced and every person affected by substance use is empowered to improve their health and wellbeing and quality of life. (Department of Health, 2017:16)

While the strategy proposed a health-led approach, Irish drug policy has long contained a tension between criminal justice and public health (Butler and Mayock, 2005). Such tensions are not unique to Ireland, and are found within the three international drug control conventions, which contain the humanitarian aspirations of improving health and well-being alongside the more repressive goal of suppressing an 'evil' which threatens the 'fabric of society' (Lines, 2017). These tensions were starkly illustrated in recent debates at the 2023 Citizens Assembly on Drugs (2024), and then Oireachtas Joint Committee on Drug Use (2024), especially around the issue of decriminalisation of simple possession.[2] The current strategy is coming to an end, and, discussion and consultation has begun around core topics for the next strategy.

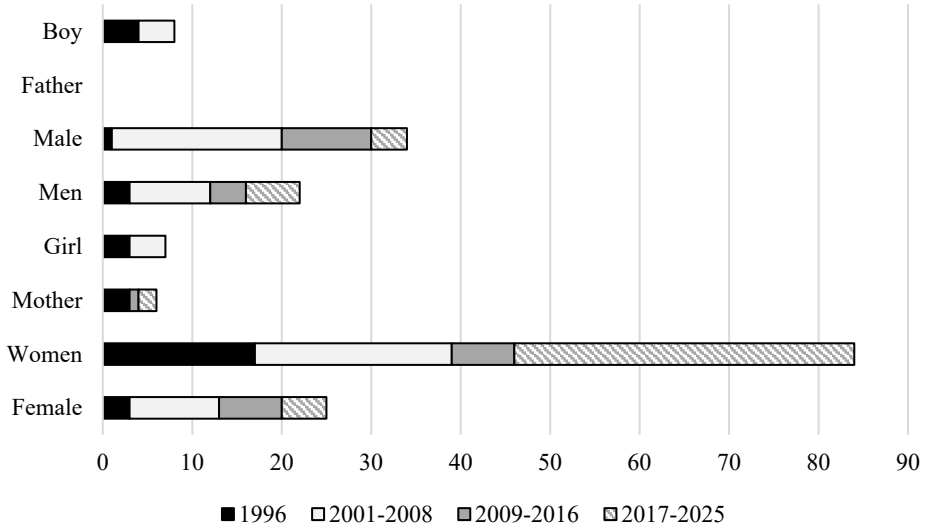
Method

We analysed the four national alcohol and drug strategies – *National Alcohol Policy* (Department of Health, 1996), *Building on Experience: National Drugs Strategy 2001–2008* (Department of Tourism, Sport and Recreation, 2001), N*ational Drugs Strategy (Interim) 2009-2016* (Department of Community, Rural and Gaeltacht Affairs, 2009), *Reducing Harm, Supporting Recovery: A Health-led Response to Drug and Alcohol Use in Ireland 2017-2025*

[2] The Citizens Assembly (2024) comprised 99 residents of Ireland, who listened to 130 speakers and read 800 submissions before submitting a report to the Oireachtas (Irish parliament). The Assembly narrowly rejected the legalisation of cannabis (39 votes against to 38 votes in favour) but strongly recommended decriminalisation of drugs for personal use, and that people found in possession of drugs be referred to health or addiction services, rather than criminalised. The first author attended the Assembly, and witnessed some speakers lobbying for the status quo and others for reform. An Oireachtas Joint Committee on Drug Use (2024) was later convened to consider the recommendations of the Assembly. It invited presentations from state bodies, practitioners and academics. It broadly agreed with the Assembly recommendations, but emphasised that healthcare must be voluntary and recommended cannabis be regulated.

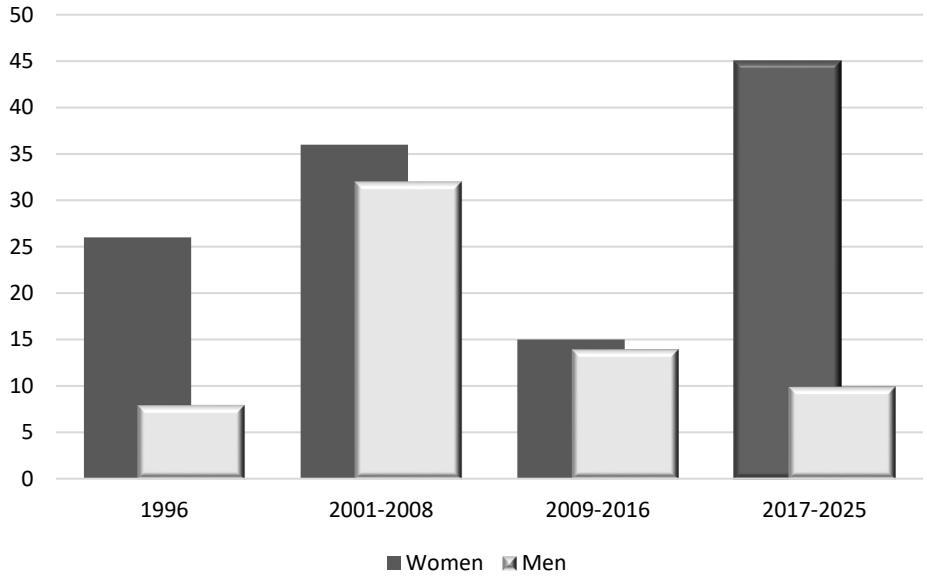
(Department of Health, 2017), and other key documents. We initially conducted a basic content analysis (Neuendorf, 2017), which was useful but limited. Each document was searched for words to describe men and women: women/men, female(s)/male(s), women/men, girls(s)/boy(s) and mother/father. Figure 1 shows the frequency counts of each word used to describe women and men. 'Women' was the most common word found (N=238) followed by 'female(s)' (N=72), 'mother(s)' (N-16) and 'girl(s)' (N=16). Female and women were often used interchangeably in strategies, although women was the preferred term in the 2017 strategy.

Figure 1: Content analysis. Counts of words used to describe men and women in national drug strategies



All words describing men or women were then combined (Figure 2) and the overall frequency counts of any mention of men or women shows that words used to describe women were more common than words used to describe men. This is, however, because women are explicitly mentioned as a 'special population' compared to the 'male norm' (Wincup, 2019:2). If men are 'the norm' they do not need to be mentioned.

Figure 2: Content analysis. Overall counts of mentions of men and women in national drug strategies



As such, we then conducted a critical policy analysis influenced by Bacchi's (2009) WPR approach. Bacchi's work on problematisation has its foundation in feminist policy analysis (i.e. Bacchi, 1999), and the method has been applied to drug policy in Ireland (Devaney, 2017), and elsewhere (Bacchi, 2018; Brown and Wincup, 2010; Duke, 2020; Lancaster and Ritter, 2014; Lancaster et al., 2015; Smith et al., 2022; Thomas and Bull, 2018), and other policy realms in Ireland (FitzGerald and McGarry, 2016; Swirak, 2016).

For Bacchi (2009:xii) policy analysis can be guided by six questions which identify how governments respond to problems and are 'active in the creation (or production) of policy "problems"' (Bacchi, 2009:1). The six questions are:

1. What's the problem represented to be in a specific policy or policies?
2. What deep-seated presuppositions or assumptions (conceptual logics) underlie this representation of the 'problem'?
3. How has this representation of the 'problem' come about?
4. What is left unproblematic in this problem representation? Where are the silences? Can the 'problem' be conceptualized differently?

5. What effects (discursive, subjectification, lived) are produced by this representation of the 'problem'?
6. How and where has this representation of the 'problem' been produced, disseminated and defended? How has it been and/or how can it be disrupted and replaced?

We focused our attention on questions one to four, as Bacchi (2009:10) acknowledges that not all of the six questions need to be addressed in every study. That is, we reviewed each document to identify how the problem is represented, or ignored as the case was. Indeed, WPR is interested in both what's written and policy silences. That is, the topics unattended to in policy documents.

Results

While not a national strategy, the influential 1996 Rabbitte Report set a foundation for future strategies, so was analysed. The report framed the 'typical heroin addict presenting for treatment' as a young male. It mentioned women[3] just six times across two paragraphs in reference to a submission by the Ruhama Women's Project, who reported a decline in women presenting for treatment against an increase in males presenting for treatment. The report assumed that declining treatment meant declining drug use by women.[4] It's instructive that Ruhama were the only third-sector organisation to mention women, as they are a support service for women involved in sex work.[5] The report did, however, acknowledge gender

[3] The words women and female were often used interchangeable in the strategies. We use the word women in this paper, instead of female, unless directly quoting from a document, as female 'focusses too narrowly on the reproductive system' (Norris, 2019).

[4] As drug use and binge drinking of alcohol was rising across Europe at this time (see Measham, 2002) declining treatment admissions may not have pointed to declining drug use. It's possible, instead, that use was increasing while treatment admissions were declining. It is also possible that barriers for women seeking treatment were also rising during this period.

[5] https://www.ruhama.ie/about-ruhama/

differences by reporting that a ‘higher proportion of female addicts are living with a partner and that partner is also quite likely to be an addict’, and then pondering whether ‘female addiction’ was ‘to a significant degree driven by personal relationships?’ (Ministerial Task Force, 1996:10). That is, women’s drug use was tied to their relationships with men. While some research supports this proposition (i.e. Azim et al., 2015; Shand et al., 2011), others highlight a more complex picture whereby, while romantic partnerships are important, women are introduced to drugs, or particular modes of ingestion, by friendship networks, including friends who are women (Taylor, 1993; Tuchman, 2015), and through the pursuit of pleasure (Measham, 2002).

The quantitative frequency of mentions in Figure 1 obscures important context. Ireland’s first national alcohol strategy, the 94 page 1996 *National Alcohol Policy*, mentions women 26 times. These were, however, limited to the risks of alcohol use during pregnancy and, to a lesser extent, brief mentions of concern about breast cancer and domestic abuse (Department of Health, 1996). Nonetheless, there was some acknowledgment of gender within other government publications around this time. That year, Ireland launched Local Drugs Task Forces in Dublin and Cork City ‘to ensure a fully integrated response to the drug problem in the worst hit areas’ (CLDATF, no date). A 1999 government handbook designed to support Local Drugs Task Forces acknowledged childcare as a barrier to treatment and called for the development of:

> … new or specific services to cater for the diverse needs of drug misusers (e.g. crèche facilities for single parents, residential drug treatment/rehabilitation centres where parents can bring their children with them, etc.) (Department of Tourism, Sport and Recreation, 1999:35).

This recommendation was included in the next strategy. The 144 pages of the *National Drugs Strategy 2001–2008* mentioned women 36 times. The summary 'of main points of drug misuse in Ireland' is important because it contained the information that the strategies writers wished readers to remember, and provided a foundation for the broader strategy. The summary reported that the 'majority of those presenting for treatment' are young unemployed males, and mentions women only once: 'there is a serious problem of poly-drug use, including heroin, among men and *women involved in prostitution*' (Department of Tourism, Sport and Recreation, 2001:49, italics added). Almost all mentions of women in the strategy were reports of trends found in empirical studies concerning prostitution (p.42), alcohol use (p.36-37) or the gender breakdown of the methadone waiting list (p.45). There were no gender-specific recommendations, outside of a proposal to:

> consider as a matter of priority … how best to integrate child-care facilities with treatment and rehabilitation centres and how childcare can best be provided in a residential treatment setting (Department of Tourism, Sport and Recreation, 2001:123).

At this stage, the Rabbitte Report and first two national strategies identified those presenting for treatment as working-class, young, men. Women were absent from the Rabbitte Report, the first strategy only mentioned pregnant women, the second provided some data on women's alcohol use, methadone treatment and sex workers, and recommended childcare provision. Some documents explicitly identified sex workers and parents as women but other mentions were more ambiguous. Gender can, however, be assumed as childcare and sex work were commonly identified as women's domains at this time (Connolly, 2014; Cronin, 2021; FitzGerald et al., 2020; McGinnity and Russell, 2008). That is, the early reports are silent on women while problematizing sex workers and mothers/pregnant women who use drugs.

In-between the 2001-2008 and 2009-2016 strategies, the government convened a Working Group on Drugs Rehabilitation, which identified differences between men's and women's drug use, and the need for gender-specific services:

> Female problem drug users tend to present later for treatment and can have significant concerns about the implications for their children of presenting for treatment. Partly as a result of later presentations, they tend to have multiple health problems, and they experience particular health problems in relation to pregnancy. They are often financially dependent on illicit drug using partners, and can have experience of domestic abusive relationships. All of these factors need to be taken into account when providing rehabilitation programmes for women (Department of Community, Rural and Gaeltacht Affairs, 2007:19)

The Working Group identified insufficient childcare access as a barrier to treatment, and proposed: 'drugs-related services, including residential services, should have access to an appropriate level of childcare services and facilities either on-site or elsewhere'. The Working Group also identified a risk that children could be stigmatised by attending childcare connected to services (Department of Community, Rural and Gaeltacht Affairs, 2007:42).

The Working Group recommendations did *not* feature in the next strategy. The 128 page *National Drugs Strategy (Interim) 2009-2016* mentions women just 15 times. Women were again only mentioned regarding trends in alcohol use, including a concern for increased binge drinking by women. There were *no* mentions of women using drugs nor accessing treatment or harm reduction services, and there were *no* gender-specific key performance indicators nor recommendations. The 2009-2016 strategies denial of gendered drug use represents a regression from a very low baseline.

Morton and colleagues (2020:3) argue that a 'policy shift took place in 2017' with the current strategy - *Reducing Harm, Supporting Recovery: A Health-led Response to Drug and Alcohol Use in Ireland 2017-2025* (Department of Health, 2017) - attending 'extensively to the issue of women and substance use'. Two of the 50 strategic action points, across five strategic goals, related directly to women (strategic actions 2.1.20, 2.1.21) and another two more general action points identified the need for 'gender specific' services (strategic actions 2.1.19, 2.2.25). All sit within the second strategic goal of minimising the harm caused by drugs and alcohol, and promoting rehabilitation and recovery. Strategic action 2.1.19 identified 'gender specific barriers' to treatment, including a lack of childcare provision. Strategic action 2.1.20 focused on the expansion of addiction services for pregnant and postnatal women, including the strengthening of cooperation between maternity and addiction services. This action called for 'additional residential placements for pregnant and postnatal women who need in-patient treatment', developing services to 'support the development of the mother baby relationship', 'examining the need to expand the role of the Drug Liaison Midwife'[6] and providing 'drug liaison midwives and specialist medical social workers in all maternity networks'. Strategic action 2.1.21 sought to 'respond to the needs of women who are using drugs and/or alcohol in a harmful manner' by developing 'interventions to address gender and culturally specific risk factors for not taking up treatment', and increasing:

> The range of wrap around community and residential services equipped to meet the needs of women who are using drugs and/or alcohol in a harmful manner, including those with children and those who are pregnant.

Strategic action 2.1.25 acknowledged the need for 'gender and culturally specific step down services' to support women at risk of homelessness transitioning from residential rehabilitation

[6] Corbett and colleagues (2023) provide a history and analysis of this service in Dublin.

treatment and increase. The report also identified the association between drug use and domestic abuse, and called for services to be ‘equipped to respond appropriately to this issue’, and identified a need for ‘greater awareness’ of the ‘implications of domestic violence, trauma and mental health for treatment and rehabilitation of women with addictions’ (Department of Health, 2017:42).

Wincup (2019:1) was critical of the strategy for framing women as vulnerable by ‘highlighting the barriers women face engaging in or sustaining involvement with treatment and rehabilitation services’. The identification of the need to address ‘gender specific risk factors’ (Department of Health, 2017:44) was, however, the first time that any Irish strategy identified the needs of women who were not pregnant, parents or sex workers. The strategy expresses much more attention towards women than previous strategies. The 110 page report mentioned women 45 times - three times more than in the previous report. This said, there are no women-specific performance indicators in the strategy, the needs of women in prison are unaccounted for and the majority of text is again given to the risks of substance use during pregnancy (see also Wincup, 2019).

The focus upon pregnancy has been *the* core women-specific theme across all alcohol and drug strategies since 1996. Supporting pregnant women who use alcohol and/or drugs should be a priority. Pregnant women *are* a vulnerable group, with unique needs. Decades of research has shown how prenatal substance use can have significant negative impacts upon the physical and mental health of the mother, and health and development of the child (Cleary et al., 2012; Corbett et al., 2023; Oei, 2020; Popova et al., 2017). The extent of harm depends on type and quantity of drug(s) consumed, and various genetic and environmental factors. For example, however, opioid dependence during pregnancy has been linked to:

> …a six-fold increase in obstetric complications, such as low birth weight, toxaemia, third trimester bleeding, malpresentation, puerperal morbidity, fetal distress and meconium aspiration. Neonatal complications include neonatal abstinence syndrome (NAS), postnatal growth deficiency, microcephaly, neurobehavioural problems, increased neonatal mortality and a 74-fold increase in sudden infant death syndrome (Minozzi et al., 2020:7).

As such, the issue is not the inclusion of pregnant women in drug strategies, but the exclusion of non-pregnant women.

Figure 3 summaries how successive Irish drug strategies have accounted for women, and the key issues. Early strategies almost completely ignored women who were not pregnant, and focused almost exclusively upon men who problematically consumed drugs and alcohol. Later strategies begun to consider the needs of parents accessing drug treatment. While women are seldom specifically mentioned as parents, this was implied when placing the strategies within the context of the patriarchal family structures inherent in Irish society (Cronin, 2021, 2023; McGinnity and Russell, 2008). Indeed, analysis of British policy has shown how fathers are seen as ‘largely irrelevant to the parenting and child welfare agenda’ (Whittaker et al., 2020:181; also Flacks, 2019) and consistently ‘constructs parental drug use as a woman's “problem”’ (Wincup, 2019:5).

The modest gains from 1996 onwards were met with regression in the 2009-2016 strategy, which almost completely ignored women. The 2017-2025 strategy was a milestone, with greater acknowledgment that women have individual needs separate from men and included gender-specific recommendations. There were, however, notable gaps. Arguably the most pressing was the lack of attention to women who have been imprisoned. Women in prison, or recently released from prison, have different needs to their male counterparts (Grace, 2017).

That is, taken together, the national strategies between 1996 and 2024 present drug use within pregnancy and, to a lesser extent by sex workers, as *the* problems. The strategies are largely silent on women who are not pregnant, mothers or sex workers.

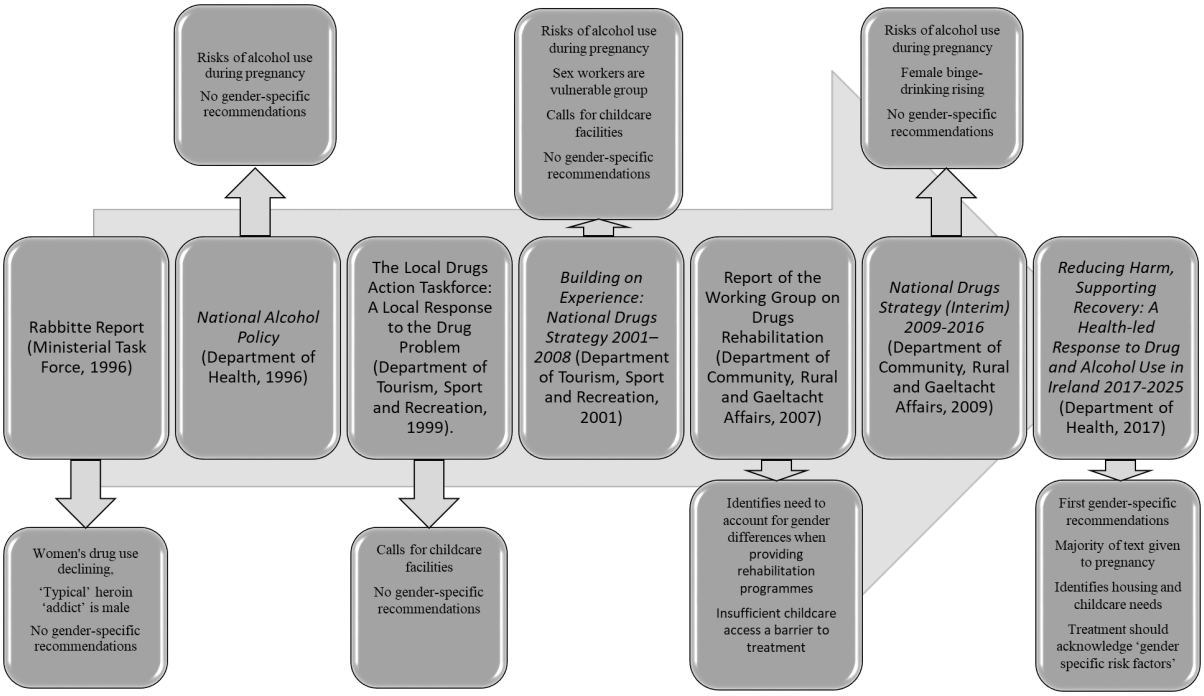


Figure 3: The development of Irish drug policy

Discussion: The past and future

Morton and colleagues (2020:3) frame the pre-2012 Irish drug strategies as 'relatively gender-neutral'. This may be a kinder way of saying that the pre-2012 strategies were patriarchal – drug use was often shorthand for male drug use. Until 2017, women only really featured in government publications on drugs or alcohol as mothers, expectant mothers or sex workers. Part of this denial of women's drug use may be due to societal constructs whereby women were not expected to consume drugs, or become intoxicated, and those who did were considered 'doubly deviant' (Grundetjern, 2018; Measham, 2002; Seaman and Lynch, 2022). There is a further embodiment issue at play as women who consume drugs are seen as even more deviant when selling their bodies for sex, are pregnant or mothers of children (Ettorre, 2004; Taylor,

1993). Indeed, Macaulay (2020:23) notes the pervasive gendered expectation that women will be mothers and ‘the flipside of the mother and wife is the sex-worker’.

In 2023, Ireland held a Citizens Assembly on Drugs, partly to inform the next national drug strategy. Several experts highlighted the particular and unique needs of women living with addiction. Two key themes emerged from two panel discussions. The first was the need to increase the number of treatment centres designed to address the ‘complex needs’ of women, including domestic violence and childcare (Citizens Assembly, 2024:65). The second was the observation that women who use drugs suffer ‘additional stigma’, especially if they are mothers (Citizens Assembly, 2024:74). Participants who spoke specifically about gender included two women with lived experience of addiction, a representative of SAOL (Women’s Recovery and Education Project), and Jim Walsh, the Principal Officer in the Department of Health Drugs Policy and Social Inclusion Unit, who proposed that the next iteration of the National Drugs Strategy should take a more ‘gendered perspective’ which considered the unique needs of women (Citizens Assembly, 2024:54). While it may be imprudent to predict the content of the next strategy, such public pronouncements from an influential drug policy actor (see Stevens, 2025) may provide cause for hope. Especially when coupled with progression in Ireland’s gender politics since the 1990s (McCarthy, 2023).

Drug policies are never formulated in a vacuum, and seldom only about drugs. Drug policies often reflect wider social and political issues (Windle, 2016, 2018). Drug policy actors are often influenced by personal values and political ideologies (Stevens, 2025) and, react to periodic crises and anxiety (Ryall and Butler, 2011; Windle and Murphy, 2022) when fitting ‘pre-existing bureaucratic and cognitive structures and interests’ (Stevens, 2021:12). As Irish drug policy cannot be separated from the countries wider patriarchal culture, placing Irish drug strategies in historical context may explain some of the problemitisations, and silences, found in the documents reviewed. After the initial denial of women’s drug use, strategies began

focusing almost exclusively on sex work and pregnancy. This narrow focus may reflect the centrality of the nuclear family to Irish culture and the historically strong influence of patriarchy in Irish society (Connolly, 2014). Sex work and substance use were perceived as contrary to 'ascribed notions of femininity and motherhood' (Buxton et al. 2020:1), depending on the type of drug consumed, mode of ingestion and stage in the life-course:

> For drug users, reproduction becomes a complicated body issue because drug use is not seen as conducive to making babies or even supportive of family life (Ettorre, 2004:331).

Women who defy socio-cultural norms by the type, quantity or frequency of substance consumed, or mode of ingestion, become topics of social concern due to the potential impact on capacity to procreate (see Cronin, 2021, 2023). A concern founded upon 'the assumption that women's bodies are being contaminated' by drugs 'and not worthy of reproducing' (Ettorre, 2015).

As such, it may be unsurprising that the last national drug strategy was published a year before the 2018 abortion referendum. This repealed laws which had encroached upon women's bodily autonomy, limited healthcare choices and physical movement, and prioritised the foetus over the mother's health (see Field, 2018; Gilmartin and White, 2011; Mullaly, 2005). This follows Thomas and Bull's (2018:34) finding that Australian national drug strategies communicated that 'women matter by virtue of their capacity to reproduce' when 'the focus is on the role of women in producing children and the potential negative effects of drug use on this role'. Successive Irish drug policy strategies have been silent on women's drug use in general, while choosing to focus almost solely upon pregnancy. This communicates that the problem is not drug use by women per se, but the perceived threat of drug use to reproduction.

As the last national drug strategy committed Ireland to a health-led drug policy approach, women's drug use should be viewed as an element of women's health-care. Ettorre (2004) argues that gender-sensitive drug policies would acknowledge that men's needs and experiences have been privileged over women's. This is not unique to drug policy. Such gender-related inequity continues to be a concern across healthcare in Ireland and elsewhere. The relative paucity of women-specific research dovetails gender biases endemic in medical research. Women have historically been underrepresented in medical research and issues that mainly affect women (i.e. migraines, endometriosis) have attracted significantly less funding than conditions predominantly affecting men (Mirin, 2021; see also Galea and Parekh, 2023; Smith, 2023). In the UK, for example, just 'two per cent of medical research funding' goes towards 'pregnancy, childbirth, and female reproductive health' (Cawthera, 2023) and the Women's Budget Group (2024:4) have been critical of the underfunding of gynaecology services, pointing to a 'medical sector which overwhelmingly views the male body as the default in research, trials, medical training and public health campaigns'. The Royal College of Surgeons in Ireland (2025) has noted:

> Despite significant medical advancements, women's health remains under-researched and underfunded. Women experience unique health challenges across the life-course, yet many conditions remain poorly understood or lack tailored prevention, diagnosis and management strategies.

A 2019 report by the National Women's Council of Ireland found that many women face barriers to accessing healthcare, especially those unable to afford private healthcare and/or with minority status. They acknowledge several advancements in women-specific services, but note that there remains:

> A lack of awareness among health care professionals about the importance of sex specific differences in disease manifestation and response to treatment (Walsh, 2019:59).

For example, in Ireland, Windrim and colleagues (2024) interviewed 14 women experiencing abdominal pain who reported medical professionals dismissing and invalidating their pain, and that private healthcare costs are a barrier to treatment. Similarly, Lightbourne and colleagues (2024) interviewed 20 endometriosis patients who felt their pain was dismissed and expressed a general sense of being 'let down' by the healthcare system. They concluded that 'the under-provision of women's healthcare has been compounded' by 'two powerful, conservative influences': the Catholic Church's historical role in both providing healthcare and obstructing the 'provision of reproductive and sexual health services' and medical professionals resistant to the provision of universal public healthcare (Lightbourne et al., 2024:312). The defence of Ireland's two-tiered private/public healthcare system generates inequality as women are less likely than men to be able to afford private healthcare (Walsh, 2019). This shows that healthcare cannot be divorced from wider structural inequality in paid and unpaid work (see McGinnity and Russell, 2008).

Ireland's approach to women's drug use is consistent with its dismal history of reproductive health, and current approach to women's health in general. That is, women's drug use becomes a particular issue when it affects reproduction or parenting, rather than when it affects the health of women who use drugs. There are signs that women's healthcare is changing for the better, and being prioritised by government (see Walsh, 2019), but change is slow. Irish gender politics has liberalised and made great strides since the mid-1990s. It's likely that this will be reflected in subsequent drug strategies, however, this historical review has shown that drug policy developments are not linear. Limited progresses has been followed by regression.

Limitations and future research

Only so much can be uncovered from an analysis of drug strategies. A fuller picture could be uncovered through analysis of strategy consultations, parliamentary debates and interviews with key policy actors (see Stevens, 2025). Baachi's (2009) final two questions cannot be answered by documents alone. That which was left silent in the published strategies may have been articulated loudly in other documents, and by policy actors. There were likely many policy actors who lobbied strongly for more gender-sensitive policies, and other actors who pushed back just as strongly. Uncovering this history would add much to our understanding of how Irish governments have problematized drug policy and other areas of women's health-care in Ireland.

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