

12-2015

# Delivering health care to women who use crack : a Brazilian example.

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## Recommended Citation

Connors, Kristen, "Delivering health care to women who use crack : a Brazilian example." (2015). *College of Arts & Sciences Senior Honors Theses*. Paper 116.

<http://doi.org/10.18297/honors/116>

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**Delivering Health Care to Women Who Use Crack:  
A Brazilian Example**

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Submitted in partial fulfillment of the requirements  
for Graduation summa cum laude

University of Louisville December 2015

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### **Introduction: a Crack “Epidemic” in Brazil**

Years after fears of ‘crack babies’ rocked the US, crack is in the spotlight in Brazil, in the midst of its own ‘epidemic.’ The drug first emerged in Brazil in the 1990s, but was mostly limited to select zones in São Paulo, Rio de Janeiro, and Salvador. Now officials are preoccupied with an increase in prevalence since 2007, expanding beyond major cities and affecting the whole country. Brazil has used a public health approach to address crack addiction. In 2011, President Dilma Rousseff announced the allocation of \$2 billion dollars in funding for the program *Crack É Possível Vencer*, aimed at crack prevention and treatment (Forero 2013). While that program has a national agenda, distribution of funding has allowed varied localized responses.

In order to understand the local response to crack, I carried out ethnographic research in June-July 2014 in São Luiz, my pseudonym for a typical large city in the interior of São Paulo state. The region of has seen significant increase in crack use starting in 2009, with now more than 195 cities reporting to have a severe crack problem (Marchiote e Berti 2009; Brant 2014). As crack use has spiked, delivering health care to women who use crack has emerged as a challenge for both private organizations and health departments; however, providing service is complicated not only by the health issues this population faces, but also because many drug users do not seek care. Reflecting these concerns, São Luiz provides several interventions for women who use crack aimed to reduce structural barriers to care and mitigate stigmatization of drug use. At the time of the interviews, these interventions were the only of their kind; the municipality served as a model in the region, receiving calls for advice to replicate programs in other cities.

Drawing on the ethnographic case study in what follows, I examine how causal explanations for the health problems of female crack-users contribute to the limitations of health interventions. Interviews were conducted with medical personnel at various levels of care (community health worker, program outreach director, public health nurse, women's health nurse, and pharmacist) to understand the problem of health care delivery for women who use crack and interventions aimed to mitigate the challenges. Individualist explanations for female crack-users' problems contributed to the limitations of interventions, and even to practices that can disenfranchise and further marginalize the population at the center of such outreach. Certainly the intentions of practitioners are typically not malign; however I seek to demonstrate that social scientific analysis can help improve well-intentioned policy.

First, I consider the problem of delivering health care to female crack-users. Next, I provide the context of causal explanations of addiction and crack in contemporary Brazil. The case study follows and considers one municipality's efforts to improve health care delivery for female crack-users. In the analysis I demonstrate how the problem of delivering healthcare to female crack-users is explained by both individualist and structural explanations, and argue that only structural explanations are capable of addressing solutions to the problem.

### **Delivering Healthcare to Women Who Use Crack**

The use of crack is often associated with increased health problems, in particular, sexually transmitted infections (STIs), unplanned pregnancies, other infections, and malnutrition, (Lima 2000; Sterk 1999; Butters and Erickson 2003). Despite Brazil's provision of universal healthcare, healthcare delivery for women who use drugs is complicated due to patients' failures to seek care. This is consistent with findings of delayed and under-utilization of health care among drug users (Sterk 1999; McCoye et al. 2001; Ahern et al. 2007), including a Brazilian study (Faller et al. 2014). Structural barriers to care for drug users have been identified to include limited geographic mobility of patients and the hours and capacity of facilities (Cruz et al. 2013; Sterk 1999). Stigmatizing of drug users also contributes to a reluctance to seek care (Ahern et al. 2007).

This study investigates the problem of delivering health care to women who use crack in Brazil. Reducing both structural barriers to primary and secondary care as well as mitigating the stigmatization of patients is necessary to provide adequate and complete women's health coverage including prenatal care, services for family planning and sexually transmitted infections among other services. While scholarly work has identified barriers to care specific to female crack-users in Canada (Butters and Erickson 2003), patterns of utilization of healthcare and barriers among mostly male Brazilian crack-users (Cruz et al. 2013), there is currently a lack of study devoted to the barriers to care for women's health and evaluation of Brazilian intervention efforts to mitigate those barriers. To understand the problem, a specific context is necessary.

### Context

Users' failure to seek care consistently is one of the primary challenges to health care providers. What explains the failure? Several explanations are available. Of these, moral and biological explanations are reductionist and therefore insufficient.

Drug users have long been considered deviants for their behavior (Boyd 2004; Campbell and Ettore 2011). In a deviance explanation for drug use, the person is believed to engage in drug use because of their moral failing. Women in particular are affected by deviance explanations. Their drug use is considered a transgression representing "emblematic failures of gendered performativity," contributing to societal breakdown (Campbell and Ettore 2011:2; Boyd 2004:21). This makes women's drug use prone to moral panics. A "moral panic" is a term coined by Stanley Cohen (1972) to mean "[a] condition, episode, person or group of persons [which] emerges to become defined as a threat to societal values and interests." During a moral panic a drug is often perceived as causing increases in crime, such as in Brazil (Cruz 2014). Drug-using women are viewed as "willfully wayward... morally corrupt and deviant in socially unacceptable ways...contributing to an underclass of children who may become criminals," (Boyd 2004:22). The fear of the spread of anti-social, deviant activity justifies harsh criminal justice approaches to drug use. Despite its predominance, the deviance explanation now competes with biomedical explanation.

Increasingly the medicalization of addiction has altered the deviance discourse. Medical authority considers addiction a disease of the brain, and promotes replacing jail sentences with medical intervention in the form of drug therapy and hospitalization (Courtwright 2010; Campbell and Ettore 2011). Thus, biological explanations of addiction as a disease reflect the

larger medical and public health discourses based on the biomedical paradigm. At the most basic level the biomedical paradigm examines the individual for deviations from statistical normal functioning, called pathologies, which it then treats medically (Berman 2011; Campbell and Ettore 2011). Additionally, public health policies and healthcare providers advance a personal responsibility for health rhetoric by informing a population about health risks and expecting it to modify behaviors to avoid risks (Berman 2011; Lupton 1993;1999; Crawford 1980;2006; Ayo 2012).

Deviance and biological explanations of addiction are insufficient because they consider individuals separate from social relations and their environments. The belief that health can be achieved reflects the dominant view of individuals as autonomous agents. Accordingly, the onus to be healthy lies on the individual who is solely responsible for her health outcomes. One consequence is treating individuals as morally responsible for their (perceived) lack of health. Deborah Lupton (1993) calls the premise of such treatment “secular sin.” The scientific rhetoric is considered objective and neutral which conceals the moralizing of health and lifestyle choices (Metzl 2010). Therefore, while the medicalization of addiction is presented as a shift from an explicit deviance explanation, health behaviors in fact maintain an implicit deviance explanation.

Accounts of individual responsibility are pernicious because they distort reality. They are based on a false sense of personal autonomy that Berman warns is dangerously false (2011). Moreover, the personal responsibility rhetoric draws attention away from structural factors that reduce agency and perpetuate the social determinants of health (Lupton 1993;Berman 2011). As a “disease of the brain” addiction is individualized and “resistant to acknowledging the gendered, classed, racialized power differentials that structure the lives of drug-using women,” (Campbell

and Ettorre 2011:1). Therefore, only a structural explanation that examines the role of sociality, political economy, gender and racial oppression, violence, among other factors, can adequately provide an account for addiction. Thus, in order to understand the problem of healthcare delivery for Brazilian female-crack users, a structural context is necessary.

### **The Brazilian Context**

A national epidemiological study conducted in 2012 by the Oswaldo Fiocruz (2012) research group was used to identify demographic and behavioral characteristics of the crack-using population. Crack users occupy a marginal social position illustrated by low rates of educational attainment, and high rates of unemployment and homelessness (Fiocruz 2012). Moreover, of the roughly one million users accounted for, 80% of users were non-whites, male (78.7%) and young adults under the age of 30 (50%). Another study of patients seeking substance abuse treatment in Brazil found the population to have unemployment rates of 60%, higher than the national rate of 8% (Faller et al 2014).

The Fiocruz study also revealed information specific to women who used crack. While women and men rely on a variety of economic strategies, sex-for-crack exchanges and prostitution disproportionately affect women. Sex-for-drug exchanges are the primary strategy for 29.9% of women, but only 1.3% of men. Women also experience sexual violence at a much higher rate than men (44.5% compared to 7.0%).

Factors contributing to drug use were also included in the study. Curiosity to try crack or having obtained it easily accounted for the most popular reason to start using it (58.3%). Similarly, 26.7% of users attributed peer pressure as their motivation to try crack. The other reasons reflected using crack to cope with social and personal problems. 29.2% of users tried

crack as a result of family problems or sexual violence. 8.8% contributed starting to use crack to cope with a bad life or because they had lost their job (1.3%). These findings were consistent with anthropologist Clare Sterk's work with crack-using women in Atlanta (1999). This data suggests the current political economy has precipitated a climate in which crack is pervasive.

### *Brazil Since the 1990s*

Crack first emerged in Brazil in the 1990s after economic stagnation and high inflation in the 1980s. The period is characterized by increased unemployment and crime and a "generalized climate of fear, criminalization of the poor, [and] support for police violence" (Holston 2008; Goldstein 2001). The fluctuating economy steadied and began to improve after structural readjustments were implemented in the 1990s--marking Brazil's neoliberal period. Yet as the economy has grown, crises of capital and unemployment have been accompanied by a retraction of the state (Reid 2014: 171). The effects on the poor have been devastating.

Accompanying the improvements to the economy has been an increasingly precarious life for the marginal. Frequent unemployment and limited availability of jobs in the formal economy for low-income workers creates instability and "states of anxiety, desperation, unbelonging, and risk," for the poor (Millar 2014:34). Black women, who have historically faced discrimination, often are limited to domestic work (Goldstein 2001: 60,66). Beyond unstable employment, precarious life for the country's indigent is characterized by "multiple forms of insecurity that destabilize daily life: health vulnerabilities, makeshift housing, environmental hazards, debt, incarceration, and crime and violence," (Millar 2014:34; Biehl 2005: 21,50). While the poor are most vulnerable to current economic and public policies, middle-and upper-class sociophobia contributes to the justification of their exclusion (Biehl 2005:48).

It is in this historical context that crack has recently become widespread. Officials note a marked rise in use since 2007. As neoliberal policy has exacerbated the precarity of labor, organized crime has grown to offer one of the few alternatives to the low-wages, discrimination, and dehumanizing labor available to poor youth of color (Goldstein 2001; Bourgois 1997; Teixeira 2012). Well-organized drug trafficking that provides product for middle-class cocaine consumers has also led to the ubiquity and low prices of crack, feeding the demand.

### *Crack in Brazil*

Considering the US War on Drugs a failure, Brazilian officials have elected an alternative approach to drug policy replacing punitive action for drug users with public health interventions (Teixera 2012:58). The “*Crack É Possível Vencer*” program aims to eliminate crack through its focus on drug prevention and treatment.

In Brazil, public treatment for substance abuse is delivered through the Center for Psycho-Social Attention-Alcohol and Drugs (CAPS-AD). Inpatient and outpatient services are provided in treatment communities as well as hospitals depending on the severity of addiction and the state of the patient’s mental health (Faller et al. 2014). CAPS-AD functions as part of the larger Unified Health System (SUS, or *Sistema Único de Saúde*) which provides universal health care for all Brazilian citizens. SUS is characterized by its decentralized, neighborhood family health posts that provide primary care and referrals to specialist care. Additionally, state and municipal-level programs are carried out, varying the outreach for target “risk” groups.

Both the expansion of private health plans and the decentralization of the public health sector, which has focused on family and community primary care, have led the family to serve as the medical agent of the state (Biehl 2005:22,47). ‘Deviance’ can be treated with psychotropic

drugs, administered by the family, which became responsible after the mental health reform of 2001 (Biehl 2006: 46-47). Mental illness, degenerative disease, and addiction often pose too much of a burden on the family. São Paulo state legislation allows for compulsory drug treatment demanded by families of users and court orders (Globo 2013). Finally, in Brazil widespread abandonment not only by the state which underfunds social services, but also by the family, leads many marginalized to live on the streets (Biehl 2006).

### **Case Study: Crack and Healthcare Accommodations in São Luiz**

The proliferation of crack has led to the formation of “crackland” neighborhoods across the interior of São Paulo state. Newspapers in the region report on the spike in crack users seeking drug treatment and the opening of hospital beds to meet the growing demands. Women have since emerged as the focus of media attention. Sensationalist headlines such as “In the Maternity Ward for Women Addicted to Crack, Mom Gets High and the Baby Stays” and “Pregnant in Crackland” are accompanied by exposés of destitute black and brown bodies. This treatment of female crack-users conforms to Cohen’s definition of a moral panic. The media portrays the devastating effects of the drug, raising fears of the risk of users’ unintended pregnancies, and infants born addicted to crack. It calls for medical intervention.

The case study follows the implementation of public health programs in São Luiz, my pseudonym for a middle-sized city in the region. I selected the site after I spoke with a public official who told me congenital syphilis was running rampant. Crack using women purportedly were to blame. Their solution: a subcutaneous hormonal implant, known by the brand Norplant in the US, offered only to women who use crack and who are homeless. At the time of interviews this policy was the only municipal project to the knowledge of the administrators. In fact, they had received calls from other municipalities inquiring about its success and seeking a model for further implementation. As an ‘example’ model, I wanted to trace the institutional response to crack, the ways in which women who use crack experience reproductive care and how these women were perceived by health personnel.

São Luiz is a typical city in the interior of São Paulo. After coffee production was mechanized and came to play a smaller role in the overall post-industrialized economy, many of

the rural poor flocked to urban centers. The city exploded, more than doubling in population since the 1970s. This was in part the result of a public housing program implemented by politicians in the 1980s. Residents I asked could never quite agree on whose idea it was. The *periferia*<sup>1</sup> that emerged from pasturelands is now called Cidade Nova, or New City. It has the amenities of a mature neighborhood with shopping centers, factories, and health posts of its own. During my time there, modest houses and corner bars crowded the streets where people filled the sidewalks. Caught up in small talk with neighbors people sat outside drinking beers, eating, and smoking cigarettes. Despite Cidade Nova's prolonged expansion, zones remained unfinished spotted with construction abandoned but for the cows that crossed the streets.

While the history of economic development in São Luiz follows a common pattern for the region, the city is somewhat special for prioritizing health. Administrators were proud to link the city's public health programs and very high health outcomes as signs of the city's progress. Public health institutions in São Luiz include a public and several private medical schools, a leading regional public-private hospital, with several smaller ones, plus many health posts and health sector jobs. Additionally, the secretary of health<sup>2</sup> emphasized public health and outreach programs. This is made possible through allocation of resources to health projects. In São Luiz, about 22 percent of the municipal budget is spent on health, exceeding minimum of 15 percent required by federal law (Paim et al. 2011).

Crack's presence was quite visible in the city since many users smoke in public, consistent with the Fiocruz study. In the early evening, abandoned constructions serve as

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<sup>1</sup> A Brazilian term for a poor, distant neighborhood

<sup>2</sup> In Brazil, both the office (equivalent to department) and the director-level title are referred to as "Secretary of Health." In this case I am referring to the department.

common spots for people to share cigarettes, beer or *cachaça*<sup>3</sup>, and smoke crack. In one open field people had collected construction materials, a tarp, and an old couch to make a lean to. These squatted sites and makeshift shelters were referred to as *mocós*. Crack users also crowded under the extended awnings of mechanic shops on an industrial, commercial street that were abandoned after business hours. While there was no one present the day of our visit, I was told that on average nights fifteen to twenty people meet in the enclosure. We came across a few users gathered outside a large tent next to a recycling drop-off site. Since many crack users collect items for recycling as a form of income, it is a site that often serves for users to congregate to socialize and smoke.

Outside of Cidade Nova, many homeless gathered on the streets of a busy down town where residential areas have been rezoned for commercial use. Boutiques, language schools, upscale cafés, private doctors offices lined the streets on either side of the main boulevard. There were several religious homeless shelters and a special health outreach post for the homeless. I talked to several of the homeless when I shadowed the ambulatory health outreach that works with the homeless population. We mostly encountered men that day, some of whom were smoking crack. Of the few women we met with, one in particular appeared to be very high. The outreach worker who had given all the men about three condoms, gave about 15 to this woman, explaining that if she possessed them there was a better chance they would be used.

According to the health personnel, crack use has increased substantially in the past two years. The rise of crack was attributed partially to the fact that São Luiz is a center of prostitution and drug trafficking due to its role for commercial truck routes. The city's social programs that

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<sup>3</sup> Brazilian sugarcane rum

provide outreach to the homeless population were also considered factors that drew in homeless and crack users from the region.

As crack has become a more visible public health concern in São Luiz, delivering health care for the crack-using population has emerged as a concern for health officials. In order to study health outreach in São Luiz, I interviewed health personnel from different levels of care and conducted participant observation. At the Jardim do Sol neighborhood post (primary care) I spoke with a public health nurse, a pharmacist, and a community health worker (*agente comunitaria de saúde*). Additionally, I interviewed two nurses at the specialized women's health center (secondary care) and the program outreach director of the harm reduction program, with whom I also carried out participant observation. The interviews, conducted in Portuguese, lasted between forty-five minutes and two hours with questions that covered health and interventions for the crack-using population as well as questions on social roles and motherhood. The personnel had gained knowledge about the crack-using women through their own prior experiences as well as clinic interactions.

### **The Challenges of Delivering Health Care to Female Crack Users**

The most fundamental problem for providers is that many drug users do not seek medical care. When I interviewed health personnel their responses fit into three basic reasons: patients do not think they need medical attention, marginalization and fears of mistreatment, and institutional barriers to care. “They don't perceive a need for medical attention, especially prenatal care...They fail to care for themselves,” said one of nurses at the women's health center. The neighborhood post nurse echoed, “They don't think they need STI testing and don't take care of their health.”

Another factor contributing to a low use of health care is marginalization and fear of mistreatment. As a result of their marginalization, many crack users lose contact with public sector and social services. The community health worker explained, “They know they need to come, but they don’t. Why? Shame of society--they’re afraid of being exposed. They’re on the street a lot and come here thinking people will treat them poorly.” One nurse informed me that patients who use crack are usually dirty and smell badly. Living on the streets, they do not have regular access to basic hygiene. Women known for their crack use are accused of trading sex for drugs. When they sit in the waiting room they are stared at, made fun of, and insulted.

In addition to mistreatment by the general population, medical personnel can contribute to negative experiences in the health care setting. Studies indicate the role of primary care providers in furthering the stigma of substance abuse (Ronzani et. al. 2009). Additionally, women may fear mistreatment due to Brazil’s history of medical abuse, institutionalized racism in the medical system, and eugenic policies of compulsory sterilizations of poor and black women (Marinheiro 2006; Meloni 1996; Kalckmann et. al. 2007). As one nurse stated, “the biggest challenge of working with this population is to not gaze with judging eyes.” Moreover, respondents attributed patients’ fears of repression or the threat of child apprehension to the reluctance to seek care.

Institutional barriers affect crack users’ seeking of care. Health personnel expressed concern for how bureaucratic processes such as scheduling appointments, often more than a month away, can be burdensome tasks, especially for crack users. Additionally, when a patient receives prenatal care at a primary post they are sent referrals to specialists for exams, ultrasounds, and other specialized care. This means additional steps for the patients. All of these

interactions are complicated by the fact that patients may lack the necessary documents and identification to be seen. Further, anxiousness and paranoia, possible side effects of smoking crack, exacerbate the potential for bad experiences. When patients cannot be seen readily, as is often the case at the neighborhood posts, they leave, feeling too jittery, impatient, or marginalized to wait their turn.

Crack user's decreased utilization of health care is detrimental because of the health problems associated with crack use. These include malnutrition, STIs, and hepatitis, which can be spread by sharing a metal pipe that first burns the lips and then contact with the virus. These compound with general health maladies not addressed with regular primary care.

### **Program Sites and Accommodations**

Providing adequate and appropriate health care to the crack-using population is a priority for the secretary of health in São Luiz. Administrators have worked to provide female crack-users with accommodations and interventions at various levels of care including primary care, outreach, and a specialized women's health center.

#### *Primary Care at a Neighborhood Post*

The Jardim do Sol health post was a typical neighborhood primary care clinic. I entered into the dated building complete with some paint peeling. In the reception area, 20 or so patients filled the plastic seats--mostly women, some accompanied by children or older relatives. A few men also waited to be seen. The clinic had two small consultation rooms, offices, an on-site pharmacy and an area for triage and vaccinations.

Primary care accommodates female crack users by expediting their wait time. When a pregnant woman who uses crack enters the post, the receptionist alerts the administrator to

attempt to have the patient seen immediately. Public health posts are supposed to prioritize prenatal care visits, allowing patients to move up the wait list. This is especially the case for women who use crack. The aim of attending to this group first is two-fold: to accommodate the patient and to control the immediate social problem of the crack user's presence. Administrators do not want the patient's presence to cause a disturbance. The crack user represents the constant threat of causing a scene by growing impatient while waiting and disrupting other patients. I was told that some other patients leave or refuse to go to the post because they do not want to be in the presence of crack users they deem unsafe and morally unacceptable. The administration also looks to take advantage of the fact that the crack-using women were present. I was told that such women often make appointments they do not keep, and they even go missing so that community health agents cannot track them down.

This form of intervention, while perhaps with the good intention of alleviating the marginalization that occurs in the waiting room, often falls short because of a structural problem in the community health posts. The posts have one general medicine physician and one gynecologist, but the hours are not fixed. Thus, the gynecologist may not be present. As an administrator in the Secretary of Health explained to me exasperated, many doctors are on the payroll in three sectors. It is common for physicians to work simultaneously for a public community health clinic, an insurance group in their network practice, and also have a private practice. While it seems that these doctors are working extended hours, they are in fact often not present during their hours in the public sector. Finding their hourly wage inadequate, it is common for doctors to only work half of their scheduled time so that they are earning what they

think they deserve. This poses a problem for women who use crack. After the harm reduction team's long work of convincing them to seek care, the patients may not even be seen.

### *Harm Reduction Outreach*

The Municipal Center for Diagnosis and Prevention of STI/AIDS was created in 1992 as part of Brazil's response to the global AIDS epidemic. Brazil's National STI/AIDS Program has been given much attention for its aggressive universal coverage, strong multi-sectorial interaction with civil society, focus on human rights, and programs focused on both prevention and treatment (Levi and Vitória 2002). The decentralization of health care has also allowed states and municipalities to implement their own projects, while contributing to federal funds. The center provides free HIV testing in addition to providing various outreach programs directed at vulnerable groups. These include prostitutes, drug users, and homeless among other populations.

Rather than take an abstinence only policy, the center advocates for harm reduction programs. Workers leave drug users to make their own decisions regarding their use. Interviewees conveyed a message amounting to this: "Since you can't force people to stop using drugs if they don't want to, you might as well help them minimize the chances they will harm themselves."

One evening I observed the harm reduction community visit. As we walked up to an abandoned construction one of the health workers called, "*Salve*," a greeting typical in drug communities. At first no one responded, but finally a young man in his late twenties named Leo emerged. After a few minutes of small talk the workers asked if he wanted any supplies. Familiar with the offerings, Leo asked for water and condoms. The workers distribute harm reduction supplies, like cacao butter lip balm to keep crack users' lips from blistering and transmitting

disease. They also provide condoms, post-it notes for clean cocaine use, and water cups with an aluminum foil lid, to be used as a safer crack pipe or simply for hydration.

In addition to distribution of harm reduction material the health care workers provide medical counseling and health promotion information. They hope that teaching the users small strategies to limit harm will motivate them to manage their risks. After receiving the free condoms Leo proudly used the language of health promotion in explaining why he needed to use them and get tested regularly for STIs. “You can only know what you have if you have been tested. You can’t know what a lady has, so you have to always use a condom. They might think they don’t have anything, but if they haven’t been tested, they don’t know.” Leo was praised for his understanding and the distributed items served as rewards. According to the workers, he benefited from their contact and served as a success story. He was a client who learned to identify risks and practice self-management.

The program also served to rebuild institutional relationships with the marginalized. The goal was to create relationships with clients. “Drug users,” a worker explained, “don’t trust easily,” and are “hard to access.” To aid in the process of relationship building, interventions were carried out in the streets to avoid the power imbalances of clinical settings. In São Luiz, the harm reduction program workers were all afro-Brazilian residents of Cidade Nova. These workers were able to speak in the same register as the participants. Additionally, they had all used drugs, common for harm reduction program (Ratner 1993). Some workers had even smoked crack. This allowed them to establish credibility and to serve as examples of individuals who ‘battled addiction’ and won.

Harm reduction workers encouraged clients to seek medical care, then, helped to arrange medical appointments, and provided health counseling. Women were especially sought out by outreach workers. The staff explained that they tried to convince crack-using women to use permanent and semi-permanent family planning options available to them. The fact that many women did not have custody over their children was used as evidence to persuade the women to avoid further pregnancies. For those who were found pregnant, the outreach workers tried to arrange care, even driving the women to the specialized health center. The trust gained facilitates the relationship-building and plays an important role in bringing crack-users to seek medical care.

*Specialized Care: Women's Health Center*

To address the shortcomings of the primary health post, the specialized women's health center has been designated as the point of delivery of prenatal care for women who use crack and/or are homeless. The facility was brand new and not even open for services the first time I visited six months prior. I passed through automatic glass doors and entered into the air conditioned reception where 50 patients sat waiting with comfort in new plush chairs to be attended on my later visit. The building had state of the art ultrasound, bone density, x-ray equipment. While the gynecologist is not always around at the primary health post, the center had three consultation rooms for the several gynecologists on staff.

Community health workers and special intervention programs that provide ambulatory care, like the harm reduction program, often arrange appointments with family or bring in patients directly. Once arriving at the center, patients are ushered in by the receptionist. Nurses informed me that the entire staff has been specifically trained to work with this target population

group. This is important because as noted medical staff often contribute to the marginalization of women who use drugs. Training that seeks a humanized approach is important in realizing the role that medical staff play in the care of patients.

Another challenge for the women seeking prenatal care at the primary health post is that they need referrals and other appointments to have standard testing, ultrasounds, and more specialized procedures. Rather than schedule these appointments and hope that the women who use crack will show up, medical staff see to it that the greatest number of procedures are done in one visit. This includes making exceptions to send out lab work on off days, especially important given the high incidence of infants born with congenital syphilis reported by several nurses and administrators. Syphilis was attributed to crack users' low reproductive agency and failure to use condoms. Pregnant women who used crack also were considered at risk for spreading the illness to their fetus, thus requiring medical intervention.

Finally, the most controversial intervention the center provides is the expansion of contraceptive coverage to include socially funded subcutaneous implants for homeless women and women who use crack. These women are assumed to be incapable of using other more involved forms of contraception. That is, negotiating condom use is considered beyond their capacity as is remembering to take oral contraception every day, or coming in to the health post once a month for an injection. Therefore long-term contraception was considered more advantageous. Intrauterine devices are also inadequate because of the high risk of infection associated with multiple partners. The devices also require regular appointments for reexamination of their placement. Thus, the administration selected subcutaneous implants as an appropriate alternative for this population.

Once inserted in the arm through a small incision created by a physician, the implant releases small amounts of a form of progestin to maintain ovulation suppression and contraceptive efficacy that is approved for the duration of three years. At the time of interviews, this policy had been in place for about a year. While serious complications of the implant are not too common, most women experience irregular bleeding (Post 1994). Nurses explained that this poses a problem for women who exchange sex for crack. Their irregular bleeding is inconvenient and prevents them from working in some cases. Dissatisfied with the implant, many women wish to remove the device shortly after its insertion. This is a source of frustration for medical staff. One administrator complained about how once the implants were removed they could not be repurposed.

#### *Drug Cessation and Treatment*

Drug treatment and patients' failures with crack cessation emerged from interviews as a factor in the accommodations for crack-users. According to several nurses pregnancy can be a motivating force for women to enter into treatment and quit using crack. "A baby and the possibility of motherhood serve as a stimulus for change..." reported one nurse at the women's health center.

The drug treatment carried out through CAPS-AD consisted of drug replacement therapy and isolation at "tranquil" drug treatment farm outside the city. They had a meetings, activities, and health education for patients. Traditional drug treatment centers assume to have male participants so activities are androcentric, often focusing on traditional male skills, such as woodworking, or sports (Sterk 1999:141). To make women feel more welcomed CAPS-AD was implementing beauty workshops to address this problem. Unfortunately for many women who

enter drug treatment it is rare to overcome addiction. “Yet, even with the desire to be a mother, women don’t manage to quit during pregnancy,” a saddened nurse explained.

### *Program Evaluation*

Closing the interviews I asked personnel about positive and negative effects of their interventions with crack-using women. Answers varied, but generally the programs appear to be on the right track, but fall short of achieving the desired results. The positive remarks reflect the patients’ acceptance of care, opening up to institutional relationships, attempts to change one’s condition, and at the institutional level with providing an open space where staff care and are trained to deal with the population. Negative effects, however, include a lack of crack prevention, patient interest in material incentives and not in changing behaviors, child removal policies which result in distrust of medical personnel, refusal of future care, failure to address the needs of male users, and that ultimately many users continue in the same condition.

### Analysis

During the course of interviews, it became apparent that what was initially described as a single problem of providing adequate health care for women who use crack in fact comprised a set of more fundamental problems. These were 1), the failure to prevent pregnancy and sexually transmitted infections with appropriate contraception use; 2), the failure of crack cessation; 3), and the failure to seek care, especially prenatal care together warranted the special interventions for female crack-users. As was the case for causal explanations of addiction, health personnel provided a mix of deviance, biomedical, and structural explanations for each sub-problem. I discuss them in this order except for the second problem, for which the biological explanation precedes the deviance explanation.

#### **1.Failure to Prevent Pregnancy and Sexually Transmitted Infections**

The increased incidence of pregnancy and sexually transmitted infections among female crack-users has warranted special interventions and health care accommodations for the population, such as the goal to convince all female crack-users to use the hormonal implant. Health personnel's responses covered several components to women's failure to prevent pregnancy and disease.

##### *Deviance Explanations*

A deviance discourse produces explanations that suggest something about what type of person uses crack. The women's behavior both provides evidence of and is explained by their deviance. The clearest example was provided by the public health nurse who spoke of a pregnant woman who was still exchanging sex for drugs. Her expression revealed shock and disgust with just how far these woman would go for the drug. She appeared to believe there were inherent

moral flaws about women who chose to use crack thereby explaining their pregnancies. This was later elaborated when she was horrified by the possibility of these women ever being allowed to keep their children. “No, (sigh), I don’t even want to think about it.” Rather than explain the women’s position, this explanation does not offer any account of difference. Anyone who uses crack would be the type of person would be considered irresponsible and hypersexual.

### *Biomedical Explanations*

The health promotion activities operated under the assumption that when presented with information about the consequences of lifestyle risks participants will use this information to change their behavior. Leo, the example of a good participant, was able to evaluate risks and act to avoid them. For this he was praised. Similarly, personnel distinguished between prostitutes and crack-users who engage in sex either directly for crack or for drug payment. Prostitutes manage health risks by getting routine STI testing and come in to health posts for their monthly quota of free condoms. This contributes to the perception of their responsibility reflected in the ‘professionalization’ of prostitutes often referred to as “sex professionals” (*professionais do sexo*); however, the same level of respect is not given to women who use crack.

Failure to take information about contraception and consistently put it into practice was given as evidence of crack users’ need for (sometimes coercive, invasive) health interventions. Health personnel were disappointed and frustrated with patients who failed to act to avoid risk-behaviors after having been informed. The nurse at the neighborhood post elaborated, “They know what they should do [to avoid pregnancy/STIs], but even knowing they don’t do it.” Using a biomedical-individualist explanation, the failure to make ‘healthy’ choices gains a moralizing element which reflects the individual’s presumed lack of willpower, or character flaw for not

caring about her health. When I pressed her asking if this does not happen to other women, she conceded, “This is the case for many women, but more so for crack users.” Thus while not explicitly moralizing identified deviants, the biomedical explanation transforms a deviance explanation. Rather, the moralizing is implied in comments such as “they don’t care about their health.”

In addition to a lack of individual responsibility for one’s health, the failure to consistently practice “healthy” sexual behavior is also explained by a belief that the drug inherently produces certain effects due to its pharmacological characteristics. An explanation that accounts for crack-use the same without considering the context of its consumption can usefully be called “drug fetishization” (Campbell and Ettore 2011). Drug fetishization treats crack alone as the cause for women’s failure to use contraception and condoms. Unlike prostitutes, whose professional behavior reflects an avoidance of health risks, crack-users are too disoriented and desperate for the same self-management. One nurse stated, “With crack, they can’t manage or control themselves.” The community health agent informed me, “They use the whole day.” Female users were considered incapacitated and unable to understand the available contraceptive methods or to use them effectively. Someone informed me, “They don’t know what day it is.” These explanations contribute to the belief that the implant is the only proper birth control method for female crack-users.

### *Structural Explanations*

The dominant view treats the population of crack-users as indistinguishable assuming uniform drug use thus systematically overlooking difference. Drug fetishization is problematic and incomplete because it presents the drug as an agent and fails to account for the variability

and social context of drug use. Equally problematic is holding individuals responsible for their health outcomes and ability to realize healthy behaviors without considering constraints on agency. While clearly drug use contributes to why female crack-users fail to prevent pregnancy and STIs, only a structural explanation can provide a complete account. The dominant caricature of women who use crack fetishizes the drug. It portrays all crack users as desperate, lacking self-control, hypersexual, and thus, compelled to engage in sex acts (Boyd 2004). This assumption conceals the reality that crack is largely ineffective as an aphrodisiac; women and men experience decreased libidos and impotence as a result of crack use (Sterk 1999:85; Lima 2000). Additionally, a fetishizing account is subject to ideology and compounds with historical attitudes that portray afro-Brazilian women as hypersexual (Caldwell 2007; Goldstein 2001).

Some personnel rejected an individualist view when explaining that an individual's agency and ability to manage herself is affected by her situation. The community health agent differentiated between those who could manage or get by with their drug use and those whose use was considered problematic. "[Autonomy] depends on each person, their use...Some are more aware (*orientadas*) than others." The pharmacist also explained that there were some women who, even using crack, manage to arrive on time to pick up their contraception refills. This counter example to the dominant view demonstrates the incompleteness of considering the entire population as incapable or chooses not to use contraception. Perhaps this can be attributed to his experience administering contraception where he encountered the patients who did manage to use contraception whereas most nurses only attended to women seeking prenatal care--already pregnant.

These perspectives were consistent with two studies of crack-users that revealed variation among users. Anthropologist Lima found from ethnography conducted with female crack users in São Paulo that many users do not consider themselves dependent or “dominated” by crack because they take measures to regulate their use (2000:72-74). Another Brazilian study compared the executive functioning among crack-users and found that those who had not experienced physical neglect as children were far more capable (Viola et al. 2013). This study is significant for exposing the differences within a population rather than just comparing between user and non-user groups.

It is possible that personnel had a nuanced understanding of gender and recognized structural violence and the women’s oppressed social position; however, many responses tended to naturalize women’s weakness and submission, reflecting a patriarchal ideology. For example, “Crack is dangerous for women. They’re more vulnerable,” and, “Women are more delicate.” These reflect the need to monitor women because they cannot do so for themselves and need controlling.

A better explanation for female crack-user’s failure to use condoms and other contraception considers structural factors that constrain women’s agency. Additionally, a structural explanation can include a more comprehensive characterization of female crack-users to contest reductionist stereotypes that contribute to the women’s stigma. Fetishization of crack in which women are hyper-sexualized furthers the idea that every woman exchanges sex for crack. In fact, Lima was surprised to discover the variety of economic strategies employed by women including begging, recycling, theft, trafficking, selling condoms, selling candy, items donated by charity or stolen, in addition to or exclusive of selling or trading sex (Lima 2000: 68,

80). Additionally, a structural explanation can avoid a false dichotomy between prostitutes and female crack-users who exchange sex for drugs. Sterk revealed that many women who use crack were prostitutes who began using crack to cope with their violence (1999).

One nurse challenged the idea that crack using women operate as autonomous, individuals. Instead, she said that the women live depending on the decisions of the others with whom they interact, particularly their partners. This poses a problem for women when men are ambivalent or resistant to condom use. The harm reduction director's response illustrates this, "Men are not interested in using condoms." Because condoms are worn by men, the negotiation of condom use is heavily affected by unequal power relations in heterosexual relationships. Financial dependence on a partner and social norms of male dominance can constrain a woman's agency (Lorber and Moore 2002:121-122). Another nurse explained, "They [female crack-users] are submissive to a partner or a drug dealer; their desires don't predominate. They suffer violence and the drug diminishes their decision making." Several personnel responded with examples of gender-based violence. "These women are abused by their partners. There are fights over the crack pipe. Sometimes their dealers beat them." Also, as the Fiocruz study shows many women who use crack had been sexually assaulted and raped (2012). This clearly represents constraints on agency. Rather than treat individuals as the same, a structural explanation considers how economic, racial, and gender-based oppression constrains women's agency.

Such a structural explanation is also needed to understand why female crack-users and their infants have such a high incidence of syphilis. Explanations that describe these women as deviants who keep engaging in sex even after they are pregnant or that the drug makes these women hyper-sexual contribute to the perpetuation of the problem by focusing on the women as

individuals. Unfortunately, many women are recontaminated because their partners are not treated. A nurse told me, “Their partners never come to prenatal visits.” The role of care is viewed to be exclusively that of the mother. The male partner’s responsibility is disregarded. A structural explanation could help provide better treatment by identifying the role of her partners and focus treatment on all of the women’s partners, rather than treat her as an individual.

## **2.Failure with Crack Cessation**

For many female crack-users a pregnancy, while not necessarily desired, can serve as an impetus to reduce their drug use and even enter drug cessation treatment. Unfortunately, many women are unsuccessful in their attempts. In addition to personal feelings of failure, women who do not manage to quit their crack use are also faced with the consequences of child apprehension policies where they are unable to leave the hospital with their infant. Personnel gave varied explanations for why women fail to quit using crack despite the initial enthusiasm.

### *Biomedical Explanations*

In biomedical explanations, the drug itself is perceived to cause the devastating conditions associated with crack-use. One nurse expressed that there is largely no hope for drug users, claiming that crack is too hard to overcome. The public health nurse shared the story of a lawyer who became homeless after using crack. This case was used to contrast the typical poor crack user and illustrate how crack was so harmful that it stripped even a professional woman of her autonomy.

There is little to no agency attributed to the addict. Only therapeutic drugs could restore normal brain function and eliminate addiction. As Courtright explains, when individuals fail to quit, individual explanations are given such as who is simply biologically predisposition to

addiction or brains that are too altered to recover from a pathological state (2007). In this case, “addiction is not a matter of personal choice but a disease that is beyond the drug user's control,” (Campbell and Ettore 2011).

### *Deviance Explanations*

Regarding the failure to quit using drugs, a biomedical explanation cannot fully be separated from a moralizing deviance explanation. One implication of the biomedical explanation is that if drug treatment fails to restore brain function, there is no hope for recovery. Then, the choice to use crack in the first place is entirely blameworthy. Personnel expressed the problems of crack as matter-of-fact, fetishizing the drug. Several nurses' responses reflect the destructive narratives, but of the poor women, typically associated with crack. “They abandon their jobs and school. They already have children, but they don't live with them,” and, “They abandon their families and isolate themselves.” All of the problems associated with crack were considered foreseeable. They also showed how crack was seen as the problem keeping these women from fulfilling productive roles, and keeping them from getting out of their unpromising situations. Since there appeared no real chance at recovering, choosing crack was not only considered a poor health decision, it was essentially equated with deviance and moral failure.

If women are condemned for abandoning their families because of their drug use, could they be absolved of the ‘crime’ if they chose to keep their children? When I asked this question, the public health nurse was horrified because this seemed so obviously impossible. One nurse at the women's health center stressed the need for drug treatment. “First she [female crack user] must change her situation before she's able to keep the children.” But as previously mentioned, treatment is often ineffective. This is problematic for women who hope to keep their child. Child

apprehension is a foreseeable consequence of crack-use. Considered nearly impossible to quit crack, if women ever want a family, they should avoid this risk of crack use entirely. Their choosing crack use (and failure to quit) gave evidence of their moral lacking an ineptness to parent.

### *Structural Explanations*

Medicalization of addiction supports drug treatment as the sole cure for addiction by treating the individual diseased body in an isolated facility. Unfortunately, treatment is often ineffective. This individualist disease discourse does not consider the reasons why people may start using drugs; instead, it focuses on avoiding bad, risk behaviors. Nor does this approach consider the context of drug use. When an individual's failure to quit is perceived as reflection of her character rather than constraints on agency, structural problems of treatment are concealed and even ignored.

Rejecting an explanation that fetishizes crack, some medical personnel attributed the cessation failures to the limitations of the programs and patients' lack of sufficient social support. The pharmacist offered, "Many people avoid going because they don't want to be seen by others. They are embarrassed, especially women who are in the presence of men they know." This is consistent with limitations to drug therapy for female crack users in Atlanta discussed by anthropologist Claire Sterk (1999). She explains users are typically imagined to be men due to normative gender roles that make women's drug use more problematic. Consequently, there are many programs and facilities for men and few that accept women, let alone provide separate programs and spaces for women. The women she interviewed said to have been harassed by

male participants and program staff, facing more severe scrutiny than the male participants (ibid).

When there are spots available for women, geographic barriers or wait-lists often deter women seeking treatment (Sterk 1999). Many women lose the motivation or simply fail to abstain in the time lapse between deciding to enter and when they actually are admitted. In São Luiz the demand for treatment and the bureaucratic steps required for admittance result in a wait time of 20-30 days. The public health nurse explained, “Patients become ambivalent, discouraged. They don’t like to wait or ask for help. With pregnancy, they are happy and stop using, but they... give up.”

Additionally, drug treatment works at treating the individual without regard for her social relations. One nurse pitied the women in treatment, “They are so lonely, all alone without the support of family. That is why they abandon the facility. They have service, but it is insufficient.” Due to traditional gender roles female patients are often exhorted to enter treatment in order to be stable enough to provide for their families (Campbell and Ettore 2012:179). However, this puts them in a bind because children and dependents cannot come so a woman must choose between entering inpatient care and neglect or forgoing treatment (Sterk 1999:133). If they do select treatment they must find alternative supervision for their dependents.

A structural account for failure of drug cessation also examines the environment of crack use. The rigid schedule of structured activities in treatment is incongruous with most user’s lifestyle of living on the street (Sterk 1999:137). The harm reduction coordinator told me these users “are on schedules of their own,” consistent with an alternate sense of autonomy described by anthropologist Kathleen Millar (2014) where people in the slums of Rio preferred control of

their time to fixed employment. Further, for those who manage to remain abstinent for the course of the inpatient program, relapse is common because drug treatment does not provide an effective strategy for users who return to the same environment where crack is ubiquitous. The drug operates as a vehicle for sociality, similar to coffee or cigarettes, and is simply part of life on the streets where drug users find inclusion (Boyle and Anglin 1993:172; Lima 2000:76).

The community health worker also lamented that there was not a drug treatment facility that offered longer periods of therapy. As a product of the medicalization of drug addiction, biomedical treatment is viewed to be the most legitimate way to cure addiction; however, the limitations create incredible obstacles for those seeking drug treatment. Reflecting neoliberal demands of efficiency and austerity, two weeks of inpatient care is supposed to be sufficient. Even in a perfect drug treatment that accounted for holistic social realities, forming habits (and especially breaking habits already formed) takes time. The community health agent lamented there was not a longer treatment option available.

Considering these limitations, there are many reasons why drug therapy fails to cure addiction. Rather than consider treatment ineffective the individuals charged with non-compliance and reverting to poor choices. Those who cannot be 'reborn' with self-control and health-consciousness through medical salvation, are viewed to be certain lost causes, incapable of change.

### **3. Failure to Seek Care**

The accommodations made for female crack users in São Luiz have the intention to provide better access to health care. Health personnel provided different explanations to why despite a variety of efforts, many women still did not seek primary care, especially prenatal care.

*Deviance Explanations*

Health personnel believed prenatal care was an obligation of their patients. The community health agent furrowed her brow disapprovingly and told me, “They don’t come.” Similarly appalled, the public health nurse scorned women who wait too long to arrive at the hospital to deliver. She explained “Their labor cannot be monitored, and they’re too late for epidural and additional intervention.” Health care personnel were outraged. They attributed female crack users' failure to seek prenatal care to their apparent lack of regard for the fetus. This reflects how prenatal care has become essential to monitor the mother, perceived as posing a risk to her fetus as an adversary (1999). When women’s failure to seek care confirms their deviance and inability to care for their children, deviance can justify strict child apprehension and where fetal rights have advanced criminalizing the drug -using women.

*Biological Explanations*

Biological explanations do not offer much more than the deviance explanation for women’s failure to seek prenatal. The specialized women’s health nurses gave similar accounts: “They don’t care about their health;” and, “They fail to care for themselves;” The neighborhood post nurse echoed, “They don’t think they need STI testing and don’t take care of their health.” These responses portray avoidance as an active choice to ignore health problems. Under this view, those irresponsible for their health present evidence of their lack of deservingness.

Additionally, personnel explained patients’ perception of reality was altered because of crack use. Drug fetishization provided an explanation that reduces the problem of women’s failure to seek care to the effects of the drugs. “They don’t perceive a need for medical attention, especially prenatal care.” When recounting of a woman who had a baby shower, the nurse was

dismayed by how the user could fathom gaining all these presents knowing the outcome of separation that likely awaited her. “The women are delusional if they think they can keep the their child.” If this were the case, nothing more than abstinence could be done to improve care, concealing factors insufficiently addressed by interventions.

### *Structural Explanations*

Structural understanding provides more than individualist explanations. One reason women may not seek care is that they may not recognize their lack of menstruation as caused by pregnancy since female crack users often experience amenorrhea due to their malnutrition and weight loss (Sterk 1999). Another cause for reluctance to seek care is the fact that women may be ambivalent about their pregnancies. Personnel explained that nearly all pregnancies were unplanned, yet, in Brazil abortion is illegal and only available to those who can afford a clandestine procedure. This can make prenatal painful for women who are unhappy or whose pregnancy resulted from violence.

The requirement for abstinence also contributes to some crack users’s failure to seek prenatal care. Harm reduction programs are widely accepted because users decide for themselves when or if to quit. This approach helps outreach workers gain acceptance from users whose lifestyle is not under direct scrutiny. Yet, when pregnant women enter prenatal care after encouragement from outreach workers they are faced with personnel who exhort abstinence, explaining the harm crack poses to the fetus.

Additionally, abstinence and prenatal care may seem unnecessary due to women’s experiences. The nurse spoke of a patient who smoked throughout her pregnancy before giving birth to an apparently healthy baby. This diminishes the perception of significant harm. The nurse

was disappointed that the reality of the birth did not match the risk she was trying to convey to her patient and undercut the medical authority. Fetishizing crack obfuscates contestations of the dominant view according to which crack is an obvious harm. While caffeine, nicotine, and tobacco are proven to have deleterious effects on fetal development, evidence of crack's harm to the fetus is not so obvious (Boyd 2004). Longitudinal studies of children exposed to crack during pregnancy show that on various selected outcomes such as longterm health, educational attainment, those exposed to crack fared normally with their peers who were not exposed (FitzGerald 2013). The reality of growing up impoverished in violent neighborhoods proves to be much more an indicator of life outcomes.

Child apprehension policies play a significant role in women's reluctance to seek care. The nurses explained that most women who are known to use crack do not leave the hospital with their newborns. These child removal policies along with restrictive birth control practices prevent women who use crack from full social participation by denying their reproduction. Campbell and Ettore (2012) use the concept of reproductive loss to describe how some women are robbed physically, metaphorically, or legally of their capacities for biosocial reproduction (157). As 'unfit' parents, the loss of a child further contributes to feelings of isolation and loss. Some female crack-users try to have another child to replace those removed (Sterk 1999:108).

When health personnel described female crack-users who had another child after apprehension or because she desired to conceive with a new partner these decisions were not recognized as legitimate choices. Rather they were given as evidences for why this group needs intervention. Campbell and Ettore argue that rather than be viewed as symptoms of addiction and loss of control, these behaviors are "rational responses to extraordinarily persistent social

stigma faced by pregnant drug users,” (2012:180). This illustrates that as social persons, crack users aspire to live a normal life of motherhood which they are denied. When evaluating the interventions in São Luiz, nurses explained that the practice and threat of reproductive loss contributed to increased mistrust of the medical institutions, concealment of pregnancies, and resistance to prenatal care in future pregnancies. Thus, reproductive loss as part of a structural explanation is necessary to understand female crack-user’s failure to seek prenatal care.

Women’s failure to prevent pregnancy and STIs, quit using crack, and seek care outlined in the analysis contribute to the greater problem of delivering health care to women who use crack. Health personnel presented deviance, biomedical, and structural accounts for these primary problems. Responses that drew on individualist explanations, such as those that included drug fetishization or individual responsibility, were incomplete, failing to account for variations in crack-users’ consumption patterns, social relations, and living environments.

An inadequate recognition of female crack-users’ constraints on agency not only perpetuates incomplete and false stereotypes of the women, it also obfuscates contestations to those portrayals. Further, they promote paternalist and coercive health care policies that deny some women’s ability to care for themselves. However, responses did not fall systematically under one type of explanation. While personnel often gave individualist explanations, which were inconsistent, they also offered more structural understandings, reflecting the partial, incompleteness of the individualist explanations. Often the same person provided both individualist explanations along with structural understandings, demonstrating they were not fully captured by ideology divorced from social reality.

### **Conclusion**

In Brazil, providing adequate health care to female crack-users has emerged as a challenge stemming from the proliferation of crack cocaine. Stigma and institutional barriers to care, especially prenatal care, are of particular concern for women. In an effort to better understand a local response to the problem, this study examined the public health sector in São Luiz, São Paulo. Accommodations for female crack-users were implemented through outreach, primary and secondary levels of care to establish trust, minimize institutional barriers, and reduce the stigmatization of patients seeking care. These well-intentioned efforts produced mixed results. Outreach programs, expediting care at the women's specialized health center, and sensitivity trainings are all exemplary efforts for a community health program; however, there were limitations to delivery of care. The interventions were insufficient to address women's failures to prevent pregnancy and STIs, quit using crack, and seek prenatal care.

In order to deliver better health care to female crack users, health personnel need to adopt a structural understanding to the problems associated with the population's health. The predominance of deviance and drug fetishization causal explanations contributed to personnel's ignorance of the condition of their patients and a lack of recognition to ways in which the program failed to address their needs. Instead, a structural explanation accounts for limitations to intervention rather than ascribe culpability to patients. For example, recognizing women's mistrust of health personnel and the patients' social relations as contributing to failure to prevent pregnancy and disease and to seek drug treatment can help improve interventions. The good news is that structural explanations were not foreign to health personnel, though they do tend to be overshadowed by individualist explanations.

Failing to adopt a structural account of crack is not merely a question of theoretical orientation; it has moral consequences for the lives of female crack-users. Media depictions of crack attribute increases in criminal activity and violence to crack and crack-users. The recent increase in these unidimensional portrayals has furthered the stigmatization of women who use crack in Brazil (Romanini and Roso 2014). Individualist accounts of crack present women as undeserving rather than attempt to understand how their existence is conditioned by constraints on agency, illustrated by the fact that most women who use crack are poor, afro-Brazilians who have experienced sexual violence. This has serious consequences for health of female crack-users. A structural explanation reveals that a complete solution to the problem requires more than just health care. As epidemiologist Francisco Bastos remarks, drug policy must address structural violence if it is to make strides (2012). Female crack-users need services for sexual abuse, more economic and educational opportunities, and efforts to combat gender violence, and racial oppression. Overlooking these factors due to reductionist accounts not only maintains, but actually perpetuates harm to the most marginal.

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