SALUD COLECTIVA. 2020;16:e2517. doi: 10.18294/sc.2020.2517

Drug policies in the Brazilian context: an intersectional analysis of "Cracolândia" in São Paulo, Brazil

Políticas de drogas en el contexto brasileño: un análisis interseccional de "Cracolandia" en San Pablo, Brasil

Ana Lucia Marinho Marques[1], *Marcia Thereza Couto*[2]

[1]***Corresponding author***. *PhD in Collective Health. Occupational therapist, Faculty of Medicine, Universidade de São Paulo, São Paulo, Brazil.*

[2]*PhD in Sociology. Postdoctoral Degree in Collective Health. Professor, Department of Preventive Medicine and Postgraduate Program in Collective Health, Faculty of Medicine, Universidade de São Paulo, São Paulo, Brazil.*

ABSTRACT From the analysis of a specific conjuncture, "Cracolândia" in São Paulo, Brazil, and the "De Braços Abertos" program, this article discusses the complex relationships between drug use and the formulation of public policies directed to the care of users. In methodological terms, this work is based on the qualitative research by using semi-structured interviews with thirteen key informants. The empirical material was analyzed from the content thematic analysis and the intersectionality perspective, especially from the theoretical contributions of the "difference" category. The results point out that "differences" are marked by gender, race and social position in the society, reinforcing stigmas and their different impacts on social relations. This paper contributes to the debate on the need to formulate different approaches to the specific needs and demands of populations or social classification categories regarding drug public policy.

KEY WORDS Public Policy; Public Health Policies; Harm Reduction; Crack Cocaine; Intersectionality; Brazil.

RESUMEN A partir de un contexto específico como es la zona de "Cracolandia", en San Pablo, Brasil, y el programa denominado "De Braços Abertos", este artículo analiza las complejas relaciones que se establecen entre el consumo de drogas y la formulación de políticas públicas dirigidas a la atención de usuarios. En términos metodológicos, el trabajo se basa en una investigación cualitativa, en la que se realizaron entrevistas semiestructuradas a trece informantes claves. El material empírico se analizó desde el análisis temático de contenido y desde la perspectiva de la interseccionalidad, a partir de las contribuciones teóricas de la categoría de "diferencia". Los resultados señalan "diferencias" marcadas por género, raza y posición que los sujetos ocupan en el tejido social, reforzando los estigmas y sus diferentes impactos en las relaciones sociales. Este documento contribuye al debate sobre la necesidad de formular diferentes enfoques para las necesidades y demandas específicas de las poblaciones o categorías de clasificación social con respecto a las políticas públicas sobre drogas.

PALABRAS CLAVES Política Pública; Políticas Públicas de Salud; Reducción del Daño; Cocaína Crack; Interseccionalidad; Brasil.

SALUD COLECTIVA. 2020;16:e2517. doi: 10.18294/sc.2020.2517

INTRODUCTION

Starting in the second half of the 19th century, regarding the debate over drugs as a "social issue" for the State and society, and the resulting formulation of drug policies as a governmental field of work, several religious, political, economic, and moral factors, among others, have converged to create a complex fabric of forces and discursive productions. For this reason, these factors cannot be addressed in isolation.[1,2,3,4]

Drug policies are a set of regulations and programs influencing individuals' decisions regarding the consumption of psychoactive substances and intervening in the impacts and consequences of such consumption. Both are related to individuals' and communities' safety, health, and social welfare.[5] Babor el al[5] consider that current drug policies encompass a wide range of administrative measures which can be grouped into three categories: 1) programs directed toward prevention; 2) health and social assistance programs aimed at the health care of users; and 3) the set of regulations that forbid or regulate the use, possession, distribution, and production of certain substances and set forth penalties upon violation of such bans.

The current debate over drug policies in Latin America has led governments to reconsider the traditional approaches in this field, particularly those that only stand up for the reduction of supply to adjust interventions to the local cultures and dynamics of their countries and regional-specific issues.[6,7] This debate is based on the premise that the so-called "war on drugs," ruled by prohibition, regulation and suppression of use, trafficking, and production of certain psychoactive substances, not only failed but also caused, as the main consequence, a profound and widespread inequality reflected in the high social and economic cost arising out of the violence involved in the war against drug trafficking.[7,8,9] Several research studies reveal that the strategies focused on reducing supply have led to increased violence rates, resulting in an increase in homicide rates, corruption in institutions and state actors, a rise in the prison population, prison overcrowding, and human rights violations.[10,11,12] Understanding the impact of prohibitions and its effect on Latin America is essential for this region to build its own strategies and policies based on its local needs and knowledge to replace the coercive approach with an approach that values the building of social cohesion.[7,13,14] In this respect, the harm reduction approach should be highlighted; its main premise is based on the health perspective as the focal point of drug issues. In Latin America, the conceptual outlook of harm reduction has broadened, thus becoming an ethical-political field that considers of substantial importance both the intervention in the contexts in which people live and the need to reduce violence and inequalities triggered by the war on drugs, anchoring the debate on health care in the strengthening and guarantee of social and human rights. [6,9,15,16]

Against the internationally recommended guidelines based on scientific evidence, Federal Act No. 13840 of Brazil's National System for Public Policies on Drugs was passed in Brazil in June 2019. This act amends previous legislation and has been considered a regression, especially in terms of healthcare measures addressed to people who abuse alcohol and other drugs. Among the critical points, we would like to highlight both the refusal to acknowledge harm reduction as a healthcare approach and guideline, focusing on the presupposition that abstinence is the sole goal to be achieved through people's "treatment" and the central role of admissions as a strategy, with the adoption of executive orders that increase funds transferred to psychiatric hospitals and establish specific financing procedures for therapeutic communities.

In this respect, it should be highlighted that under a given medical discourse and the need for "treatment," segregation and isolation strategies favoring an increase in drug users' stigma and marginalization are repeated.[13,17] Furthermore, therapeutic communities have been considerably questioned as "treatment" and "rehabilitation" strategies

SALUD COLECTIVA. 2020;16:e2517. doi: 10.18294/sc.2020.2517

in Latin America. They have likewise been reported for the systematic violation of human rights through practices described as deprivation of freedom, punishments, penalties, public humiliation, contention, compulsory religious practices, and forced labor, among others.[18,19,20]

The purpose of this article is to discuss the context of formulation of policies addressed to crack users based on the analysis of "Cracolândia," area-territory generally named to describe a "drug use scene" where people buy and use crack in the streets of Luz, in central São Paulo. The analysis focuses on the development period of the *De Braços Abertos* (DBA) program, carried out between 2014 and 2017. In this sense, and regarding the sociopolitical context, it is crucial to consider the social significance attached to crack use in Brazil and the importance of bringing to light experiences and projects developed in the country aiming at addressing that issue with a comprehensive, balanced, and rights-based approach.

The analysis of the case of "Cracolândia" and of the policies formulated to address the issues that arise in that context is crucial to understand the complex relationships established between drug use, severe inequalities that characterize the Brazilian society, and the formulation of public policies directed to the health care of drug users. In this respect, and in the pursuit of an approach that helps understand the complex relationships among individuals, agents, structures, social markers, and institutions, the theoretical and methodological framework selected was intersectionality.

The concepts of "intersectionalities" or "articulated categories," often used as synonyms, are defined by this article as the relationships between "multiple dimensions and modalities of social relations and subject formations"[21] and the outcomes of the interactions – in terms of power – between categories and markers of differences in social practices, identities, and subjectivities, institutional arrangements, and cultural ideologies.[22]

The term "intersectionality" was first introduced in 1989 by the US attorney-at-law and feminist theorist Kimberlé Crenshaw[23] to "capture both structure and dynamic consequences of the interaction between two or more axes of subordination," and also in order to address how "specific actions and policies create oppressions along such axes, thereby constituting dynamic or active aspects of disempowerment"[24] [own translation].

Intersectionality has gained ground over the ensuing decades. It is considered one of the four perspectives that represent the third wave of feminism (together with poststructuralist and postmodern approaches, feminist postcolonial theory, and the agenda of the "generation of young feminists")[25] or even as "the most important theoretical contribution that women`s studies, in conjunction with related fields, has made so far."[21] Also, increasing popularity, expansion, and articulation with new frontiers of knowledge can be noticed.[26,27]

As this research falls within the collective health field, it is vital to highlight the increasing relevance of intersectionality as a theoretical and methodological referential for investigations in this field. These investigations seek to understand the articulation of social markers in complex matters involving the health-disease-care process (HDCP) and the analysis of health programs and institutions, especially due to their potential to anchor debates concerned with demonstrating possibilities of policy formulation and organization of health programs and services committed to social justice and safeguards.[28]

Piscitelli[29] presents a good summary of what a work proposal in this perspective implies: to offer analytical tools to capture the articulation of multiple differences and inequalities. It is important to emphasize that it is not a matter of analyzing only sexual differences, nor of thinking only about the relationship between gender and race or gender and sexuality. It is about thinking about differences in a broad sense. In this respect, intersectionality should be construed as an open question that can only be answered in specific contexts and based on particular investigations.[30] The analysis to be developed in the light of this perspective does not need

SALUD COLECTIVA. 2020;16:e2517. doi: 10.18294/sc.2020.2517

to be based on a specific social marker. Besides, it can adopt an open approach aimed at grasping the articulations among those considered relevant or, as noted by Henning,[31] "differences that make a difference" in particular historical, sociocultural, and political contexts.

Before delving into this understanding, we would like to highlight Avtar Brah`s contribution,[32] chosen as an analytical referential for that analysis. To this author, the concept of difference refers to the variety of ways in which specific discourses of difference are constituted and how they are contested, reproduced, and resignified. Some constructions of difference postulate fixed and immutable boundaries among particular social groups, whereas other constructions may present differences as relational, conceivable, and variable. Considering that, *a priori*, the difference will not always be a marker of hierarchy or oppression, the person who conducts research should permanently question whether difference pans out as inequality, oppression, exploitation, egalitarianism, diversity, or democratic forms of political agency. Therefore, the issues to be analyzed do not refer to "difference" itself but to who defines difference, how categories and groups within discourses of "difference" are represented, and whether a lateral or hierarchical difference is postulated.[29,32]

METHODOLOGICAL DESIGN

The empirical evidence and analysis that support the debates of this article are part of a more extensive research study aimed at describing and analyzing the management and formulation processes of public policies directed to the health care of drug users in the municipality of São Paulo, Brazil.[33]

The research adopted a qualitative approach characterized by a comprehensive, contextualized, interpretative, and dialectal nature.[34] The collection of empirical material was based on in-depth interviews due to their potential to address, following a flexible predefined guide, the meanings of social players' intentionalities and the structural aspects involved in the analyzed social processes.[35]

The research design was based on a convenience sample with key informants. The group of participants was made up of people who were significantly involved in formulating policies, programs, and practices focused on addressing problems related to alcohol and other drugs in the municipality of São Paulo, Brazil.

An initial list of potential participants was drawn to achieve a comprehensive framework with multiple voices (agents, health and social assistance workers, researchers, participants from drug user associations, and representatives of social organizations and movements) that could offer accounts built upon different places and perspectives. After conducting all interviews, the initial list of informants was revised. In order to supplement the information obtained or understand any aspect that had not been initially foreseen, the chain sampling or "snowball sampling" technique[36] was used. This technique involves a non-probability sampling by which research participants recruit other participants.

From September 2017 to June 2019, thirteen interviews were conducted (eight men and five women). The interviews were conducted in person; nevertheless, when the in-person modality was not possible or upon the participant's request, interviews were conducted through Skype, with an average length of 90 minutes. All interviews were audio recorded and transcribed; the transcription accuracy was verified afterward. Following the regulations of the National Health Council of Brazil relating to human subject research, the project was submitted to the Investigation Ethics Committee of the Faculty of Medicine, Universidade de São Paulo (CEP-FMUSP) and approved under record Number 2.056.573. All interviewees accepted and confirmed their participation upon executing a document that sets forth all terms and conditions related to the investigation, whereby they granted their free and informed consent.

SALUD COLECTIVA. 2020;16:e2517. doi: 10.18294/sc.2020.2517

The analysis process of the empirical material was conducted on a sequential basis by employing thematic content analysis.[37,38] After repeated readings and defining the priority issues for the analysis (which were already provided in the interview guide or otherwise were presented as new), the process of data interpretation was based on the intersectional perspective and analytical referential proposed by Brah,[32,39] who suggests addressing "difference" as an analytical category and presents four forms of conceptualization: difference as experience, social relation, subjectivity, and identity. Following that conceptualization, the author brings the articulation of the different elements to be considered to the forefront of analysis. In that articulation, the dichotomy between micro and macro is not construed as opposed to levels of analysis but as elements inherent in the articulation processes, whereby discourses and practices define social relations, subject positions, and subjectivities. In other words, it is not a matter of favoring "macro" and "micro" as levels of analysis but, instead, of identifying and analyzing the relationships between affections, subjectivities, contexts, social relations, and policies.[32,39]

RESULTS

São Paulo's "Cracolândia" and municipal public policies directed to the health care of drug users

Since the beginning of the 1990s, there have been records of crack users' presence in the central region of São Paulo, especially in the streets of the central neighborhood of Luz. Over the years, along with an upsurge in the number of users in that region and the social and media construction of crack as a public danger and social threat, this space-territory has come to be known as "Cracolândia." This area has become well-known due to squatting and the flow of crack users and homeless people, called "*nóias*" (abbreviation of the word paranoia) in a pejorative sense and "crackers." All of them are associated with the "degradation" of the urban space and increased crime and violence in the region.[40,41,42,43,44]

Considered the greatest and most famous open space of crack use in Brazil, "Cracolândia" has been the focus of social interventions since its emergence. Throughout the 1990s and 2000s, several initiatives were developed, principally based on users' repression through threatening maneuvers performed by state and municipal public safety bodies and on the revitalization of the urban area not only through structural alterations to buildings and cultural spaces but also through the expropriation and demolition of tenements, boarding houses, and hotels.[40,41,42,43,44]

Throughout the 2000s, investments were made in expanding the health service network in that region. In this sense, health teams specialized in the approach and monitoring of homeless people, services of the community, and territorial psychosocial care with the uninterrupted operation, emergency and specialized outpatient services, transitional care units and beds in general, and specialized hospitals were implemented. Moreover, investments were made in equipment and expanding the network of social assistance services.[45]

Nevertheless, neither repression nor the availability of health and socio-attention services was enough to tackle the issue. In that context, and based on initiatives for communication, bond, hearing, and negotiation between agents of socio-attention services, managers, and the people to be cared for, the program *De Braços Abertos* was implemented.[44,46,47] In order to foster psychosocial rehabilitation for people who were socially vulnerable and abused psychoactive substances, through the promotion of rights, aid-based actions, and health care and drug abuse prevention measures, the program *De Braços Abertos* implemented intersectoral actions harmonized between municipal health policies, human rights, social assistance, work, urban safety, education, housing, sports, culture, and environment, among others.[48]

From a programmatic point of view, *De Braços Abertos* is consistent with the approach internationally known as *"housing*

SALUD COLECTIVA. 2020;16:e2517. doi: 10.18294/sc.2020.2517

first," a program that prioritizes, as its prime strategy, the provision of permanent and stable housing to homeless people, including those with mental health problems and drug use issues. Several studies evidence the connection between the adoption of that approach and the decrease in the consumption of alcohol and other drugs, violence, and the alleged perception of urban disorder due to excessive disturbances in the streets. Another fundamental and related concept is the "low-barrier admission criteria" of this approach, which means that housing access is not conditioned by abstinence or the requirement to be under treatment as a form of training or "eligibility," prioritizing housing access as a fundamental right.[44,46,47,49,50]

The *"housing first"* approach was developed in the 1990s in the United States; its methodology and principles have been implemented in experiences principally developed and narrated in cities of Europe and Canada. In Latin America, though the implementation of this approach is not yet significant, several ongoing projects share some characteristics with the *housing first* program.[51]

The program was first based on the relocation of people sleeping in improvised shacks that took up the streets' sidewalks of the city center to the hotels of the area, rented by the Prefecture to shelter the beneficiaries of the program. In addition to housing and food in a popular neighborhood restaurant, sources of employment with weekly payments were created, and beneficiaries had guaranteed access to comprehensive health care.[44,46,47]

In 2015 a preliminary program assessment was conducted to explore the profile of the beneficiaries and their perception of the actions developed. Among the information gathered, we highlight that most of the people assisted were over 30 years old (77%), with children (73%), had been detained in the correctional system (67%), and lived in areas of social disaffiliation or vulnerability,[52] with low levels of education, precarious labor market integration and fragile social networks. The information also revealed a higher number of men: 58% declared to be male, 37% were female, and 5% were transsexual. Regarding the racial/ethnic self-declaration, 68% of the beneficiaries declared themselves mixed-raced/mestizo and black, and 23% white.[44] Such data should be taken into account in the process of formulation of policies, for they are similar to the national data on homeless people who use crack, which reveal an overlapping and over-representation of difference, inequality, and exclusion markers in comparison with the data on the overall Brazilian population.[53]

Differences and the formulation of drug policies

Drugs are products whose pharmacological characteristics are virtually insignificant outside their political, economic, and sociocultural contexts. Social representations of drugs are developed in particular social and historical contexts, forging ideologies typical of each drug. Each substance in each context carries specific senses that intervene in drug consumption, control, and prohibition.[54,55] In the case of crack in Brazil, the representations constructed and reinforced through the media are associated with the concept of "garbage-drug (made from the remnants of refined cocaine), used by socially denigrated people that gather in urban areas."[56]

By being tagged as "crackers," the identities of the people that use crack and live or move around the streets of central São Paulo are destroyed and confined to the drugs they use. The connection with that "garbage drug," related to marginalization and delinquency, implies the discursive construction of a *difference* that places people in a position of inferiority, discredits them as "urban disposables,"[57] and subjects them to an exceptional legal situation where they are "culprits" and "ill persons" at the same time.[58]

In that context, that is the *difference* that entails a problem to be tackled, accounting for government interventions, mainly based on a legal and moral discourse that criminalizes behaviors and justifies repression, as well as a medical and psychiatric discourse that

SALUD COLECTIVA. 2020;16:e2517. doi: 10.18294/sc.2020.2517

pathologizes experiences and stresses the need for repression and segregation, but in "specialized environments" such as psychiatric hospitals and therapeutic communities aimed at achieving the "cure" and "abstinence."

First and foremost, the abuse of crack and other drugs is the evident marker upon which the process of public policy formulation is based. In the process of presenting the initiatives that have given rise to the implementation of the program *De Braços Abertos*, what differentiates the visibility of that marker compared to the policies previously formulated is the adoption of the perspective of crack consumption as a complex social issue, and its connection with social segregation of the people who live in "Cracolândia."

> *In that field, it is important to ask: To whom are policies addressed? Who is the user in the abusive situation I am talking about? And the formulation of policies we carried out through "De Braços Abertos" was directed to homeless people who abuse drugs and live in highly vulnerable social circumstances.* (Speaker 11)

> *Public drug policies are faced with the challenge of dealing with highly vulnerable, marginalized, and excluded people referred to as "ralé"* [scum] *by Jessé Souza. The debate over "ralé" is a more decisive factor in the drug issue than the drug itself.* (Speaker 4)

The adoption of this perspective, posed by most of our speakers, has led to the consideration that it is not the consumption of crack itself that should be set out as a priority issue to be tackled, but people's citizenship status and their social reproduction needs. Therefore, health care in that field requires integrated social policies that are not solely based on the provision of public health and social, attention-based services. That is the premise that led to the program's original design *De Braços Abertos*, following the speakers involved in that process to a more significant extent.

> *So we delved into the fact that it was not only and exclusively a matter of health, safety, or social assistance but a matter involving a great deal of complexity, and there was no simple solution to address that complex issue.* (Speaker13)

> *...the person who collaborated on developing policies in the region of Luz realized that a single health policy would not be enough because there was a dimension of misery that would not be solved.* [...] *Housing and income generation issues must be solved.* (Speaker 9)

It is essential to highlight that the inclusion of citizenship and defense of social and human rights as the approach's focal point and the core idea is coupled with harm reduction ethical guidelines, whose earliest experiences in Latin America date back to the end of the 1990s. Not only is it a health work strategy aimed at drug users but also, and principally, it is a strategy focused on changing risk practices related to HIV infection. Over the years, strategies have been expanded and applied to several programs developed in the region. However, they all share a concern for violence, poverty, and social inequality. They aim to build practices that address specific social issues and intervene in individuals' living conditions and the structures that (re) produce them. In this respect, incorporating such concepts as territory, community, and networking in formulating social policies and practices aimed at the health care of that population turns out to be critical.[15,59,60]

During the interviews, how interviewees perceived the *differences* in drug policy formulation deployed several accounts that comprised different topics and conceptualization possibilities of the category of *difference*. The reference to racism, for example, arose not only as a systematic social relation that places individuals in unequal power relationships but also as a subjective experience that triggers psychic suffering, often ignored by professionals in their clinical approach toward users.

SALUD COLECTIVA. 2020;16:e2517. doi: 10.18294/sc.2020.2517

The analysis of the empirical material was conducted based on a *difference* constructed as a form of categorizing and characterizing a social group ("crack users in situations of social segregation and vulnerability") with a particular focus on its internal heterogeneity and the power relations that mark that group. Considering the main ideas posed by the interviewees, in this article, two categories are highlighted that, according to Brah,[32] can be considered to be two forms of difference conceptualization: difference as identity and difference as a social relation.

Difference as identity

According to Brah,[32] identities are inscribed through experiences culturally constructed in social relations and marked "by the multiplicity of subject positions that constitute the subject." Hence, personal identities connect with the collective experiences of a group. However, the singularities of a person's life experiences and forged social relationships produce trajectories that do not mirror the group's experience. Similarly, collective identities cannot come down to the sum of individual experiences.

In this respect, and taking into account the idea of *difference as identity* suggested by Brah, what was most evident and explored by the participants regarding the group of beneficiaries of the *De Braços Abertos* program was the difference between *"men"* and *"women,"* from the identification of that difference as an identity marker (gender) to the description of differentiated healthcare practices (or gender-based practices) addressed to them. In other words, the visibility of that difference reveals their interpretation of gender identity, reflected in expectations and perceptions – according to the socio-cultural context to which they belong – linked to the forms of organization and belonging to the male and female gender.[61]

By identifying and focusing on both that difference in gender performativity and the characteristics related, in a hegemonic manner, to femininity or masculinity, "maternity" – in its different aspects – emerged as one of the main issues that marked the identification of demands as well as the formulation of differentiated practices for the program's beneficiaries. The relationship between drug use and the inability to autonomously take care of their lives affects the idea, considerably widespread in society, that women who use drugs are not able to take care of their children. This idea has caused many discussions on the formulation of policies regarding state intervention in providing alternative shelter spaces and children's guardianship. In this regard, the interviews highlight the concern for this aspect and the need for this situation to be more visible and discussed to develop new practices.

> *In this policy specifically, I consider gender an important marker, not only because there has not been gender delimitation so far, but also because it avoids taking the babies from their mothers as the only policy. Hence, we need a policy that helps those women get stronger and more organized; maybe a place where they can live, alone or with their partners, stay for some time with their children, etc.* (Speaker 1)

Regarding the development of healthcare practices addressed to women participating in the program, the interviews posed an initial challenge: establishing differentiated strategies for their monitoring. The conventional strategies recommended for the health care provided by health teams proved inefficient for a large portion of that population. Therefore, new strategies were introduced to give visibility to the development of health care based on the work performed by health and social assistance teams in the streets.

In that field, we identified that special attention was given to women's reproductive health, and investments were made in the formulation of approaches that enabled a reflection on gestation, and forms of protection, ranging from access to information to the provision of the most appropriate contraceptive methods for women with that demand.

SALUD COLECTIVA. 2020;16:e2517. doi: 10.18294/sc.2020.2517

> *We succeeded in providing these women with prenatal screening tests; we would manage to develop practices on pregnancy prevention and offer them contraceptive methods, those long-term contraceptive implants* [...] *because they will not take the contraceptive pill every day*. (Speaker 13)

The health teams established various approaches for the specific moment of pregnancy and considered the importance of prenatal monitoring. Based on the healthcare needs and demands regarding pregnant women and their baby and their evaluation as a moment of particular vulnerability, health teams highlighted their concern for establishing a specific housing service for that population. In the process of implementing a hotel located further away from the municipality of São Paulo, pregnant women referral was prioritized.

> *…thanks to the beneficiaries' demand to leave the territory, we founded the "Freguesia* do Ó*" hotel, but we prioritized the referral of pregnant women…. at that time, we had 30 pregnant women*. (Speaker 2)

In general, although part of the speakers used the term "gender," the reference to this category was considered, many times, a synonym of "woman" and related only to the specific needs and demands of women, whereas men's specific needs remained invisible. The perceptions about the differences between "men" and "women" described here evidence the relationship between these categories and the need to understand *gender* as a relational and transversal category that establishes and reproduces power asymmetries.[62,63,64]

The perception of this *difference* is also extensively related to understanding homeless women as "more vulnerable" than men. That perception of greater vulnerability, or disadvantage, would justify the formulation and organization of practices aimed at providing women with differentiated health care and reducing inequalities and barriers to healthcare access.

> *We had more vulnerable groups within that extremely vulnerable population of Luz* [with reference to the neighborhood]. *What group was more vulnerable? Women's group*. (Speaker 11)

> *…I do not want a service only for women who use drugs. I think much more of mechanisms within a service, for example, within a Primary Health Care Center (CAPS) for alcohol and drug users* [community service for mental health, alcohol, and drugs] *that receive the demands of women who use drugs. Hence, for example, a group or another kind of strategy should be addressed to women who use drugs and have children. For example, when women have to attend a consultation, they do not have anyone to take care of their children. If the center does not have a place that guarantees that women can leave their children with someone to take care of them while they attend the consultation, then women may not go just because the service does not respond to their needs*. (Speaker 7)

In general, the categories "women" and "men" regarding that specific context appeared in the participants' narratives as "atomized" categories, dissociated from other categories of differentiation such as age, race, origin, sexuality, and education. However, there was an exception: the difference located at the interface between gender identity and gonadal sex, identified, in practice, in transsexual women's experiences. One of the speakers, who especially highlighted that difference, was concerned about setting up strategies for organizing the services specifically addressed to that population. One path could be establishing differentiated rooms and restrooms in hotels and shelter centers to support diversity and diminish the disadvantages in access to rights and services.

SALUD COLECTIVA. 2020;16:e2517. doi: 10.18294/sc.2020.2517

> *The issue of transsexual women is critical because, first and foremost, they do not have a suitable place in society* [...] *that population, per se, suffers from a disadvantage and has difficulty accessing public policies. Hence the need for gender delimitation is evident* [...] *For example, there was a room in one of the hotels that transsexual women precisely occupied... even though that was not clearly and explicitly established, it just happened, and we understood it was important.* (Speaker 2)

Regarding the *differences* listed above, it is necessary to reflect on how they were displayed in this context. Also, how they contributed to the debate over citizenship and rights. The move toward formulating policies and strategies focused on socially constructed identities may not only support the assertion of diversity and political and cultural singularities, but also highlight the opportunities for those who suffer from discrimination, inequality, and oppression in all their experiences and social relations.[65,66,67]

The critical debate over citizenship also calls into question the rights that, upon universalization, disregard and exclude population groups. This issue leads us to question that unique subject consolidated and constituted on the denial of many others and to challenge identity policies more as a strategy and positioning rather than as an end in itself.[68,69]

Difference as social relation

According to Brah,[32] "difference as social relation" refers to "the way in which difference is constituted and organized in *systematic* relations through economic, cultural and political discourses and institutional practices."

In the meaning suggested, the concept of difference highlights the articulation of power systems, historically changeable, within which specific modes of differentiation are structured. Without privileging "structural" as an axis that determines experiences, Brah considers that the effects of social relations take place in all sites of social formation: in politics, institutions, subjectivities, affections, and everyday life.[32,39]

Within the categorization of *difference*, construed as a social relation, the first item to highlight in the speakers' accounts is the need to deconstruct the idea, considerably widespread in society, that crack use was the main factor of destabilization and disorganization of these people's lives and therefore, the reason behind the material and emotional losses that have led to the breakdown of social and family ties and the "choice" of a life of privation and homelessness. By contrast, other speakers highlight the importance of knowing the trajectories and experiences of the subjects that, in that particular moment of their lives, use crack in an urban drug scene and live on the streets. In addition to the importance of understanding the singularities of individual experiences, speakers suggest the need to recognize the contexts and relations that characterize those trajectories and the life situation of that group. In that context, the focus of the discourses was on the importance of understanding how specific power regimes tie in with the construction of differences that, through systematic relations, reproduce vulnerability, oppression, and inequalities in people's life.

> *Those people in Cracolândia did not become vulnerable due to drug use. Most of them – of course, there are exceptions – were already in a situation of extreme social vulnerability, which is why they are part of that context.* (Speaker 11)

> *Crack in Brazil is a social issue nowadays. Its impact on society, combined with misery, inequality, and considerably complex relations, serves an indirect discourse of criminalization and/or laying the blame on subjects due to their poverty by stating that crack has made them poor and is what keeps them in poverty, is the reason for prioritizing the formulation of policies.* (Speaker 9)

SALUD COLECTIVA. 2020;16:e2517. doi: 10.18294/sc.2020.2517

By understanding the dimension of "misery" and "poverty" as the axis and focal point of interventions and policies aimed at homeless users who abuse crack, social markers of "class" and "race" intersect. Several narratives in which those markers were mentioned highlighted the importance of denaturing the inequalities that form the Brazilian society and analyzing racism as a structural marker that organizes the mechanisms of social class/social disqualification, to which racism is indissolubly linked.

> *The race issue in the country is highly important because it is related not only to the economic issue but also to certain behaviors. The problem in Brazil is the intersection of slave practice and capitalism.* [...] *Our slave culture is rooted in our issue of inequality. Or I would say it is the other way round: our inequality is rooted in a slave structure.* (Speaker 4)

> *...the debate over drug policy needs race delimitation: most of the people arrested are black, or most of the people who die are black, and that is linked to the economic and social relations established in Brazil, a country founded on a racist pact.* (Speaker 1)

In the process of reflection on the identification of differences that structure inequality relations in that context, violence, together with the dimension of misery, was outlined as an issue to be addressed. The debate over violence must be conducted in a complex manner, questioning the effects of prohibitionist policies that contributed to the transformation of Latin America into the most violent region on the planet if we consider the rates of homicide and out-of-court executions, arbitrary detentions, and the lack of access to essential health services. The region also has the world's highest rate of youth homicide, surpassing countries, and regions at war.[6,70,71]

Castro-Gómez[72] draws attention to the formation processes of Latin American nation-states, pervaded by the perpetuation and emphasis on violence to control and manage the population. Despite the historical features of each country, the region still bears the scars of colonial exploitation and the traits of violence, usurpation, repression, and extermination of that period. However, those oppressions do not occur on an abstract level; on the contrary, they are expressed in marginalized bodies.[73]

Violence marks the bodies and experiences of crack users, expressed in police approaches, relations with traffic wardens, and high rates of homicides, considered to be their leading cause of death.[74] The narratives that specifically address the issue of violence in the territory of "Cracolândia" express the perception that violence does not have the same impact on all individuals that move around the area. Once again, concern for women prevails, for they are considered to be subject to positions of greater oppression within the relationships established in that context and to be more exposed to situations of physical, verbal, and sexual violence.

> *Gender violence is a huge issue; even in* De Braços Abertos. *Though we tried to mitigate the problem, it still happened a lot. Once a man and a woman were fighting in the use scene... so I turned to the Metropolitan Civil Guard to ask for help, and he said, "Em briga de marido e mulher, ninguém mete a colher"* [popular saying which means "in husband and wife fight, nobody steps in"]. *This way of thinking is so established that cases of femicide often occur because people cannot interfere in a "husband and wife fight."* (Speaker 2)

Regarding transsexual women, the narrative highlights the concern about their exposure to situations of violence as something prevailing in their everyday life. These violent situations are connected with the prejudice and discrimination that these women suffer in society, mainly because of constructing and performing a gender identity associated with femininity, and contradicting the socially expected behavior according to their gonadal sex.

SALUD COLECTIVA. 2020;16:e2517. doi: 10.18294/sc.2020.2517

> *We worked with the center for sexual diversity in all shelter centers and all core services for homeless adults. All of a sudden — I think fifteen days after that work was done — we received a notification from transvestites who were being discriminated against by professionals of a Social Assistance Reference Center… how could we ever imagine that our professionals would make fun of homeless transvestites?!* (Speaker 3)

> *...for example, shelter centers for transvestites... they have a room in the shelter center Zachi Nachi and they also suffer from violence inside the center.* (Speaker 2)

The distinction between the violence to which the bodies of women, transsexuals, and cisgender individuals are subject, in that context, seems crucial from a perspective that considers race, class, gender, and sexuality as overlapping and reciprocally constitutive systems. Raising this issue, in no way whatsoever, means identifying the "most oppressed" group; on the contrary, it means highlighting the need to tackle those dimensions as a whole.[69,75]

The identification of that difference and the analysis of how it is presented also make us question the stigma and the discretionary power of institutional actors who control access to specific resources and services that are established in the context of a particular public policy, and who carry out their practices based on prejudices about specific characteristics of the population. They hinder those people who most need the support and intervention of the State in order to guarantee their rights and the exercise of citizenship, creating inequality among groups and individuals.[76,77]

FINAL CONSIDERATIONS

"Cracolândia" is not a physical space. Cracolândia is the people. Unique people, both men and women, with their stories and experiences, that live in that region or pass through it, use other drugs, have affections, relationships, desires, and specific needs. The analysis of the *differences* in that specific context enables a view of singularities and the identification of power systems and regimes that characterize the trajectories of exclusion that constitute that group.

If the formulation of policies, safety and healthcare programs aimed at homeless people who use crack and other drugs were posed as a necessity, the analysis of that specific context – with so many peculiarities involved – would confirm the need to make policies that comprehensively address the relations between drug consumption and social segregation, and that intervene in people's living conditions and existence. In this respect, *De Braços Abertos* was considered an innovative program capable of replicating its concepts and approaches, respecting the singularities of local and regional contexts.[46,47] It is important to highlight that such demand is in keeping with harm reduction as a political guideline, which considers that the end of the war on drugs is the baseline of healthcare policies.[9,59] Harm reduction, in that direction, is posed as an emancipating perspective founded on a social transformation project. As such, it must be followed in an attentive, critical, and questioning way.[78]

Considering the limits of the universalist policies and practices, the reflection on the difference in the formulation of policies aimed at the health care of people who use drugs, from an intersectional perspective, enables us to understand the relationship between social markers and how they intersect with drug use in a dynamic and complex way.[58] Moreover, such a reflection helps make it possible to satisfy the needs of particular groups who claim differentiated care to their identity demands regarding access to rights and guarantee of citizenship.[65] In this sense, when confronting an identified oppression, caution must be exercised to prevent another oppression from being reinforced. Hence, the challenge is to develop strategies to tackle inequalities in a non-compartmentalized and

SALUD COLECTIVA. 2020;16:e2517. doi: 10.18294/sc.2020.2517

non-hierarchical way by understanding how they are interconnected and assembled in a given specific context.[32]

Criticism of the war model preponderantly adopted in Latin America as the matrix of public drug policies has been leveled in a comprehensive and articulated manner among the contemporary social and political movements that fight for political sovereignty, economic independence, and social justice in the region.[7] In this sense, we would like to emphasize the opportunity for conversation with the Latin American researchers who use the intersectionality approach in a critical and contextualized manner, highlighting that the analysis of social inequalities should consider the heterarchy of the multiple power regimes that place local States and societies in a subordination position, in the context of complex power relations that make up the global capitalist system.[69,75]

Lastly, it is vital to highlight the concern that the acknowledgment of the differences and singularities gives rise to a discourse focused on neoliberal ethics, whose purpose is to exempt the State from responsibility and hold individuals accountable for their "competencies" for the exercise of citizenship and social inclusion.[79] Within the current social and political context, where democracy is weakened and the role of the State is called into question, we can find lots of challenges aimed at consolidating drug policies in Brazil and Latin America that would opt for non-war models and aim for civic ethics that guarantees rights.

REFERENCES

1. Fiore M. A medicalização da questão do uso de drogas no Brasil: reflexos acerca de debates institucionais e jurídicos. In: Venâncio RP, Carneiro H, (orgs.). Álcool e drogas na história do Brasil. São Paulo: Alameda; 2005. p 257-290.

2. Rodrigues T. Narcotráfico: um esboço histórico: Álcool e drogas na história do Brasil. São Paulo: Alameda; 2005.

3. Carneiro H, Del Priore M. Pequena enciclopédia da história das drogas e bebidas: histórias e curiosidades sobre as mais variadas drogas e bebidas. São Paulo: Elsevier; 2005.

4. Berridge V. Dependência: história dos conceitos e teorias. In: Edward G, Lader M, (eds.). A natureza da dependência de drogas. Porto Alegre: Artes Médicas; 1994.

5. Babor T, Caulkins J, Edwards G, Fischer B, Foxcroft D, Humphreys K, Strang J. La política de drogas y el bien público. Washington DC: Organización Panamericana de la Salud; 2013.

6. Carvalho IS. O despertar da América Latina : uma revisão do novo debate sobre política de drogas. Rio Janeiro: Instituto Igarapé; 2014.

7. Ralón G. Consecuencias de la guerra contra las drogas. In: Touzé G, Goltzman P (comps.). América Latina debate sobre drogas: I y II Conferencias Latinoamericanas sobre Políticas de Drogas. Buenos Aires: Intercambios Asociación Civil; Facultad de Ciencias Sociales, Universidad de Buenos Aires; 2011.

8. Fraga PCP. A geopolítica das drogas na América Latina. Em Pauta: Teoria Social e Realidade Contemporânea. 2007;(19):67-88.

9. Menéndez EL. Sustancias consideradas adictivas: Prohibición, reducción de daños y reducción de riesgos. Salud Colectiva. 2012;8(1):9-24.

10. Dammert L, Zúñiga L. La cárcel: problemas y desafíos para las Américas. Santiago de Chile: Facultad Latinoamericana de Ciencias Sociales-Chile; 2008.

11. Institute Transnational on Latin America Washington Office. Sistemas sobrecargados: Leyes de drogas y cárceles en América Latina. Washington: Washington Office on Latin America; 2010.

12. Werb D, Rowell G, Guyatt G, Kerr T, Montaner J, Wood E. Effect of drug law enforcement on drug market violence: A systematic review. International Journal of Drug Policy. 2011;22(2):87–94.

13. United Nations Office on Drugs and Crime, Escritório das Nações Unidas sobre drogas e crime. Da coerção à

SALUD COLECTIVA. 2020;16:e2517. doi: 10.18294/sc.2020.2517

coesão: Tratamento da dependência de drogas por meio de cuidados em saúde e não da punição. Documento para discussão com base em uma oficina técnica. Viena: United Nations Office on Drugs and Crime; 2009.

14. United Nations Office on Drugs and Crime. People at the centre: UNODC support for UNGASS 2016 on the world drug problem. Vienna: United Nations Office on Drugs and Crime; 2018.

15. Galante A, Rossi D, Goltzman P, Pawlowicz MP. Programas de reducción de daños en el escenario actual: Un cambio de perspectiva. Revista Escenarios. 2009;(14):113-121.

16. Petuco DR. Redução de danos: das técnicas à ética do cuidado. In: Ramminger T, Silva M, (orgs.). Mais substâncias para o trabalho em saúde com usuários de drogas. Porto Alegre: Rede Unida; 2014. p. 133-148.

17. Ministério da Saúde, Coordenação Nacional de DST/AIDS. A Política do Ministério da Saúde para a atenção integral a usuários de álcool e outras drogas. Brasil: Ministério da Saúde, Coordenação Nacional de DST/AIDS; 2003.

18. Tomasini-Joshi D. Ni Socorro, Ni Salud: Abusos en vez de rehabilitación para usuarios de drogas en América Latina y el Caribe. New York: Open Society Foundations; 2016.

19. Conselho Federal de Psicologia, Mecanismo Nacional de Prevenção e Combate à Tortura, Procuradoria Federal Dos Direitos do Cidadão, Ministério Público Federal. Relatório da Inspeção Nacional em Comunidades Terapêuticas. Brasil: Conselho Federal de Psicologia; 2018.

20. United Nations International Children's Emergency Fund, Oficina del Alto Comisionado de las Naciones Unidas para los Derechos Humanos. Compilación de observaciones finales del Comité de los Derechos del Niño sobre es de América Latina y el Caribe (1993-2006). Santiago de Chile: UNICEF, Oficina del Alto Comisionado para los Derechos Humanos; 2006.

21. McCall L. The complexity of Intersectionality. Signs: journal of Women in Culture and Society. 2005;30(3): 1771:1800. doi: 10.1086/426800.

22. Davis K. Intersectionality as buzzword: A sociology of science perspective on what makes a feminist theory successful. Feminist Theory. 2008;9(1):67-85. doi: 10.1177/1464700108086364.

23. Crenshaw K. Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color. Stanford Law Review. 1991;43(6):1241-1299. doi: 10.2307/1229039.

24. Crenshaw K. Documento para o encontro de especialistas em aspectos da discriminação racial relativos ao gênero. Revista Estudos Feministas. 2002;10(1):171-188. doi: 10.1590/S0104-026X2002000100011.

25. Mann SA, Huffman DJ. The decentering of second wave feminism and the rise of the third wave. Science & Society. 2005;69(1):56–91. doi: 10.1521/siso.69.1.56.56799.

26. Brah A, Phoenix A. Ain't I a woman? Revisiting intersectionality. Journal of International Women's Studies. 2004;5(3):75-86.

27. Bilge S. De l'analogie à l'articulation : ThéOriser la différenciation sociale et l'inégalité complexe. L'Homme & la Société. 2010;176-177(2):43-64. doi: 10.3917/lhs.176.0043.

28. Couto MT, De Oliveira E, Separavich MAA, Luiz ODC. La perspectiva feminista de la interseccionalidad en el campo de la salud pública: revisión narrativa de las producciones teórico-metodológicas. Salud Colectiva. 2019;15:e1994. doi: 10.18294/sc.2019.1994.

29. Piscitelli A. Interseccionalidades, categorias de articulação e experiências de migrantes brasileiras. Sociedade e Cultura. 2008;11(2):263-274.

30. Vigoya MV. La interseccionalidad: una aproximación situada a la dominación. Debate Feminista. 2016;52:1-17. doi: 10.1016/j.df.2016.09.005.

31. Henning CE. Interseccionalidade e pensamento feminista: as contribuições históricas e os debates contemporâneos acerca do entrelaçamento de marcadores sociais da diferença. Mediações. Revista de Ciências Sociais. 2015;20(2):97-128. doi: 10.5433/2176-6665.2015v20n2p97.

32. Brah A. Diferença, diversidade, diferenciação. Cadernos Pagu. 2006;26:329-376. doi: 10.1590/S0104-83332006000100014.

33. Marques ALM. Políticas públicas de cuidado dirigidas a pessoas que usam drogas no município de São Paulo/SP: uma análise desde a perspectiva da interseccionalidade [Tesis de Doutorado]. São Paulo: Faculdade de Medicina; 2019. doi:10.11606/T.5.2020.tde-11032020-110156.

34. Minayo MCDS. Origen de los argumentos científicos que fundamentan la investigación cualitativa. Salud Colectiva. 2017;13(4):561-575. doi: 10.18294/sc.2017.942.

35. Becker HS. Métodos de pesquisa em ciências sociais. São Paulo: HUCITEC; 1993.

36. Noy C. Sampling knowledge: The hermeneutics of snowball sampling in qualitative research. International Journal of Social Research Methodology. 2008;11(4):327-344. doi: 10.1080/13645570701401305.

37. Bardin L. Análise de Conteúdo. São Paulo: Edições 70; 2011.

38. Minayo MCDS, Deslandes SF, Neto OC, Gomes R. Pesquisa Social: Teoria, método e criatividade. Rio de Janeiro: Editora Vozes; 2011.

39. Brah A. Cartografías de la diáspora: Identidades en cuestión. Revista de Estudios Sociales. 2014;(49):223-225. doi: 10.7440/res49.2014.19.

40. Frugoli Junior H. Da cracolândia aos nóias: percursos etnográficos no bairro da Luz. Ponto Urbe. 2010;4(6). doi: 10.4000/pontourbe.1870.

SALUD COLECTIVA. 2020;16:e2517. doi: 10.18294/sc.2020.2517

41. Gomes BR, Adorno CF. Tornar-se "noia": trajetória e sofrimento social nos "usos de crack" no centro de São Paulo. Etnografica. 2011;15(3):569-586. doi: 10.4000/etnografica.1076.

42. Nasser MMS. Entre a ameaça e a proteção: categorias, práticas e efeitos de uma política de inclusão na Cracolândia de São Paulo. Horizontes Antropológicos. 2018;24(50):243-270.doi:10.1590/s0104-71832018000100009.

43. Rui T. Depois da "Operação Sufoco": sobre espetáculo policial, cobertura midiática e direitos na "cracolândia" paulistana. Contemporânea. 2013;3(2):287-310.

44. Rui T, Fiore M, Tófoli LF. Pesquisa preliminar de avaliação do Programa "De Braços Abertos". In: Plataforma Brasilera de Política Drogas [Internet]. Brasil: 2016. [cited 17 Jun 2019]. Available from: https://tinyurl.com/y792vgt2.

45. Prefeitura de São Paulo. Instrumento normativo para monitoramento técnico, administrativo e financeiro dos serviços de saúde mental no Município de São Paulo. São Paulo: Secretaria Municipal de Saúde; 2012.

46. Evans S. Crack: Reduzir Danos: Lições Brasileiras de Saúde, Segurança, e Cidadania. New York: Open Society Foundations; 2017.

47. Carvalho IS, Pellegrino AP. Políticas de Drogas no Brasil: a mudança já começou. Rio de Janeiro: Instituto Igarapé; 2015.

48. Brasil, Prefeitura de São Paulo. Decreto Nº 55.067, de 28 de abril de 2014. Diário Oficial Cidade de São Paulo [Internet]. 2014 [cited 10 May 2019]. Available from: https://tinyurl.com/y93webo3.

49. Marlatt GA, Larimer ME, Witkiewitz K. Harm reduction: Pragmatic strategies for managing high-risk behaviors. London: Guilford Press; 2011.

50. Tsemberis S, Gulcur L, Nakae M. Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals With a Dual Diagnosis. American Journal of Public Health. 2004;94(4):651-656. doi: 10.2105/ajph.94.4.651.

51. Moreira RS, Mendes APT, Sciammarella APDO, Amado F. População em situação de rua: direitos humanos, políticas públicas e programas de housing first. Rio de Janeiro: Escola de Direito do Rio de Janeiro, Fundação Getúlio Vargas; 2017.

52. Castel R. As metamorfoses da questão social: uma crônica do salário. Petrópolis: Vozes; 1998.

53. Bastos FIPM, Bertoni N. Pesquisa Nacional sobre o uso de crack: quem são os usuários de crack e/ou similares do Brasil? quantos são nas capitais brasileiras? [Internet]. Rio de Janeiro: Instituto de Comunicação e Informação Científica e Tecnológica em Saúde, Fundação Oswaldo Cruz; 2014 [cited 17 Jun 2019]. Available from: https://tinyurl.com/y7ugm2jx.

54. Bourgois P. Crack and the political economy of social suffering. Addiction Research and Theory. 2003;11(1):31-37. doi: 10.1080/1606635021000021322.

55. Escohotado A. Historia general de las drogas. Madrid: Espasa Calpe; 2005.

56. Garcia M. O uso problemático de crack e a classe média. In: Souza J, (ed.). Crack e exclusão social. Brasília: Ministério da Justiça e Cidadania, Secretaria Nacional de Políticas sobre Drogas; 2016. p. 103-118.

57. Varanda W, Adorno RCF. Descartáveis urbanos: discutindo a complexidade da população de rua e o desafio para políticas de saúde. Saúde e Sociedade. 2004;13(1):56-69. doi: 10.1590/S0104-12902004000100007.

58. Zafiropoulos M, Pinell P. Drogas, desclassificação e estratégias de desqualificação. In: Pinell P, (ed.). Análise sociológica das políticas de saúde. Rio de Janeiro: Editora Fiocruz; 2010. p. 143–176.

59. Goltzman PM. Memorias del Encuentro Intervenciones desde la Reducción de Daños: perspectivas y desafíos actuales [Internet]. Ciudad Autónoma de Buenos Aires: Intercambios Asociación Civil; 2016 [cited 17 Jun 2019]. Available from: https://tinyurl.com/y8xe54r6.

60. Galante A. Experiencias de atención a usuarios de drogas en América Latina. In: Touzé G, Goltzman P (comps.). América Latina debate sobre drogas – I y II Conferencias Latinoamericanas sobre Políticas de Drogas. Buenos Aires: Intercambios Asociación Civil, Facultad de Ciencias Sociales, Universidad de Buenos Aires; 2011. p. 129-130.

61. Seffner F. Identidade de gênero, orientação sexual e vulnerabilidade social: pensando algumas situações brasileiras. In: Venturi G, Bokany V. Diversidade Sexual e homofobia no Brasil. São Paulo: Fundação Perseu Abramo; 2011. p. 39-50.

62. Moraes M. Gênero e usos de drogas: porque é importante articular esses temas? In: Moraes M, Castro R, Petuco D, (orgs.). Gênero e drogas: contribuições para uma atenção integral à saúde. Recife: Instituto PAPAI; 2010. p. 15-20.

63. Couto MT, Gomes R. Homens, saúde e políticas públicas: a equidade de gênero em questão. Ciência & Saúde Coletiva. 2012;17:2569-2578. doi: 10.1590/S1413-81232012001000002.

64. Granja E, Gomes R, Medrado B, Nogueira C. O (não) lugar do homem jovem nas políticas de saúde sobre drogas no Brasil: aproximações genealógicas. Ciência & Saúde Coletiva. 2015;20(11):3447-3455. doi: 10.1590/1413-812320152011.19972014.

65. Mello L, Gonçalves E. Diferença e interseccionalidade: notas para pensar práticas em saúde. Revista Cronos. 2010;11(2):163-173.

66. Silveira ML. Políticas Públicas de Gênero: Impasses e Desafios para Fortalecer a Agenda Política na Pers-

SALUD COLECTIVA. 2020;16:e2517. doi: 10.18294/sc.2020.2517

pectiva da Igualdade. In: Godinho T, (ed.). Políticas públicas e igualdade de gênero. São Paulo: Coordenadoria Especial da Mulher; 2004. p. 65–76.

67. Castro MG. Políticas Publicas por Identidades e de Ações Afirmativas: Acessando gênero e raça, na classe, focalizando juventudes [Internet]. Portal de e-governo, inclusão digital e sociedade do conhecimento; 2006 [cited 17 Jun 2019]. Available from: https://tinyurl.com/y96wrhhk.

68. Lugones M. Subjetividad esclava, colonialidad de género, marginalidad y opresiones múltiples. In: Pensando los feminismos en Bolivia. La Paz: Serie Foros; 2012. p. 129-140.

69. Curiel Pichardo RYO. Descolonizando el Feminismo: Una perspectiva desde América Latina y el Caribe [Internet]. In: Primer Coloquio Latinoamericano sobre Praxis y Pensamiento Feminista. Buenos Aires; 2009 [cited 17 Jun 2019]. Available from: https://tinyurl.com/y773qpvt.

70. Waiselfisz JJ, Instituto Sangari, Rede de Informação Tecnológica Latino-America, Ministério da Justiça. Mapa da violência: os jovens da América Latina. Brasilia: Rede de Informação Tecnológica Latino-Americana; 2008.

71. Count the Costs. The war on drugs: Undermining Human Rights [Internet]. 2012 [cited 17 jun 2019]. Available from: https://tinyurl.com/y8g3dhp5.

72. Castro-Gómez S. Ciências sociais, violência epistêmica e o problema da 'invenção do outro'. In: Lander E, (ed.). A colonialidade do saber: eurocentrismo e ciências sociais. Perspectivas latino-americanas. Buenos Aires: CLACSO; 2005. p. 169-186.

73. Borges J. Encarceramento em massa. São Paulo: Pólen; 2019.

74. Ribeiro M, Dunn J, Sesso R, Dias AC, Laranjeira R. Causes of death among crack cocaine users. Revista Brasileira de Psiquiatria. 2006;28(3):196-202. doi: 10.1590/S1516-44462006000300010.

75. Espinosa Y. La política sexual radical autónoma, sus debates internos y su crítica a la ideología de la diversidad sexual. In: Pensando los feminismos en Bolivia. La Paz: Conexión Fondo de Emancipación; 2012.

76. Dutra V, Henriques V. O poder discricionário dos agentes institucionais que lidam com usuários de crack: invisibilidade de classe e estigma de gênero. In: Souza J, (ed.). Crack e exclusão social. Brasília: Ministério da Justiça e Cidadania, Secretaria Nacional de Políticas sobre Drogas; 2016.

77. Ronzani TM, Furtado EF, Higgins-Biddle J. Stigmatization of alcohol and other drug users by primary care providers in Southeast Brazil. Social Science & Medicine. 2009;69(7):1080-1084. doi: 10.1016/j.socscimed.2009.07.026.

78. Moraes M, Montenegro M, Medrado B, Romaní O. Los retos de la reducción de daños como política pública de drogas en Brasil. Psicologia em Pesquisa. 2015;9(2):148-158. doi: 10.5327/Z1982-1247201500020005.

79. Boneti LW. Políticas Públicas, Direitos Humanos e Cidadania. Juris. 2006;26:189-204. doi: 10.14295/juris.v26i0.629.

CITATION
Marques ALM, Couto MT. Drug policies in the Brazilian context: an intersectional analysis of "Cracolândia" in São Paulo, Brazil. Salud Colectiva. 2020;16:e2517. doi: 10.18294/sc.2020.2517.

Received: 31 Aug 2019 | Modified: 1 Jun 2020 | Accepted: 16 Jun 2020 | Publication online: 17 Jul 2020

https://doi.org/10.18294/sc.2020.2517

The translation of this article is part of an inter-departmental and inter-institutional collaboration including the Undergraduate Program in Sworn Translation Studies (English < > Spanish) and the Institute of Collective Health at the Universidad Nacional de Lanús and the Health Disparities Research Laboratory at the University of Denver. This article was translated by María Julieta García Vago under the guidance of Mariela Santoro, reviewed by Rebekah Yohannes under the guidance of Julia Roncoroni, and prepared for publication by Vanesa Martinez under the guidance of Vanessa Di Cecco. The final version was approved by the article author(s).