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The (non)space of the young man in health policies regarding drugs in Brazil: genealogical approaches

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Abstract *The study seeks to problematize the negotiations and conditions of possibility for the inclusion or exclusion of young men in the process of health policy formulation regarding drugs in Brazil. Situated in the field of gender studies and proposing to discuss the relationship between masculinities and the use of drugs from an intersectional perspective, the framework considers that: the increased vulnerability of young males to problems with drug use and the difficulties in access and/or links to services also need to be understood in light of the literature about gender and health; and that the form in which debates about gender are manifested in health policies – whether in official documents, or in the understanding of persons linked to the elaboration and/or implementation of such policy– directly or indirectly influence the way in which these men are recognized by, access, and are accepted by the services of the Unified Health System (SUS). Drawing upon three episodic and semi-structured interviews with managers who participated in the elaboration of health policy about drugs at the municipal, state, and federal levels, and through the study of the documents cited during the interviews, we develop a genealogical text that seeks to retell the history of drug policy in Brazil, guided by the events emphasized by the interlocutors.*

Key words *Gender, Masculinities, Drugs, Youth, Health policy*

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Introduction

Male, young, black, and poor. How are these social actors recognized in the public health policy in the context of drug use in Brazil? What spaces were and are being defined for this demographic, to the degree that it corresponds to that which, according to epidemiological studies[1], presents the highest index of morbidity and mortality for the harmful use of drugs in our country? The genealogical exercise undertaken here seeks to trace the threads and weave the webs that make up the history of the elaboration of Brazilian drug policy, highlighting the creases and the pieces, with the intention of problematizing the negotiations and conditions of possibility for inclusion or exclusion of young males from the process of policy formulation. Within the policies, we chose as the point of departure for this study the National Policy of Integrated Healthcare for Users of Alcohol and other Drugs[2], elaborated by the Secretary of Healthcare, in the Ministry of Health. This is a broad document, which begins with a definition of a *theoretical-political framework,* continues with a *Contextualization* of drug use as a health problem, presenting epidemiological data, and concludes with *Guidelines* for policy. We chose this document, even while aware of subsequent regulations, viewing this as a more forceful document that, in fact, ignited the debate in public health policy towards questions related to drug use.

When it released the aforementioned Policy contained in this document, the Ministry of Health recognized that the Unified Health System (SUS) has been lagging behind in proposing actions in response to problems related to drug use in Brazil. Machado and Miranda[3] point out that, since the beginning, the history of interventions by Brazilian governments in the area of alcohol and drugs has tended to favor frameworks and initiatives that originated and consolidated mostly in the fields of law and public security. According to the author, there is a clear difficulty in the incorporation of these problems into an agenda for public health.

The necessary reading of gender and generation

Situated in the field of gender studies and proposing to discuss the relationship between masculinities and the use of drugs from an intersectional perspective, this study focuses on public health policy, considering that: 1) the increased vulnerability of young males to problems with drug use and the difficulties in access and/or links to services also need to be understood in light of the literature about gender and health; and 2) that the form in which debates about gender are manifested – whether in official documents, or in the understanding of persons linked to the elaboration and/or implementation of such policies – directly or indirectly influence the way in which these men are recognized by, access, and are accepted by the services of the Unified Health System. Gender is here understood as one constitutive element of social relations based on the differences produced between the sexes,and as a primary form to give meaning to these relationships; meanings are shaped by the exercise of power[4]. We refer to power as something that circulates, functions in a chain reaction, and – rather than being localized here or there – is exercised in a network, branching in multiple directions[5].

The production of a body, gestures, discourses and desires, that demarcate the recognition of a person, beginning with their localization in the sex-gender system, is thus considered one of the main effects of power. A person is simultaneously an effect of power and the center of its transmission, as they circulate and dialogically produce, exercise, and suffer actions of power[5].

No masculinity can be known outside a system of gender relations and, by extension, outside the constructions of truth regimes that are effects and at the same time (re)produce the aforementioned relations of power. The masculinities are produced in the framework of practices in which men and women commit themselves to gender positions and experience their effects through bodily experience, personality, and culture. In this sense, it is necessary to take into account other social structures that dialogue with gender[6,9].

Even considering that the phenomenon of drugs is broad and involves the population in a general way, when we look for those people who use them and have resulting problems, we encounter men. These are also, in the majority, black and poor[1]. The present study, although it has prioritized gender as a category of analysis, also considers these intersections and how they structure social organization and, consequently, must be part of the discussions that subsidize the construction of practices and proposition of public health policies.

The studies done by the Brazilian Center for Information on Psychotropic Drugs (CEBRID) demonstrate the necessity of being attentive to *intersectionalized* social spaces, when they ap-

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proach and produce information about persons who use drugs. In one of the 2005 population surveys of nationwide scope, for example, the conclusions emphasize the fact that socio-demographic characteristics – such as age, sex, and race – are associated with regular consumption of alcohol. To be female and white, for example, is indicated as one factor for protection from the regular use of alcohol. In the same survey, while discussing reports of illicit drug use throughout life – in this case, excluding alcohol and cigarettes – a significant difference between men and women was noted: 13.2% of men and 5% of women interviewed reported that they had used illicit drugs. This consumption appears to be greater in the younger age ranges, 16 to 24 years and 26 to 36 years – 11.7% and 12.1%, respectively – when compared to persons in the older age ranges – 8.8% for persons 34 to 46 years, and 3.1% for 47 to 65 years[10].

This information alerts us to the necessity of incorporating more complex interpretations about age groups and youth into the debate about the elaboration and implementation of health policy in the context of drugs, since this demands the construction of therapeutic strategies that are both specific and broad, that cover prevention as much as assistance to this population, whose data demonstrate conditions of vulnerability[11].

Youth here is understood according to the writings of Raymond Montemayor[12], who defines it as an age category whose sense is polysemic. He asserts there are five components that allow us a broader definition of adolescence: 1) chronological age, 2) biological development, 3) cognitive and psychological development (which includes the construction of an identity and interpersonal development), 4) the change of legal status, and 5) the possibility of participation in the events of adult life. Thus, we deal with a complex concept, tacitly utilized in research in which its transitory condition – spanning childhood dependence to full adult autonomy - is one of the fundamental objects under discussion.

It is also necessary to recognize that the perspective of gender can bring important contributions to the experience of what are considered *stages of life,* much like for death, sickness, and risk referred to earlier. The defense for incorporating the sex/gender dimension into discussions about health is accompanied by a reaffirmation that it is necessary to recognize the singularities of gender, that is, to recognize how experiences of specific problems can be different and to problematize the impact that normative behaviors of masculinity and femininity have on men and women[13,14].

The production of scientific knowledge can be one important space for the consolidation of this critique. Nevertheless, according to Aquino[15], the incorporation of gender as an analytical category in the field of health can be slow. The majority of work that utilizes the framework of gender as a social construction is qualitative research produced by the social sciences in health. In a more fine-grained analysis, it can be perceived that the work about gender and health is primarily focused on discussions about *reproduction and contraception.* These are followed by studies about *Sexuality and health;* and *Labor and health,* respectively. Lastly, in the *Other*category, listed alongside themes like aging, are studies that focus on mental health and, within these, those that deal with drug use[15].

The articulation between the fields of discussion about gender, masculinity, and drugs is not as common nor simple as it may seem. The limited incorporation of the concept of gender - restricted to the differentiation of the sexes and, therefore, failing to explore it as a marker of social organization - may be at the root of this difficulty[16].

Footprints of a genealogy

This study is part of a doctoral thesis that has the broader objective of understanding the meanings of masculinities and the places that are being defined for young men in Brazil's drug policies. Starting from a genealogical approach, we suggest two important contexts of analysis: 1) the context of the elaboration of health policy about drugs in Brazil, considering as a reference the publication of the document that established such policy[2]; and 2) the current context of implementation, in which it is hoped that the understanding created in the period of policy elaboration is manifested – strengthened or resignified.

The study that resulted in this article, in light of these contexts of analysis, is focused on the elaboration of policy and on interviews with people who were managers at the time. We interviewed three people from different spheres of management: municipal, state, and federal. We elected Recife and Pernambuco as our reference municipality and state, respectively.

The choice of these three interview subjects was due to the closeness to the field and the dialog with key interlocutors, who were identified as helpful to understanding the history of this field.

Thus, we arrived at Antônio (fictitious name, as are all the remaining names to be cited), who is a psychologist and was invited to work at the Ministry of Health in 2003 –the year in which the official document on drug policy was published – and, therefore, accompanied the elaboration and the beginning of the implementation of these policies at the federal level. At the time, he had recently concluded undergraduate training and worked in mental health policy management in São Paulo. Suzana is a doctor and psychiatrist, and worked in a psychiatric hospital in the state of Pernambuco, when she was called to put together a team and organize one of the first health centers for people with drug problems in the state in 1998. Mateus is also a doctor and psychiatrist. After contributing to the organization of state services attending to this population, he was invited to coordinate their implementation in the municipal healthcare network for drug users.

The interviews were guided by a script, based on the reflections derived from the standard of the episodic interview[17]. This aims to analyze the quotidian knowledge of the interview subject regarding a specific theme or field. The three interviews began with the construction of a *foundation,* a moment in which – in addition to familiarizing the interviewee with the theme and format of the interview – the ethical procedures were carried out, such as the reading and signing of the Free and Clarified Consent Form, in accordance with the provision in Resolution 196/96 of the National Health Council and with the obligations assumed in the approval of this research by the Ethics Committee on Research of the Fernandes Figueira National Institute for the Health of Women, Children and Adolescents (IFF/Fiocruz-RJ/MS).

The initial interview question was a *trigger.* We asked that the interlocutor recall the history of drug policy, inserting themselves in it in the sphere in which they participated. The construction of a *foundation* has the effect of weaving together the threads of the speech of those interviewed, localizing and considering the aspects related to gender or to young men. Afterwards, we asked more guided questions, with the aim of highlighting those aspects. It is this spoken testimony, webs and tapestries woven by them, together with the documents cited in the current literature on the subject, that we will construct what we call *a genealogical exercise regarding drug policy in Brazil.*

To follow the threads, curves, shadows, and (re)weave the webs that make up the history of the elaboration of drug policy in Brazil, beginning with the interlocutors who participated in that process, constitutes a genealogical exercise with the aim of identifying controversies, demarcate singularities, and – at the same time – ask ourselves about the established truth regimes that demarcate spaces equally singular for young men, whether in the quotidian life of policies or of healthcare practices. Genealogy is understood here as an epistemological gaze that opposes the notion that there is a single narrative of history, an unequivocal origin for events[5].

Thus as a way to systematize the genealogical exercise, the interviews were transcribed and began a construction of *episodic or narrative lines.* These are used to schematize *content of the histories utilized as illustrations and/or identity positions in the course of an interview*[18]. We use the idea of *episodic* with the intention of breaking the linearity that can be implicit in the concept of narrative lines, in that research experiences that work with such a concept demonstrate a fealty to a linear temporal perspective, that is not always consistent with the flow of the argumentation. We created an episodic line for each interview and in the path to analysis we seek to construct webs, and in certain cases networks, beginning with lines and the resulting identification of events.

The speeches of Antônio, Suzana, and Mateus are recurring threads in our genealogy, along with the documents cited by them, that refer to drug policy in Brazil, and the scientific production about the subject at hand. What are the conditions of possibility for the emergence of drug policy in Recife, in Pernambuco, and in Brazil? Who does it serve, or what subject positions are produced in the proposition of policy as well as the quotidian life of healthcare practices generated therein? And, thus, we arrive at our central question: what is the place of young men in this process?

The (non) space of the young man

The first thread in this web brings us to the Secretary of Health for the State of Pernambuco, near the end of the 1980s, and to the movement to implement two services oriented to people with drug problems. Mateusrecalls that the first statewide activity in this regard was in the context of discussions about the humanization of one of the largest psychiatric hospitals in Pernambuco. Nationally, it can be said that the conditions were established for what would historically come to be known as Psychiatric Reform.

This generated a discussion about the efficiency of psychiatric hospitals, and their effects in the lives of people in psychiatric suffering. Consequently, it brought to the center of the mental health debate the ideas of social norms and madness, seeking to reposition the latter as a socially produced condition. The psychiatric hospital came to be seen as an institution that should be problematized. There is a forceful critique, according to which the hospital is framed as a place of segregation, violation of human rights, and sickness. In paying attention to humanization and discussing the singularity of care, Psychiatric Reform showed the importance of offering specialized attention to persons with drug problems. Previously, they all fell under the same aegis of madness[19,20].

With a background in these critiques, when he was called to coordinate the process of restructuring one of the largest psychiatric hospitals in Pernambuco, one of the first measures Mateus took was to divide the hospital into small Units. One of the ten structured Units was dedicated to caring for people with drug problems, specifically alcohol. Suzana, who also formed part of this team, said that initially this Unit was created *way in the back of the hospital, in an abandoned place, separated.* She referred to this process of service implementation as a struggle. According to her, such challenges were met with political coordination and the institutionalization of training spaces in the routines of the recently implemented services.

Initially there were 30 beds designated for alcoholics. All were occupied by men, the majority of them adults. Later, the Unit grew larger and came to occupy the old infirmary of the Psychiatric Hospital, where it was known as the Center for Prevention, Treatment, and Rehabilitation of Alcoholism (CPTRA). Around the same time, another service was implemented: the Eulâmpio-Cordeiro Center (CEC), whose priority was people who used *other drugs,* especially marijuana and cocaine.

The speech of Suzana is complimented by the statements of Antônio, when he made general observations about the people who sought out these health services because of drug use up until the decade of the 1980s. Antônio refers to the same population of male alcoholics, but of more advanced age – many times, beginning at 40 years and older. He recalls the arrival of young people at the end of the 1990s, still mostly males, predominantly because of problems caused by the use of illicit drugs, and he problematizes the effect of their arrival on the routine functioning of health services and practices: *So, on one side, we had the older alcoholics, quiet, off on their own; and, on the other side, these young boys upsetting the service, running around, messing with everyone.*

According to Antônio, this arrival sparked questions about *what to do with these young boys. What type of provision would function the best?* However, he said at that time there was no policy with guidelines or specific orientation, and concluded that even today this remains *a question* for health policy.

Once again, it is important to note the conditions of political possibility in a historic moment. To speak of the decade of the 1990s is to refer to a period of effervescence in Brazilian public health, in which the Unified Health System (SUS) was implemented and regulated. Within the discussions of the day, the polysemy implied in the principle of the SUS –integrality – became strategic for the guarantee of universal care[21].

The concept of integrality and, along with it, tools like accommodation and bonding lead us to look at the singularities of healthcare practices[22,23]. Thus we begin to search within our threads and webs, and ask where and under which conditions the singularities relevant to gender are perceived and considered in the everyday life of such practices. It is in the CPTRA that we find the first experiences where aspects related to gender are mentioned. Designated as a *gender-based program* by Mateus, a group for alcoholic women was instituted inside the CPTRA for approximately two years, coordinated by Suzana. The group was formed due to demand from women attended by the service, who communicated that they felt more at ease to address certain so-called feminine questions:*Women have a lot of shame in seeking help, and they are also very discriminated against when they do ask for help. In those days, in this very health service here at CPTRA, when a woman arrived… we staff people had to struggle against our own prejudices.* Suzana affirmed that a group comprised of only women functioned very differently and was richer. Among the topics worked on within the group, she cited *feelings, self-esteem, exposure to violence, personal care, the role of "mother," the role of "woman"…* and concluded: *all these things come up often in a women's group. In a group of men they aren't so important.*

The statement of Suzana, in listing themes that would be more important for women than for men, touches on discussions about normativity, about what it means to be a man and a wom-

an in our society and therefore about what must be interesting to discuss among men and among women.Consequently, we arrive at the problematization of regimes of truth that institutionalize this normativity. Between the threads and webs of our genealogy, it is possible to discover points of connection that, from a Foucaultianperspective, can be called *archives*[24]. We understand *archive* as one or more groups of rules, situated in a determined historical period and within a given society. Such rules are comprised of an arrangement of discourses, socially sanctioned and legitimated, in the face of the truth status attributed to them. These are archives which, distributed in the social fabric, characterize the thought of a particular historical time and, consequently, the construction of subjectivities, which brings us to a discussion about hegemonic masculinity[25,26].

Similar to the notion of *archive* in this perspective is the recognition of a male standard of expected and unexpected practices, that is in dialog with the meanings implied by Suzana about themes and subjects that would not be welcome in a group of men. Hegemonic masculinity is normative, in that it *states the honorable way to be a man, and demands that all other men position themselves in those terms, and ideologically legitimates the global subordination of women to men*[27]. In spite of the fact that the majority of men do not stick closely to the normative and hegemonic model of masculinity, they nonetheless feel its effects[25].

If we take this normative model as one of the important factors in the legitimation of inequality between men and women, we begin to understand that it is necessary to denaturalizeor "make strange" the concept of hegemonic masculinity. We speak of an exercise of "making strange" similarly proposed by Miguel Vale de Almeida[26], in discussing the construction of masculine identity in an anthropological study of the community of Pardais (in the region of Alentejo, Portugal). The author proposes an exercise of denaturalization of hegemonic masculinity and problematizes the existence of other masculinities – there is a hegemony of one model *because* there are other models.

We believe that health practices committed to a minimization of social inequality – including gender inequality – can be placed at the disposal of challenging such concepts as hegemonic masculinity, and that the routine practices of therapy offer possibilities for its denaturalization and, therefore, the resignification and construction of other ways of experiencing masculinity. Especially if we note that the apparently privileged rank attributed to men, when the subordination of women is determined, does not bring them only benefits. However, in distinct moments of their interviews, Antônio, Suzana, and Mateus recognize that, initially, discussions like this were still secondary. They argued that their initial concern was to construct a network, implement equipment and procedures, and form teams.

One digression is given in a story about the history of drug policies in Pernambuco. Mateus indicated there was a *hiatus between the time of implementing the two initial services, at the end of the 1980s, and the beginning of municipal management in 2004.* During that time, there was a preoccupation with implementing a municipal network for the care of users of alcohol, tobacco, and other drugs, characterized by the incorporation of two already existent state-level services, in accordance with the guidelines of SUS, and by the implementation of other services. It is important to note that this happened in the year prior to the publication of the Health Ministry Policy regarding the care of users of alcohol and other drugs.

This document is considered a pivotal moment in health policy about drugs. It is a broad text, which begins with a definition of the theoretical-political framework of the Policy, in which harm reduction is singled out as strategic to the recognition of the individuality of persons who use drugs, and their willingness to use them, when planning for health practices. The text continues with the *Contextualization* of drug use as a health problem, presenting epidemiological data that point to a global tendency: the use of psychoactive substances, including alcohol, is happening earlierin life and in a more intense way. Some considerations on this subject are offered about vulnerable demographics. Among them are young men, especially vulnerable to violence. The document thus arrives at the proposal of *Guidelines.* In these, while discussing what would be necessary to reformulate drug policy in Brazil, the document indicates a recognition of singularities and, in this sense, of young people: *the rise in early use of legal drugs among youths and the increasingly frequent use of designer drugs and crack, and its impact on the physical and psychiatric health of young people, notably by the infection by HIV and hepatitis*[2].

Referring back to this document, Antônio – who had begun to work at the Health Ministry at the time of its publication – said: *it spoke of some questions related to the young demographic, not necessarily masculine, in this very specific con-*

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text, but it already made reference to the necessity of working with this young population, with young adults. Thus, it implied the recognition of an epidemiological profile considered vulnerable, although it did not yet recognize gender as also being a condition of vulnerability, nor race and class. Mateus recalled the beginning of the structuring of the municipal care network in 2004 with the Life+ Program, which was born out of a harm reduction program. The following years were taken up with implementation of services. Centers of Psych-social Care, oriented towards users of alcohol, tobacco, and other drugs; Detox Units; Halfway Houses (therapeutic hostels); teams for harm reduction in the country. The network in Recife established itself, seeking to diversify its offers of healthcare and attention. Among the resources created, Mateus emphasized a hostel for women. Once again, the understanding that women need an individualized perspective and the maintenance of a space reserved only for them would guarantee the most efficiency in their treatment.

When questioned about the other aspects of gender considered in the discussions around the implementation of the network, Mateus said: *There was much more of that type of discussion regarding the epidemiological profile … you characterized the young adult as being in the age group with the highest rate of drug consumption, and therefore with a greater need for protection. And you would discuss female gender. There was a preoccupation with the question of women and with creating specific spaces for women, specifically for their protection, like with Jandira (a therapeutic hospital for women).* In identifying young men as the most vulnerable group, Mateus and Antônio both show us that this is the demographic with *the vast majority of people attended by the services.* Soon after, Antônio adds that, in spite of not having guidelines or specific orientation about gender, the effects of the actions reached these men.

Suzana, in discussing the organization of services, recognizes the cultural privilege of men and at the same time affirms that the network of services earmarked for drug users is comprised of services intended for men: *In truth, men use more drugs. It's a cultural thing, isn't it? It's our society. And the majority of services are also created for the male population, targeting the male population.* This observation seems to be a reason to implement specific services for women. This is a strategy for the accommodation of a demographic – in this case, women – that has difficulties approaching and joining the healthcare network.

Contradicting Suzana's argument that services are created for the male population, studies about masculinities in the field of public health actually emphasize the absence of men as care-workers in the vast majority of health services. Once again, it is highlighted how hegemonic models of masculinity, socially constructed, in which care is not seen as an activity for men, can create obstacles in the access to services by the male population[28]. Once again, we emphasize the importance of being familiar with the particularities of gender in order to problematize the difficulties in access, bonds, and attention in healthcare. Can there be services regarding drugs created by men, and other services like basic care oriented towards women? Or do the ways that these services are constructed dialog with the ways to be a man or to be a woman that are specific and are, consequently, limited?

The interdiction of women from spaces meant for people with drug problems, added to the difficulty of incorporating gender as an analytic category, means that creating specific services tailored to different sexes could be an alternative to guarantee access and diminish gender inequalities. Antônio, however, questions and at the same time elaborates on what might be a strategy for facing this question: *Maybe separate services would not make much sense, don't you think? Specific services for men and services for women, right? I'm not very clear on this.* […] *the services were always thought of in a mixed way, right? Maybe, what I can think might be a way out of this dilemma or at least an intervention that would be interesting, would be the creation of gender-specific sub-services, within each service.* Within this argumentation, he cites the experience of the women's group and considers the possibility of also establishing men's groups. Thus, he maintains the focus on the specificity of the sexes as a strategy for the discussion of gender, but not for specific services; this time, it is with groups.

To attribute discussion about gender to specific services or groups seems similar to the understanding that accommodation is effective only when guaranteeing a sympathetic entryway to services. If, on one hand, the groups or services targeted at specific sexes can be strategic and add prominence to themes that have not had space in the discussions that impact the structuring of drug policies, on the other hand, it invites us to underscore that these artifices are no guarantee of the recognition of gender as a structuring category that produces effects and demarcates in-

equalities in the everyday routines of services, in health practices, or life in general. It is certain that, as stated by our interview subjects, men are already in the services. Heilborn and Carrara[29] note that men are considered implicit references in discourse, in as much as they are positioned as universal representatives of the human species. However, what this study claims is that drug policy can also be an instrument in the gendering of the gaze for these populations; in this specific case, for young men.

Final considerations

Although the official document of the National Policy for Integral Care for Users of Alcohol and Other Drugs[2] does not directly mention gender in its guidelines, the interviewed professionals understand that incorporating this discussion is a task that must follow the present movement of implementing networks of services, and limit their interventions to the creation of services and/or groups according to sex, we insist on the gendering of the gaze for men and women in health practices and policies as an important route to the consolidation of integrated healthcare. Lilia Schraiber[30], in referring to healthcare practices, notes that professionals are awkward about integral healthcare, and defines this awkwardness as an *alienation of the social markers of their practices.*

The everyday routines of healthcare services, targeting people with drug problems, often produce this alienation. As one example, the repetition of practices that have the drug as the focus and the so-called user as a body devoid of culture, adds to the construction of therapeutic strategies that revolve almost exclusively around the diminution or elimination of drug use. The centering of the substance and the paradigm of abstinence obfuscate the sociality of the supposed sicknesses, reducing them to the biomedical sphere, extinguishing the social life of the person.

May the genealogical exercise undertaken here help rupture with this alienation, contributing to the politicization of discussions in the field of health. May the reflections herein produced be knowledge longing for truth[5]. And thus we can construct, in the policies and in the routines of healthcare practices, other regimes that receive and welcome people in their wholeness who use and/or have problems with drugs.

Collaborations

E Granja worked on the elaboration fo the project, development of the research, fieldwork, analysis of data, and writing the article. R Gomes, B Medrado, and C Nogueira guided the whole research process and participated in the revision of analysis and writing of the article.

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