Published in final edited form as:

Int J Health Serv. 2017 July ; 47(3): 477–488. doi:10.1177/0020731416679351.

The Quest to Extend Health Services to Vulnerable Substance Users in Rio de Janeiro, Brazil in the Context of an Unfolding Economic Crisis

Noa Krawczyk[1], **Deanna Kerrigan**[2], and **Francisco Inácio Bastos**[3]

[1]Department of Mental Health, Johns Hopkins Bloomberg School of Public Health, Baltimore, USA

[2]Department of Health, Behavior and Society, Johns Hopkins Bloomberg School of Public Health, Baltimore, USA

[3]Institute for Scientific and Technological Information and Communication in Health (LIS/ICICT), Oswaldo Cruz Foundation (FIOCRUZ), Rio de Janeiro, Brazil

Abstract

Calls to address crack-cocaine use in Brazil among homeless and street-frequenting populations who are in urgent need of health services have questioned the capacity of the Brazilian Unified Health System to attend to the nation's most marginalized citizens. In recent years, Brazil has launched several actions to escalate care for substance users, yet many obstacles hindering accessibility and effectiveness of services remain. Paradoxically, these actions have been implemented in the context of a growing economic crisis, and expanding services for a population of poor and stigmatized substance users while cutting other government programs tends to elicit harsh criticism from citizens. In consequence of such prospects, this commentary aims to discuss barriers marginalized substance users face in accessing health services that are at risk of worsening with government cutbacks. Using Rio de Janeiro as an example, we explore two primary issues: the resource-strained, under-staffed and decentralized nature of the Brazilian Unified Health System and the pervading stigma that bars vulnerable citizens from official structures and services. Abandoning initiated government efforts to increase access to health services would risk maintaining vulnerable citizens at the margins of public structures, inhibiting the opportunity to offer this population humane and urgently needed treatment and care.

Keywords

substance abuse services; universal health; crack-cocaine; mental health services; marginalized groups

Corresponding Author: Noa Krawczyk, 624 North Broadway, Rm. 896, Baltimore, MD 21205, USA., noa.krawczyk@jhu.edu.

Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Calls to address the growing rise of crack-cocaine use in Brazil among homeless and street-frequenting populations have brought into question the capacity of the Brazilian Unified Health System (SUS) to attend to the health needs of Brazil's most marginalized citizens. Despite the Brazilian 1988 Constitution's commitment to guarantee all citizens' right to health, many vulnerable populations, including poor and/or homeless alcohol and drug users, remain on the margins of official government structures with little contact with formal health services.[1,2] As Brazil is currently confronting a major economic and political crisis, with budget cuts in all government sectors, the risk of further forfeiting the health and human rights of Brazilians most in need becomes even more relevant and challenging.

Crack use presents a significant public health problem throughout Brazil. A recent national survey estimated that in 2012, there were approximately 370,000 users of crack-cocaine and similar drugs in the capitals of the Brazilian States alone, and that the majority used crack in open or public settings. Most of these users are additionally alcohol and poly-drug users and most commonly young, non-white, of limited schooling, and without permanent housing or formal employment.[3] These conditions make this population especially vulnerable and at risk for serious health conditions, including the risk of toxicity from mixing high doses of alcohol and cocaine.[4] Users of this profile commonly use substances in unsanitary conditions,[5] share drug paraphernalia, and engage in sexual risk behaviors.[6] Crack users have higher rates of infectious diseases including Human Immunodeficiency Virus (HIV), Hepatitis-C Virus (HCV), and tuberculosis,[3] in addition to a plethora of non-infectious conditions and psychiatric comorbidities.[7]

Despite their need for urgent and long-term health and treatment services, crack and other substance users have largely remained out of touch with the formal Brazilian health system and experience a plethora of barriers in accessing care.[1,2] While initiatives such as the federal conditional cash transfer program, Bolsa Familia, have had a favorable impact on the health of individuals and communities,[8] such programs have targeted families in poor, but stable households, not the homeless. Vulnerable substance users have thus historically relied on religious and lay charities with partial government support, as well as private and donation-funded institutions such as therapeutic communities that offer strictly abstinence and faith-based in-patient rehabilitation with little or no regulation as to the conditions or effectiveness of their services.[9]

Federal Health Programs for Substance Users

In recent years, and in the context of growing international attention to Brazil in the lead-up to the 2014 World Cup and the 2016 Olympics, the federal government has formally recognized crack use as a public health problem and has launched several actions to increase the access of vulnerable crack and other substance users to public health and harm-reduction services through SUS. In 2009, the Brazilian Ministry of Health passed an "Emergency Plan to Increase Access to Treatment and Prevention of Alcohol and Other Drug Use," which formed the basis for the 2011 controversially termed government campaign, *"Crack, é possível vencer" ("Crack: it is possible to defeat").* Although its promotion focused primarily on crack, the programs associated with the Emergency Plan targeted all substance users, including alcohol and other drug users (generally referred to in the article as substance

users). Along with increasing prevention programs and enforcement efforts to limit the supply of illicit drugs, this plan called for the reintegration and protection of drug users within the public health and social services systems [ordinance n° 1.190, 2009].

Two specialized low-barrier health services were at the center of the federal government's Emergency Plan efforts to extend care to vulnerable substance users: The first were "Consultorios de Rua," (alternatively, they may be called "Consultorios NA rua," with slightly different operations), which are clinics that specialize in caring for street populations by bringing health services directly to drug-use settings.[10] Each clinic is designed to possess a van by which to reach patients, deliver medications for conditions such as tuberculosis or HIV, and help patients reach health services for any tests or emergency care they may need. Often, substance use problems are secondary to other mental or health conditions that arise from living in distressing conditions. Thus, these clinics' strategies are based on a harm-reduction model that aims to prioritize urgent health needs and encourage safe sex and drug-use practices.[11,12]

The second service promoted by the Emergency Plan was "Centros de Atenção Psicosocial Álcool e Drogas (CAPS-AD)," psychosocial outpatient clinics that specialize in care for alcohol and drug use disorders and that are extensions of the more general mental health clinics created as part of the Brazilian Psychiatric Reform Movement in the 1980s to deinstitutionalize mental health care.[9] Patients here receive outpatient care for substance use problems based on a harm reduction approach through a combination of individual and group therapy, recreational workshops, and psychiatric care. While both of these health services are managed by municipal governments under SUS universal health system, the Emergency Plan allocated additional federal funding for the expansion and strengthening of these low-barrier services.

Paradoxically, these new policies and programs have come at a time of shrinking budgets and what now has been recognized as a major fiscal crisis. In recent years, Brazil has experienced halted economic growth and, according to the latest estimates, the economy is estimated to have shrunk by more than 4% in 2015.[13] The quickly rising inflation and political instability that have dominated Brazil over the past year have halted much of the ongoing implementation and evaluation of these programs. And while a formal assessment of the Emergency Plan was never completed, news sources estimate that only a small percentage of the original aims of the government's plans to confront crack use were actually accomplished: For example, of the 308 promised Consultórios de Rua, only 133 were created, and of the of 175 promised CAPS-AD, only 68 were created.[14] Moreover, promised investments in services for substance users overlapped with dramatic cuts in the health budget, such as cuts to the Public Pharmacy, which provides free or discounted medications throughout the entire SUS services system. As expected, expanding services for a marginalized and stigmatized population while cutting essential health and social service programs for other segments tends to elicit harsh political criticism.

The Case of Rio de Janeiro

Rio de Janeiro, despite being the second most affluent city in Brazil, has been harshly affected by the economic crisis due to the collapse of its oil industry, among other factors. As one of Brazil's largest metropolitan centers with a significant number of crack use settings,[3] it was also a major city targeted by the national Emergency Plan to confront crack and other substance use. Yet, despite some initial steps that have taken place to expand the aforementioned low-barrier services, fiscal and political hardship and lack of follow-through with the promised resources for this population have left many substance users with recurrent obstacles in accessing care. Precisely in consequence of such unfortunate prospects, it is pressing that we document major and ongoing barriers to care throughout the Brazilian public health system, which are at risk of worsening with further government cutbacks. For if Brazil abandons current efforts to expand specialized and low-barrier services that cater to this population, it risks compromising the modest progress that has been made so far to extend the right to health to this marginalized group.

To exemplify the major challenges throughout Brazilian communities and health services, this article will focus specifically on the city of Rio de Janeiro and discuss two primary barriers that impede substance users' access to care. First, service structure barriers arise from the resource-strained, understaffed, and decentralized nature of the Brazilian unified health system, which makes health services difficult to access and navigate. Second, and perhaps the most challenging barrier in the face of the current crisis and pervading atmosphere of mistrust and conflict, the ingrained stigma and criminalization that perpetuate marginality and bar the most vulnerable citizens from official structures and services.

While these challenges are discussed specifically in the context of Rio de Janeiro and the Brazilian health services system, many of these barriers and their consequences are commonly experienced by vulnerable populations in other settings and may have implications for health service structure and practice beyond this Brazilian example.

Service Structure Barriers

When discussing public health services in Brazil, it is important to emphasize that SUS, which includes an impressive and vast network of health services that range from prevention and primary care to intensive and hospital care, is largely under-resourced in its capacity to attend to all the health needs of the majority of Brazilians that use this system. Lack of funding and standardization of services often lead to inadequate facilities, equipment, understaffing, and inadequate training. Combined with bureaucratic difficulties such as extensive paperwork, documentation, complex referral mechanisms, and long wait times to obtain care, many citizens find health services complex and challenging to navigate. And as the privileged upper classes are able to avoid SUS through purchase of private insurance plans,[15] poorer citizens that rely on this resource-limited system are subject to implicit and explicit discrimination by providers and by the lack of political will to invest adequate resources into the public system of care.[16] As the economy further deteriorates, already resource-strained facilities become more underfunded and overloaded, and the burden of bureaucratic and organizational problems is likely to worsen.

Largely responsible for the complex service structure of SUS is the inconsistent and decentralized management of services. While all SUS clinics and services are funded by a combination of federal, state, and municipal funds, most health clinics in Rio de Janeiro, including ones that provide care specifically to substance users such as Consultorios de Rua and CAPS-AD, are actually managed by third-party private organizations that are subcontracted by the Municipal Health Secretariat. Such Social Organizations of Health Care (OSS) supposedly follow basic guidelines dictated by the state, but have substantial flexibility in managing services and human resources. These organizations were originally implemented with the intention of decentralizing management and improving efficiency of health care services by alleviating bureaucratic obstacles of government services.[17] However, their managerial autonomy has led each to take on different treatment strategies and health practices, which causes similarly natured services to be inconsistent throughout different institutions. Lack of standardization and regulation across public services makes it difficult to assess whether funds are being utilized appropriately, to evaluate the effectiveness of current strategies, or to implement evidence-based care.

The multiple managing-organization structure also complicates the referral of patients between services as each clinic follows a different protocol dictated by its respective third-party management service, which can range from electronic to word-of-mouth with no record or follow-up. Patients with multiple service needs or medical co-morbidities, highly prevalent among substance users,[7] may require treatment in separate clinics and locations, each with long wait lists and a different structure of care. For vulnerable substance users, many whom have a low education level, unstable housing, and physical and mental health problems and who lack family and social support, this complexity acts as an immediate hurdle to seek and receive care, especially as they are more likely to move geographic locations or forsake treatment.[18] Moreover, unstably-housed substance users often do not possess proper documentation they may need to access SUS services or they may be hesitant to use it for fear of being persecuted for illicit drug use.[1] In the absence of persistent advocacy and collaboration between civil society, activists, and committed health professionals, initiatives such as case management for vulnerable patients have seldom been used. Instead, staff members may prioritize impersonal, inattentive assistance in detriment to disenfranchised, non-white, and poorer citizens.[19] This becomes an issue primarily in areas with highest need, such as impoverished neighborhoods where health facilities are most under-resourced and where staff is overworked and underpaid.[18]

The federal government’s Emergency Plan aimed to address some of these structural barriers by expanding the specialized Consultorios de Rua and CAPS-AD that were specifically designed to be low-barrier and address the needs of more marginalized populations that were often lost from the traditional care system. However, the extent to which these specialized services, which did not necessarily receive adequate funding or training for their staff, are able to sustainably address the needs of vulnerable substance users is questionable.[18] The most transparent limitation is the narrow capacity of amenities and staff to meet the large demand for services. Although the original government plan called for substantial expansion of these services,[14] in reality, only six Consultorios de Rua and five CAPS-AD were implemented throughout Rio de Janeiro, which cannot realistically attend to the city’s population of more than 6 million. These few clinics are especially difficult to reach for the

poorest patients, who may have to travel for hours and pay for public transportation to reach services. As specialized services are limited, substance users must rely on more widespread SUS primary care centers, but the previously discussed obstacles preside.

Stigma and Criminalization

Underlying many of these structural barriers is the deeply rooted stigma that often bars substance users not only from accessing but also seeking and continuing care. Stigma toward substance users penetrates Brazilian society in a myriad of ways, ranging from public discourse to the attitudes of health professionals to self-abasement by users themselves. The slogan of the federal program “Crack: it is possible to defeat” itself implies a war-like approach to addressing drug use, which poorly fits the harm reduction model that makes the basis of many of its health practices. This kind of war declared on crack-cocaine is especially detrimental due to the lack of evidence-based campaigns about substance use available to the public, whose substance use education consist of limited and contradictory programs sponsored by education authorities, the police, and even the alcohol industry.[20] Thus, the public’s knowledge relies heavily on exaggerations by the media and moralistic rhetoric about drugs that drive negative notions and spread misconceptions about substance users.[21]

Stigma surrounding substance use is present even within health care facilities and has been reported repeatedly by substance users as a barrier to seeking care.[1,22,23] Primary care providers are not trained to respond to this population’s unique needs and may not have the time, capacity, or motivation to provide the delicate attention needed. Moreover, health professionals may have preconceived notions regarding the immorality of drug use, which can mutually reinforce pre-existing prejudices toward poor and black patients. Studies of public health care clinics have found that black and poorer patients experience high levels of neglect, including delays and lack of commitment from health professionals,[24] and that marijuana/cocaine addicts and alcoholics, in particular, suffer high rates of rejection by health professionals.[25] Such discrimination can discourage users from seeking out services for fear of being mistreated and can lead them to further isolate themselves from care.[22] In light of budget cuts throughout the health care sector, services for substance users are likely to be even further stigmatized for shying resources away from patients perceived as more deserving. De-prioritization of resources and initiatives targeting “unfavorable” populations, as viewed by conservative politicians and local managers, has been seen in the past with HIV prevention services, in which lack of political interest has been translated into procrastination and discontinuation of programs and projects.[26]

Harsh drug laws and persecution by law enforcement also play an important role in sustaining stigma against substance users. The Rio de Janeiro military police forces, which have historically held a doctrine of violent security and hostile relations with poorer communities, commonly use intimidating tactics against poor users who frequent scenes of drug use and trafficking.[27] Many funds from the Emergency Plan initiatives to confront crack use have paradoxically been allocated to strengthen the role of security forces in “getting tough” on drug traffickers, differentiating between perceived drug-dependent users in need of care and drug traffickers, which are viewed as criminals. This distinction is grayer

in reality, as users commonly work as low-level dealers and these activities are performed in close quarters. Moreover, while federal law formally distinguishes between possessing drugs for personal use and for trafficking [law n°11.343, 2006], current legislation does not specify objective limits. Arrests and prosecutions are thus made largely at individual policemen's and judges' discretion.[28]

Tensions between law enforcement and substance users have somewhat worsened as Rio de Janeiro prepared to host the 2014 World Cup and the 2016 Olympics. Instead of encouraging users to utilize health and harm reduction services such as the Consultorio de Rua and CAPS-AD, in 2012, the municipal government supported a series of raids to forcefully detain crack users and send them to shelters and private in-patient treatment centers. These operations contradicted the health centered model championed by the federal government and exacerbated stigma by raising public fears, leading many users to flee into regions dominated by drug trafficking groups and to be less likely to trust health and other public services.[29] As public insecurity and panic ensue in light of the economic crisis all around the country, public demand for harsher policing is expected to grow, and a surge in negative relations between poor citizens and police is likely.

The Risks of False "Exceptionalism"

This article has discussed some of the intersecting barriers that play into the challenge of delivering the promise of universal health care to Brazil's most hard-to-reach groups. Although empirical evidence clearly shows substance users remain an underserved population in Brazil, in the context of a concerning economic deficit and major budget constraints, the very existence of a progressive federal program for substance users with a substantial budget may be viewed by its critics as an undesirable prioritization. This concept is similar to that of "exceptionalism" debated in the context of HIV, in questioning whether the HIV field in the last decades has received too much attention and funding in detriment (actual or perceived) to other major and urgent public health burdens.[30] It seems that a similar risk of falsely perceived "exceptionalism," or prioritization of needs of vulnerable groups above those of others, though absent in the real world in terms of concrete policies and political and budgetary privileges, is likely to become a topic of debate in Brazil. To our knowledge, wrong or right respecting AIDS policies, such a concept has never been used in the context of people who misuse substances because this disenfranchised and criminalized population is not considered "exceptional" by any means except as one of the most underserved and marginalized populations in most societies, worldwide. Yet, it is a likely scenario in contemporary Brazil and other nations experiencing economic instability that citizens will criticize government programs for substance users as an exceptional and unnecessary use of government funds for which this population is hypothetically getting much more than its "fair share."

The case of Rio de Janeiro and the Brazilian health care system, although unique, is by no means an exception to the experiences of marginalized substance users across the globe. Harsh and criminalizing drug policies along with commonly demoralizing discourse about drug use have excluded this group from mainstream social support circles and official health services in most societies. Thus, regardless of the health system being discussed, this

population, which simultaneously experiences high rates of poverty, mental illness, and infectious disease, often suffers most from heavy stigma and the bureaucratic hurdles of service systems. The example of the Brazilian federal response to crack use illustrates an optimistic and perhaps well-intentioned attempt to integrate more accessible and low-barrier care for this population within the structure of what may be a resource-limited but still impressively universal public health system. But as shown, without greater support from political leaders and greater society to prioritize the need to reintegrate marginalized populations, such services will always be the first to be sacrificed under difficult economic conditions and political crises.

The worst-case scenario can be one of aborted drug policy reform, less investment in public health services, and persisting health care barriers for marginalized populations who use substances. This would mean returning to the exclusionary discourse that criminalizes the poor and that has historically maintained vulnerable citizens at the margins of public structures, destroying in its inception the chance to offer such populations humane and proper management and care. Preserving this marginalization would not only be in detriment to public health efforts, but would also actively exasperate chronic inequality, homelessness, and structural violence that are at high cost to maintaining safe and productive societies. Given the current circumstances, extending the right to health to vulnerable substance users and prioritizing care services thus remains an elusive goal both in Brazil and nations worldwide, and as discussed by the current article, one that, in the face of ongoing criticisms, must be fought to preserve.

Acknowledgments

Funding

The authors disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This work was conducted with the support of the Fulbright U.S. Student Program and by a grant by the National institute of Drug Abuse (T32-DA007293, PI: Renee Johnson).

References

1. Santos Cruz M, Andrade T, Bastos FI, et al. Patterns, determinants and barriers of health and social service utilization among young urban crack users in brazil. BMC Health Serv Res. 2013; 13(1): 536. [PubMed: 24373346]
2. Malta M, Monteiro S, Lima RM, et al. HIV/AIDS risk among female sex workers who use crack in southern brazil. Rev Saude Publica. 2008; 42(5):830–837. [PubMed: 18833383]
3. Bastos, FI., Bertoni, N., editors. Pesquisa nacional sobre o uso de crack: quem são os usuários de crack e/ou similares do brasil? Quantos são nas capitais brasileiras?. Rio de Janeiro, Brazil: ICICT/FIOCRUZ; 2014.
4. Dinis-Oliveira RJ. Metabolomics of cocaine: implications in toxicity. Toxicol Mech Methods. 2015; 25(6):494–500. [PubMed: 26249365]
5. Mann CG, Bastos FI. A brief photo-biography of crack users from Rio de Janeiro's metropolitan area: their settings and tools. Subst Use Misuse. 2015; 50(4):520–522. [PubMed: 25540948]
6. Narvaez JC, Jansen K, Pinheiro RT, et al. Violent and sexual behaviors and lifetime use of crack cocaine: a population-based study in brazil. Soc Psychiatry Psychiatr Epidemiol. 2014; 49(8):1249–1255. [PubMed: 24519271]

7. Narvaez JC, Jansen K, Pinheiro RT, et al. Psychiatric and substance-use comorbidities associated with lifetime crack cocaine use in young adults in the general population. Compr Psychiatry. 2014; 55(6):1369–1376. [PubMed: 24933652]
8. Rasella D, Aquino R, Santos CA, Paes-Sousa R, Barreto ML. Effect of a conditional cash transfer programme on childhood mortality: a nationwide analysis of Brazilian municipalities. Lancet. 2013; 382(9886):57–64. [PubMed: 23683599]
9. Ribeiro JM, Moreira MR, Bastos FI, Inglez-Dias A, Fernandes FM. Access to treatment for those with alcohol, crack or other drug dependency problems-a case study in the municipality of Rio de Janeiro, Brazil. Ciencia & saude coletiva. 2016; 21(1):71–81. [PubMed: 26816165]
10. Teixeira, M., Fonseca, Z., editors. Saberes e práticas na atenção primária à saúde: cuidado à população em situação de rua e usuários de álcool, crack e outras drogas. 1. São Paulo, Brazil: Hucitec; 2015.
11. Londero MFP, Ceccim RB, Bilibio LFS. Consultation office of/in the street: challenge for a healthcare in verse. Interface-Comunicação, Saúde, Educação. 2014; 18(49):251–260.
12. Silva, FPd, Frazão, IdS, Linhares, FMP. Health practices by teams from street outreach offices. Cadernos de Saude Publica. 2014; 30(4):805–814. [PubMed: 24896055]
13. Campos, E. [Accessed May 27, 2016] Prévia' do PIB do brasil fecha 2015 com queda de 4,08%, calcula BC. Valor. Feb 18, 2016. http://www.valor.com.br/brasil/4442324/previa-do-pib-do-brasil-fecha-2015-com-queda-de-408-calcula-bc
14. Antonelli, D. [Accessed May 27, 2016] Plano anticrack cumpre só 20% da meta. Gazeta do Povo. Jan 21, 2015. http://www.gazetadopovo.com.br/vida-e-cidadania/plano-anticrack-cumpreso-20-da-meta-ej3b0lw54sy85l3n1wk1yt1la
15. Paim J, Travassos C, Almeida C, Bahia L, Macinko J. The brazilian health system: history, advances, and challenges. Lancet. 2011; 377(9779):1778–1797. [PubMed: 21561655]
16. Travassos C, Bahia L. What is the agenda for combatting discrimination in the Brazilian unified national health system? Cad Saude Publica. 2011; 27(2):204–205. [PubMed: 21359456]
17. La Forgia GM, Harding A. Public-private partnerships and public hospital performance in Sao Paulo, Brazil. Health Aff (Millwood). 2009; 28(4):1114–1126. [PubMed: 19597211]
18. de Andrade TM. Reflections on drug policies in brazil. Cien Saude Colet. 2011; 16(12):4665–4674. [PubMed: 22124907]
19. d'Orsi E, Bruggemann OM, Diniz CS, et al. Social inequalities and women's satisfaction with childbirth care in Brazil: a national hospital-based survey. Cad Saudei Publica. 2014; 30(Suppl 1):S1–S15.
20. Pantani D, Sparks R, Sanchez ZM, Pinsky I. 'Responsible drinking' programs and the alcohol industry in brazil: killing two birds with one stone? Soc Sci Med. 2012; 75(8):1387–1391. [PubMed: 22800917]
21. Nappo SA, Sanchez ZM, Ribeiro LA. Is there a crack epidemic among students in brazil? Comments on media and public health issues. Cadernos de Saúde Pública. 2012; 28(9):1643–1649. [PubMed: 23033180]
22. Krawczyk N, Filho CL, Bastos FI. The interplay between drug-use behaviors, settings, and access to care: a qualitative study exploring attitudes and experiences of crack cocaine users in Rio de Janeiro and Sao Paulo, Brazil. Harm Reduct J. 2015; 12(1):24. [PubMed: 26245997]
23. Kerrigan D, Vazzano A, Bertoni N, Malta M, Bastos FI. Stigma, discrimination and HIV outcomes among people living with HIV in Rio de Janeiro, Brazil: The intersection of multiple social inequalities. Global Public Health. 2015:1–15.
24. Trad LAB, Castellanos MEP, Guimarães MCS. Accessibility to primary health care by black families in a poor neighborhood of salvador, northeastern Brazil. Rev de Saúde Pública. 2012; 46(6):1007–1013.
25. Ronzani TM, Higgins-Biddle J, Furtado EF. Stigmatization of alcohol and other drug users by primary care providers in southeast Brazil. Soc Sci Med. 2009; 69(7):1080–1084. [PubMed: 19692163]
26. Fonseca EM, Nunn A, Souza-Junior PB, Bastos FI, Ribeiro JM. Decentralization, AIDS, and harm reduction: the implementation of public policies in Rio de Janeiro, Brazil. Cad Saude Publica. 2007; 23(9):2134–2144. [PubMed: 17700948]

27. Bastos FI. Structural violence in the context of drug policy and initiatives aiming to reduce drug-related harm in contemporary brazil: a review. Subst Use Misuse. 2012; 47(13–14):1603–1610. [PubMed: 23186486]
28. Boiteux, L. Drugs and prisons: the repression of drugs and the increase of the brazilian penitentiary population. In: Metaal, P., Youngers, C., editors. Systems Overload-Drug Laws and Prisons in Latin America. Washington, DC: Washington Office Latin America; 2011. p. 30-38.
29. Bastos FI. Against the tide: current perspectives in brazilian drug policy. Cadernos de Saúde Pública. 2013; 29(2):216–218. [PubMed: 23459801]
30. Smith JH, Whiteside A. The history of AIDS exceptionalism. J Int AIDS Soc. 2010; 13(1):47. [PubMed: 21129197]

Biographies

Noa Krawczyk, BA is a doctoral student in the Department of Mental Health at the Johns Hopkins Bloomberg School of Public Health and a trainee of the NIDA Drug Dependence Epidemiology Pre-Doctoral Fellowship. Her research interests relate to health service utilization among drug users and barriers to treatment and care-seeking among vulnerable groups. Krawczyk holds a Bachelor's degree in biology from the Macaulay Honors Program at CUNY Hunter College (2012) and has worked on several public health research projects both in Brazil and the U.S. In 2014, Krawczyk conducted a Fulbright research project in Brazil where she studied the barriers to public health services among homeless crack users in Rio de Janeiro.

Deanna Kerrigan is an associate professor at the Johns Hopkins Bloomberg School of Public Health. She has been engaged in public health intervention research with a focus on the study of social and structural factors influencing the adoption of health-promoting behaviors related to HIV prevention and care since 1995. A significant portion of her research has focused on evaluating the role and impact of environmental-structural factors related to HIV outcomes among marginalized groups, including female sex workers, people living with HIV and disadvantaged youth. She recently directed a large-scale, global HIV prevention operations research portfolio funded by USAID, Project Search: Research to Prevention (R2P). She is the Co-Director of the Prevention Core of the Johns Hopkins Center for AIDS Research (CFAR). Her current work focuses on Tanzania, the Dominican Republic, Brazil and Baltimore. She previously served as a Program Officer in the area of Sexuality, Reproductive Health and Rights for the Ford Foundation in Brazil.

Francisco Inácio Bastos, MD, PhD, Originally a psychiatrist by training, Dr. Bastos is a Senior Researcher and former Chair of Graduate Studies in Epidemiology and Biostatistics at the Oswaldo Cruz Foundation in Rio de Janeiro, Brazil (since 2005). He has years of experience researching substance misuse and associated harms and risks, including HIV, viral hepatitis and other STIs and blood-borne diseases. Bastos has worked with collaborators in Brazil and abroad and has published extensively on HIV among people who misuse substances and within poor communities. He has been the Principal Investigator on a number of large, multi-city studies on HIV and other blood-borne infections and STIs, including the WHO Multicity Project on HIV/AIDS and viral hepatitis among injection drug users, the multicity study of HIV and syphilis in 10 Brazilian cities, and the National survey on Crack Cocaine and Associated Harms in Brazil. His research team has developed new

methods for assessing needs and vulnerabilities of impoverished and marginalized populations.