Addiction Research and Theory, April 2011; 19(2): 161–169
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ISSN: 1606-6359 print/1476-7392 online
DOI: 10.3109/16066359.2010.545157

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Emergencies and rescues: The logics of vulnerability and care among drug users in Buenos Aires, Argentina

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(Received 28 April 2010; revised 1 November 2010; accepted 11 November 2010)

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This article addresses the informal practices of care among drug users from vulnerable populations in Buenos Aires, within a context of economic crisis, criminalization, and marginalization. Based on ethnographic research carried out since 2001, I argue that this set of practices, knowledge, and social networking known locally as ''rescuing'' seek to minimize bodily harms, harm to relationships, as well as to reduce threats to survival. This analysis shows how this logic of care varies according to the type of substance consumed, gender, socioeconomic status, social capital, access to institutions, family networks, and life trajectories. Finally, the development of this logic of care for drug use based on rescuing practices, allows us to understand the relationships between structural transformations and everyday life through the processes the privatization of care and the politicization of suffering.

Keywords: *Vulnerability, social catastrophe, drug use, logics of care*

INTRODUCTION

The steady increase of drug consumption in socially vulnerable populations in Buenos Aires has been contemporary to the increase of the poverty, social marginalization, and territorial exclusion that was generated by the neoliberal reforms implemented over the last few decades in Argentina (Bourgois, 1995; Epele, 2008b; Intercambios, 1999; Miguez, 2000; SEDRONAR, 2006, 2007; Svampa, 2005). Based on the results of an ethnographic study carried out in Buenos Aires' neighborhoods since 2001, in this article I examine a set of informal practices and knowledge which locally are dubbed as ''rescuing'', in a setting of deteriorated social and health conditions. Thus, the main objective is to analyze ''rescue'',[1] ''being rescued by others'', and ''rescuing oneself'' as practices of care which aim to promote the well-being, health, and survival of young drug users in Buenos Aires' shantytowns.

Starting with the theoretical perspective of care in general and health care in particular (Held, 2006; Kleinman, 2009; Mol, 2008), the analysis focuses on how this set of practices, knowledge, and social networking moderate, reduce harm from and/or quit drug use. On the one hand, I describe different types of practices and knowledge and the ways in which they articulate. Combining relationship dynamics, verbal mandates, bodily practices, individual decisions, group action, bodily and self-care practices, local, and expert knowledge as well as institutional strategies, *rescuing* has surfaced in these populations in order to respond to the new problems connected with intensive drug consumption in contexts of social catastrophe. Specifically, I examine how this set of practices and knowledge varies according to the type of substance consumed, gender, socio-economic status, social capital, heterosexual bonds, accesses to institutions, family networks, and life trajectories (Epele, 2008a; Miguez, 2000, 2006; SEDRONAR, 2007; Touzé, 2006).

Several studies in Anthropology and Social Science have indicated how care has been marginalized and undervalued in the Western world (Harrington, 1999; Mol, 2008; Tronto, 1994). Specifically, the importance of caregiving has been distorted not only in chronic, degenerative, and terminal illnesses but also in social catastrophes that have multiple consequences for the affected populations (Kleinman & Hanna, 2008; Mol, 2008). Based on this perspective, the development of this set of practices of care on drug use and marginality helps clarify the processes of *privatization of care and*

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politicization of suffering by which traditional ways of promoting well-being and health have been modified, displaced, destructured, creating new networks, demands, strategies, problems, conflicts as well as new vulnerabilities (Epele, 2008b).

SUBJECTS AND METHODS

The ethnographic research on which this article is based has been carried out – in different stages as well as in different neighborhoods and institutions – since the year 2001. During the first stage (2001–2008), I studied the use of drugs, specifically cocaine, psychotropic drugs, marijuana, freebase cocaine/Paco (FBC/Paco),[2] and alcohol in populations of the Greater Buenos Aires. I conducted semi-structured interviews with diverse social actors. The main recruitment strategy was the snowball technique. The snowball technique was carried out with drug using social networks and ex-drug using social networks. On the one hand, this technique was used to contact drug users and their relatives from local health care centers, soup kitchens, and neighborhood leaders. The inclusion criteria to be interviewed were that they use drugs on a daily and weekly basis for the first type social networks, and experience of drug use in life trajectory.

Among the main categories documented in the interviews were: social and economic living conditions, education, characteristics of the social networks for consumption of drugs and FPC/*Paco*, strategies to obtain resources, nature of the exchanges, family composition, drug consumption history, modes of drug use, consequences of intensive use to their health, threats to survival, and institutional trajectories. At first, 40 subjects – 24 men and 16 women – were interviewed, all who were active drug users. Ages ranged between 18 and 45. Most obtained resources through diverse strategies combining informal practices (recycling objects, street vending, selling wares at open markets, wiping windshields at traffic lights, etc.) illegal practices (shoplifting, mugging, and minor drug sales) in addition to occasional, precarious short-term work, or odd jobs, in the formal job market. Second, 20 family members were interviewed, specifically mothers, wives, and siblings. I also interviewed members of different social organizations, such as soup kitchens and neighborhood leaders, among others. Participant observation was conducted in drug users' gathering places – street corners, dwellings, outdoor spaces – and in homes where some lived with relatives. Participant observation and interviews were also conducted in health services centers. Finally, we interviewed health professionals, social workers, doctors, and psychologists.

During the second stage (2008–present), I supervised a study focusing on drug use – FBC/*Paco* in particular – in which drug users and other social actors of a neighborhood in Buenos Aires's metropolitan area[3] were interviewed. In addition, this project is currently studying the problems of networks and organizations of the area's mothers, as well as access conditions to health institutions such as therapeutic communities, general hospitals, and psychiatric facilities. In keeping with the ethnographic method, the field work has interviews and participant observation as its central axes. Although this second stage is still in progress, the preliminary results show several differences with previous research, specifically regarding social conditions, modes of drug use, repressive police strategies, territorial isolation, and access to the health care system.

CARE AND ITS CHALLENGES

The notion of care involves several challenges in studies on the health issues in contemporary societies. Integrating care means more than shedding light on a domain of life that has been marginalized, invisibilized, and undervalued. Following Tronto (1994), analyzing care questions the underlying epistemological, political, and moral presuppositions in the ways of understanding and valuing practices that promote well-being, health, and citizenship.

First, activities and practices of care – as well as those who accomplish them – are both socially and monetarily marginalized and undervalued because they are associated with the emotion, women, lower classes, ethnic minorities, and needs (Harrington, 1999; Kleinman & Hanna, 2008). By analyzing who takes care of whom, patterns of social subordination become evident: the disadvantaged sectors of the population cease taking care of their own in order to work as caregivers for members of upper social classes (Tronto, 1994). Second, to speak of care is also to question the dualities that have supported illuminist instrumental rationality and the ideology of the individual as an autonomous being (Mol, 2008). The notion of care specifically deconstructs tensions between autonomy/dependence, control/attention, local knowledge/practice, and values, and thus, the citizenship models carried on by liberal policies (Butler, 2004; Tronto, 1994). Third, Foucault acknowledged there existed relations between the techniques of care, power, and subjectivity. Care mandates of the body and self – specifically related to self-control guided by expert knowledge – has transformed a healthy body into the visible expression of an individual's morality (Foucault, 2005).

In the socio-anthropological field of health and illness research, focusing on care involves the task of questioning ''choice'', which has gradually invaded most medical treatments as the ideal practice. While choice responds to a rational logic, care is a developing process in which knowledge, social networks, technology, tasks, and bodies all intervene. With care there is room for fragility, uncertainty, and incorporating experiences (Mol, 2008).

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Questioning this divorce between medicine and caregiving, Kleinman (2009) characterizes the latter as a complex activity, which takes energy, time, financial resources, producing anguish, conflict, and doubt. The division of labor between doctors and caregivers – social workers, rehabilitation therapists, family members, and friends – corresponds to the dissociation and privilege of the technical rationality of biomedical knowledge on the one hand and everyday commitment, attention, and assistance, on the other. However, the way in which care questions Biomedicine becomes particularly pertinent in studies on chronic illnesses and in ‘‘health catastrophes’’, such as degenerative and terminal disease. In this field, medical treatments have to deal with pain and the quality of life without the power to cure (Kleinman, 2008; Kleinman & Hanna, 2008).

In sum, care is a part of everyday life, and is organized, provided, received, and evaluated according to the needs, demands, and threats that are perceived as important in certain social contexts. Thus, the characteristics, places, moral evaluations, and tensions associated to care are not universal, but rather socially and historically constructed in particular societies and specific domains of everyday life (Kleinman, 2009). For this reason, care can be interpreted as one of the most powerful motors in the bonds of a community, since it integrates an idiosyncratic view of important health problems and the local ways to solve them.

CARE AND CRISIS

The perspective of care clarifies the ways in which social catastrophes become suffering and vulnerability to health. On the one hand, social catastrophes of different types (environmental, economic, political, war-related, etc.) are no exception in the globalized world. On the other hand, the consequences that these catastrophes generate become routine for certain regions, countries, populations, and/or minorities. A complex combination of political and economic crisis as well as long-standing structural conditions in Argentina characterized the social coordinates that brought about the expansion of drug use in Buenos Aires’ vulnerable populations (Agar, 2003; Epele, 2008a; Svampa, 2005).

The spread of drug consumption in the marginalized populations of Buenos Aires was contemporary to the expansion of unemployment, poverty, social inequality, as well as to the gradual deterioration of the state health system.[4,5] Yet, together with economic reform and neoliberal policies, there were changes in the health system associated with the privatization and the de-capitalization of some services, specifically those for the most vulnerable populations (Escudero, 2003; Iriart & Waitzkin, 2006). In regard to addiction health services, a fragmentary system of attention began to form, made up of different therapeutic strategies (hospitalization, ambulatory care, forced or voluntary treatment, etc). These services, however, have been characterized by having multiple obstacles to access and a shortage of resources associated to growing demand (Touzé, 2006). Additionally, in the late 90s, harm reduction programs began to intervene in some areas of the Buenos Aires metropolitan region and in other major cities in Argentina. During the 2001–2002 crisis, these processes (lack of medication, multiple obstacle to accessing services, etc.) reached their more extreme levels (Zeballos, 2003). Even with the developments of social and political movements in addition to assistance and emergency programs, this trend toward social fragmentation, the fragility of the traditional social care and protection (labor, extended social and community networks, etc.), have also promoted the development of new strategies of informal practices specifically for the care of intensive drug users and for their survival.

THE LOGIC OF RESCUE

Drug consumption, poverty, and marginalization grew in the 90s and the new millennium. Thus, vulnerable populations in the Buenos Aires metropolitan area had to face new, complex everyday problems related to drug use. The set of practices, knowledge, and social networking that make up rescuing began to adopt a place of privilege to modulate consumption, to reduce the directly – or indirectly – associated harms and to minimize the dangers for survival (Miguez, 2006).

- I smoke a joint now when I come home from work.
- So?
- It’s not good for me because I smoke on the way to school, you want to laugh with your friends, and you can’t do things right.
- You go to school?
- Night school. I manage, more or less.
- How did you start?
- When my son was born, I tried to ‘‘rescue myself’’ (straighten up). Every job requires a high school diploma. But it’s hard, I can’t catch a break.
- Why?
- I manage by doing odd jobs, but I don’t know how long I can go on like this.
- What does ‘‘rescue’’ mean?
- It’s something we say here. When you’re go overboard, crazy, or fucked up, they tell you to ‘‘rescue yourself’’ and it plants it in your mind that you have to get out, the drugs, the bad habits, the stealing, the police, because if you don’t, you die. It means get a hold of yourself and get going.
- What is rescuing yourself like?
- It’s in the head, they can lecture you, or lock you up, but that click[6] is done on your own, on your own.
- Did anybody help you?
- Yeah, my mom. But that ‘‘click’’ is one’s own. Otherwise you just keep going. I had a cousin who used to shoot up. I never liked shooting up because I think it’s totally like bottoming out. My cousin even injected himself with pet anesthesia. He was so messed up. He spent the whole day

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> flying, stiff as a rock, a human waste. He never got out of it so he died. (Nicolás, 26 years old, drug user).

Practices of rescuing integrate everything from verbal mandates directed toward young users (rescue yourself), the permanent action in the everyday lives of certain people who offer themselves as support for the rescue of others (to be rescued by others), to the reflexive and self-referential strategy of rescuing (themselves). Even when considering these variations, a rescue refers to a complex process which combines mandates, actions, decisions, and interventions from others (informal and formal, local and institutional), and always presupposes a social bond as part of its development. Moreover, this set of practices involves also subjective actions and processes that mix decisions, emotions, and thoughts, named locally as ''click''. According to the very drug users, this ''click'' refers to a necessary condition in order to modulate or quit successfully intensive drug use. Among the people who intervene in rescuing actions in local contexts are: relatives, friends, neighbors, community, and religious leaders, and to a lesser degree, social workers and health professionals.

In the narratives on rescuing themselves – or being rescued by others – we can recognize a multiplicity of relationship-related, self-referential, and symbolic practices which, by themselves or combined in different ways, define actions particular to rescuing. According to the very drug users, rescuing practices include the following heterogeneous activities: giving advice; taking a partner who is not a drug user; lecturing; substituting substances (specifically that of cocaine or FBC/*Paco* for alcohol, marijuana, or psychotropic drugs); accompanying them to health centers; issuing threats (specifically of hospitalization or calling the police); locking them up (either self-confinement or by others at home); either users themselves or relatives' seeking help in local networks; religious organizations or health institutions' intervening (specifically from former users, religious and social leaders, health professionals, etc.); moving away or traveling to other neighborhoods or cities; looking for work outside of the neighborhood; being hospitalized in therapeutic communities or psychiatric hospitals; being punished by others (corporal, symbolic, material punishment, etc.) and being expelled from the home. Whether in its most elementary form (isolated practices, commands, etc.) or as a more complex process, rescuing, rescuing oneself, or being rescued by others, amalgamates knowledge, practices and strategies of several institutions (therapeutic communities, day hospitals, psychiatric hospitals, etc). That is, this variety of informal practices is developed on the side, whether in opposition, as a complement or articulating directly, to State, religious, or non-governmental options for drug users.

Thus the possibility of being rescued, of getting out, is directly connected to the availability of certain social capital and relationship-related resources in local contexts, to the availability of knowledge and information on how others are rescuing themselves or have been rescued, to the availability of material resources both to facilitate access to health services (such as telephone lines, transportation, clothing, etc.) and to support their survival while changes in everyday life occur. In these neighborhoods, only a reduced proportion within the total of drug users possesses all these resources. However, most interviewed users have experienced and/or have used some of these practices and strategies.

In order for the rescue to operate, the existence of the possibility for another life, another social place, and new expectations are also required. In other words, the existence of other economic, social, and political conditions that make possible the existence of other connections, activities, and future expectations outside of social consumption networks is indispensable. That is, there must be a contrast between situations and the access to other social circuits (work, school, neighborhood, home, social networks, etc.), of ''getting out,'' of ''getting better.''

- I quit. I used to do drugs and I quit on my own. I never missed work. I would sell merchandise, door to door. I never stole. Never. I always hung out with them. And later on I quit on my own.
- How did you do it?
- There were problems in the neighborhood and I went to Chaco (a province in northern Argentina) for like 6 months, because it was tough for me here. That helped. Later on it just wasn't the same, they were all in prison, and these kids started showing up, the ones that are around now, they're no good, none of them, I don't know who they think they are . . .
- But how were you able to do it?
- Thanks to my job. I stayed clean because I am a worker. I might smoke a joint, really mellow. But doing coke has to be for somebody that knows how to do coke, somebody who does something else like working or studying . . . (Gonzalo, 23 years old, ex drug user).

According to the social actors themselves (users, former users, and relatives), the complex of rescuing is done in definite moments of one's life trajectory. Based on the results of my field work, the conditions and states that resulted – whether in an isolated way or in different combinations – in rescuing actions and mandates, we can list the following: rapid bodily deterioration (weight loss, repeated illnesses, infectious diseases, etc.), worsening of syndromes or diseases (HIV-AIDS, hepatitis, tuberculosis, etc.), rapid escalation in the pace of substance consumption, having a child, the death of somebody close under circumstances directly or indirectly related to drugs, losing their job and/or goods, being expelled from the home for harming the family (stealing, abuse, and/or violence), police repression and/or persecution, being repeatedly incarcerated, and high exposure to danger in conflicts with local gangs.

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These conditions and states connected to rescuing show the local perspectives on harm, health problems, and survival. That is, indicators are important within the local living contexts, and are in keeping with the harms, problems, and risks to well-being, health, and survival of the youths in these populations. These situations are expressed in local terms such as: ''he's going to get himself killed,'' ''he's so thin,'' ''he's not himself, he's so aggressive,'' ''he keeps spitting up blood,'' etc. Yet, it should be stated that, in and of themselves, these circumstances do not lead to rescuing and carrying out actions to that end. According to local actors, specifically drug users, these experiences require certain subjective processes to occur. This is when, according to local perspectives, a ''click'' or ''changing one's head'' occurs (Blomqvist, 2002; Larkin & Griffiths, 2002). These expressions refer to the operation by which – thanks to a combination of experiences, emotions and thoughts – a decision is made, to change, to quit doing drugs. Similar to the concept of insight in Gestalt theory, or to Alcoholics Anonymous's ''hitting rock bottom,'' it is described by drug users as a particular subjective moment in which, simultaneously, ''they come to their senses'' and ''make the decision'' to quit doing drugs, at least for a while. In the local chronicles, this ''click'' only takes place previously in the aforementioned circumstances and experiences which put users between a ''rock and a hard place;'' either continue to do drugs, become sick and/or die, on one hand, or quit and stay alive on the other. Yet this response is far from generalized. According to users themselves, when faced with the same circumstances, if one does not ''click'' or ''change one's head,'' some continue to do drugs while others may radically increase the frequency of use and/or their exposure to dangers.

Rescuing practices vary according to gender. Local drug users mentioned ''rescuing out of love'' as one of the more frequent rescuing strategies. In this type of heterosexual union, two people come together, one of whom was a drug user, usually the male. However, for romance to occur, not only should the woman not be an intensive drug user, but also she must be outside of the networks of consumption, illegality, and streets. According to the drug users and non-users interviewed, the conditions that make rescuing urgent presupposes that either the user and/or the other recognizes the need for a change of life. Far from being a plan based on a rational calculation on wins and losses, what characterizes the users' state when entering into the intimate relationship is an urgency to free themselves from being shut in, produced by bodily discomfort, social isolation, and persecution, such as being marginalized for having lost their capacity to obtain resources. However, not any male intensive drug user qualifies to enter this type of relationship. Even if they have a criminal record, and have experience with hospitalization and incarceration, these men must conserve certain relationships, particularly, family bonds and references in the neighborhood in question. In other words, they must have certain social capital in order to be eligible, to be accepted.

One of the presuppositions of this type of couple relationship is that the woman (generally the non-drug user) has the ability to take care of others, and therefore to repair, modify, and heal her partner's pain and suffering (Mol, 2008; Tronto, 1994). Although care is generally assigned to the female gender, in this process of couple formation care includes a wide variety of activities and functions which goes beyond traditional patriarchal assignments. In other words, it presupposes the resolution of complex emotional states (anxiety, fear, anger, anguish, etc.) and subjective states (dissociation, alienation, lack of separation from the other, total submission to others) which keep certain correspondence with the patterns of experiences that drug users suffer because of their consumption and/or have to deal with in contexts of extreme vulnerability (Epele, 2008a).

CHANGES IN SUBSTANCES AND IN RESCUING STRATEGIES

According to social actors, rescuing actions and practices combine traditions and knowledge of different types and origins: experiences of other users, local traditions on how to solve other types of problems, knowledge and strategies to interact with the institutions of mainstream society, adapting and integrating (medicalization and psychologization) of expert practices and knowledge of different types (therapeutic, psychological and psychiatric communities, doctors, etc.), religious practices and knowledge (specifically from evangelical churches, and to a lesser extent, the Catholic church), are among the most important. Whether in an isolated way or combined with each other, fragments and elements of these arguments and services are gradually integrated with the practices, knowledge, and rescue strategies elaborated and applied in connection to each particular case. For this reason, it is possible to recognize different rescue strategies to be carried out either simultaneously or in succession by people in their life trajectory.

Based on local perspectives, there are two different moments in the logic of rescuing which in general terms correspond with the prevailing consumption of two different substances: cocaine and FBC/*Paco*. In the first moment, rescuing mainly corresponds with the intensive use of cocaine, although always mixed with other substances. Most users that were trying to rescue themselves fit the overall pattern described in the previous section. Within these dynamics, the institutional strategies, practices, and knowledge (therapeutic communities, psychiatric hospitals, ambulatory treatment centers) were progressively included as components within the logic, agenda, and goals of the rescuing. In a second moment, it corresponds with the intensive use of FBC/*Paco* which appeared in certain areas during

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the late 1990s and the 2001–2002 crisis and quickly spread through vulnerable populations.

- I first knew it in the Capital, around '94, '95. I made myself some buddies. At the time it cost like 5 pesos, but that was real Freebase cocaine, not the junk that's around now . . . it hit you great, lasted all night. That was base paste, what we have here is cocaine waste. It's the most toxic. It messes up your lungs and doesn't let you breathe. It's like it forms like a layer of cellophane around your lungs, and you can't breathe. Now it's . . . they're struggling in some neighborhoods to keep it out. There are some people who have relatives or people they know in other neighborhoods, so they talk about what happens. They say that Paco is this shit that kills kids inside of three months, it ruins their minds. Here they tried that too, but we're really hooked.
- How long has it been around?
- They started talking about it, like it was new, but people have been doing it a lot in the last two and a half years. People today are nuts with the Paco. Well, when drugs had no effect anymore, it happened to be cocaine for me . . . the kids on the corner of my house who did drugs with me and who I did base paste with, they called it Paco. I realized that I was spending 20 or 30 pesos on cocaine, and they were spending 10 pesos on Paco for 10 hits . . . I could see what they were like after and I thought Whoa, that must be something! . . . it was curiosity and the cost. Because I used to think that it was much lower, but I was deluding myself. You're deluding yourself because you think: one peso, one peso, one peso, but it adds up to 100 pesos maybe you spend in one night . . . I don't know how anyone could think 'What am I doing?' and still smoke that stuff, when they might add rat poison to it any time. (Andrés, 30 years old, drug user).

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The daily life of these neighborhoods had already undergone deep transformations. Although concentrated in adolescents and young adults, the age range of FBC/*Paco* consumption was more extended than that of cocaine: from boys and girls of ages 7 and 8 years to 60-year old people. According to drug users, due to the toxic characteristics of the substance and to the compulsive rhythm of consumption, intensive use of FBC/*Paco* produces a rapid physical deterioration: quick weight loss, breathing disorders, changes in behavior, self-aggression, and aggressive.

Furthermore, most *Paco* users grew up in the 1990s and the early millennium, that is, years when the effects of structural neoliberal reforms were most felt in marginalized populations. The low rate of enrolment in schools, quickly shrinking formal and informal job markets offered to these adolescents and young adults – as well as the deterioration of the health system – came together with the fragmentation of the social networks and a rise in conflicts within local contexts. Wherever young people did have a social and family network, it was minor and fragile. On the one hand, *Paco* displays a growing number of children, adolescents and youths on the streets, not only in cities but also in these marginalized shantytowns surrounding Buenos Aires. On the other hand, sharing a home with drug using youths becomes very difficult. Specifically, relatives of drug users and they themselves say that *Paco* brought about a higher level of bodily deterioration, more conflict, aggression, and stealing within family and local networks, and young people were more likely to run away from home, be thrown out or die young in these neighborhoods (Santis et al., 2006, 2007; Touzé, 2006).

With the spread of FBC/Paco and the changes in everyday life, rescuing strategies were deeply affected. First, the combination of low school enrolment rates, the many difficulties in joining the workforce, and the fragmentation of social networks modified the local perspectives on strategies for relationships, institutions, and individuals to quit doing drugs, at least for some time. With *Paco*, the theory of the ''click'' has changed. In these neighborhoods, it became a widespread notion that for young adults and adolescents to make the ''click,'' they had to be hospitalized. That is, confinement in hospitals or addiction treatment facilities began to form part of the subjective process of ''changing one's head'' to a much greater extent than it did in contexts of cocaine use. Although other rescuing practices and knowledge persisted, this modification implied selectively integrating knowledge and practices – which were progressively more medical and psychological in nature – to the ones utilized in previous strategies. In addition, relatives uphold hospitalization as an important resource in cases of bodily deterioration (emaciation, disease, burn sores, etc.), and the high exposure to conflicts, aggression, and danger to survival. Internment, hospitalization, or confinement in general, was one of the few institutional alternatives available in state-run treatments or state-supported therapeutic communities, and became included as the favored rescuing strategy by local actors. However, there has been a scarcity of venues of hospitalization for the underprivileged and formerly hospitalized young people have frequently ''relapsed.''

Second, norms and practices carried out in rescuing other people have changed. Because of the progressive fragility and reduction in the dimensions of not only drug users' social networks, but also family and local networks for support, care, and protection, two complementary processes occurred. On one hand, the possibilities of intervention on the part of others in processes of rescuing oneself diminished. In other words, the marginalization and isolation of users within the very local networks contributed to a rapid deterioration of users' health and to their exposure to dangers that jeopardized their survival. On the other hand – given the inescapable proof that the number of cases in which users had serious health and survival problems increased – new social and community networks were organized to collectively bring forward demands, emergencies, and actions for care.

Finally, when the multiple consequences of FBC/Paco became visible, new initiatives and demands began to emerge in these populations. At first, they took on the shape of spontaneous, isolated protests and demands,

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but in time they gave rise to new social movements. In keeping with the local organizational forms of historical human rights movements in Argentina, these organizations grouped mothers of *Paco* users as well as local female leaders who participated in communal activities (mainly community soup kitchens). These women initiated a variety of activities and actions, among which are: making statements to the press, initiating legal action for the individual protection of their children in order to hospitalize them, organizing assemblies, seeking therapeutic counsel, bringing demands to the State for greater availability for patients, charging health services with discrimination, and even reporting local drug dealers. Organizations and social networks – such as ''mothers against *Paco*'' – have begun to form not just at the neighborhood and national levels, but also internationally. As FBC/*Paco* spread in Uruguay and Chile, this type of organization began to also address the issue of other countries (Pellegrino, 2007). Network representatives increasingly participate in formal and informal debates on the issue of FBC/*Paco* and drugs in general.

PRIVATIZATION OF CARE AND POLITICIZATION OF SUFFERING

Practices, actions, and knowledge (material, symbolic, relationship-related, bodily, institutional, etc.) on rescuing are varied. Thus, this complex of rescue varies in relation to not only the people involved (self-referential, rescue by others), gender, age, social capital, and socio-economic status, but also types and modes of use of the substances consumed. Moreover, the complex of practices linked to rescuing has variations over time: through changes in these micro-practices, it is possible to track some of the main features of complex structural and social transformations.

The previous characterization of this set of local rescuing practices allows us to analyze the logic of care related directly and indirectly to drug use in marginalized populations and its transformations over time. Unlike expert knowledge and practices which focus on drug consumption as the problem, this logic of care expressed in terms of rescuing includes local categorizations in which pain, disease, harm, and dangers are important in users' everyday lives. Besides problems associated directly or indirectly with the use of drugs, this complex includes harms and dangers linked to poverty, oppression, local conflicts, the destructuralization of the family, participating in illegal activity, and the consequences of police repression and its abusive practices. In other words, the logic of rescuing is constructed in the scale of the challenges and urgencies that the social actors face every day in these neighborhoods, in view of the negligence, disorientation, or contradictory strategies from State, private, and religious institutions.

From the theoretical perspective of care, examining rescuing practices allows us to understand how well-being and health are constructed in these social spaces. Oppositions like dependence/autonomy and control/lack of control are found throughout expert knowledge, medical and psychological practices, and policy design on substance abuse. However, in the local logic of rescuing, notions of dependence, autonomy, care, and choice are not mutually exclusive (Mol, 2008; Tronto, 1994). The assortment of rescuing strategies includes relationship-related actions, emotional dynamics, self-reflective practices, choices, coordination with institutional knowledge and strategies, individual and group decisions, interventions and practices carried out by others, and the development of supporting social networks. In this sense, choice and care, the individual and the social, merge and become one, contribute to one another, and are constructed according to local parameters. Rescuing varies according to the type of substance consumed, the characteristics of the user's social and family networks, and the types of problems that the drug user is dealing with. In turn, these variations correspond to the different ways that local rescuing practices incorporate expert and institutional practices and knowledge on drug use.

As the literature of care emphasizes, unequal gender relationships have many consequences on the logics of care. With respect to rescuing practices, women (mostly mothers and partners) carry out detailed and everyday practices of care toward their drug using relatives or intimate partners. Meanwhile, female drug users barely are rescued by others and they live under more extreme conditions of marginalization and expulsion in the very social contexts in which rescuing practices have developed.

In addition to the gradual neighborhood containment caused by the reduction of social and territorial mobility, users progressively found themselves closed in as a result of criminalization practices. With the dismantlement and fragilization of the traditional social strategies of care and protection (labor, social security, public health, local mechanisms of cooperation, etc.), rescuing, therefore, reveals a progressive *privatization of care* (Epele, 2008a). This notion refers to the process by which practices and activities that promote well-being, health, and survival carried out by other social institutions (health system, labor, justice, extended social networks, etc.) shift and join the territory of close, intimate relationships, particularly bonds with relatives and significant others.

Due to the changing characteristic of experiences, the substances' high level of toxicity, situations of danger, the bodily and emotional states of users in these social contexts, the complex of rescuing has modified its patterns. Attempts to solve these problems – which are linked to complex structural conditions of poverty as well as to social and territorial marginalization – through close relationships and local micro-practices are marked not only by their failure. These practices also excessively burden community relationships with social problems that should be solved by

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other institutions (health, legal, police, etc.) and often promote new conflicts, vulnerabilities, and hazards. In other words, rescuing practices are unable to solve completely social, health, and survival issues related directly or indirectly to drug use under vulnerable settings.

In recent years – and especially in connection to the development of networks of mothers fighting FBC/*Paco* – a growing privatization of care has become supplemented and/or complemented with a process of the *politicization* of the problems of drug use in contexts of poverty and social marginalization. This *process of politicalization* consists of returning the pain, illness, and deaths related directly or indirectly to the consumption of drugs to the public domain. This process has taken place in Argentina since FBC/*Paco* began to spread in the Buenos Aires metropolitan area's marginalized neighborhoods. To be more precise, the population at large received information about the characteristics and consequences of FBC/Paco primarily and mainly thanks to the actions of these movements. Reports in the media, demanding the solution to problems from State institutions, self-help groups, congresses, summits, and diffusion of problem resolution strategies, are some of the actions that are being accomplished.

Finally, the privatization of care and the politicalization of suffering associated to the complex of rescuing helps to elucidate the complex connections between political and economic processes, State institutions, the structure and characteristics of local social networks, care, health, and survival. From this perspective, people who require care are not weak, lazy, or needy. In ordinary and extraordinary social conditions, in different moments of their life trajectories, in everyday life, in sickness, in situations of vulnerability, in conditions of wellness, taking care of others and of one's self is a core device to promote not only health but also well-being. Rescuing, being rescued by others and rescuing oneself became, therefore, a logic of care that consists of dealing with the issue of drug use in the same terms and scale as users' experience within contexts of poverty and marginalization.

Declaration of interest: The author reports no conflicts of interest. The author alone is responsible for the content and writing of this article.

NOTES

1. In Spanish, the word ''rescue'' has different meanings. Among the main ones are: to recover for payment or by force something that an enemy has taken, and by extension any object that passed into other hands; to free from danger, harm, a job, a nuisance, and oppression; to recover for one's use an object that one has forgotten, ruined, or lost (Royal Spanish Academy Dictionary).
2. Freebase cocaine and/or Paco are the names by which regular people and experts called a new kind of substances that circulates in the south cone (Argentina, Uruguay, and Chile).
3. This research is financially supported by CONICET, PIP No. 0565 and AGENCIA, (Secretary of Scientific Research Promotion) PICT No. 1675.
4. The initial neoliberal structural transformations in Argentina took place during the Military Dictatorship in the 1970s, and were intensified by structural reforms (privatization of state companies, internationalization of the financial system, work flexibility, destruction of national industry, etc.) carried out in the 1990s, until the political and economic collapse (Basualdo, 2001). During the 2001–2002 crisis, over half of the Argentine population was living in poverty. In Greater Buenos Aires the poverty rate increased 20% points in the period of 2001–2002. While unemployment reached 21.5%, demanding underemployment is 12.7%, and non-demanding underemployment is 5.9% (INDEC, July 2002).
5. With a complex health system (public, private, and social security), Argentina was inscribed in the Latin American tradition of health which integrated the following dimensions: health-illness is a component of everyday life's relationships and social actions; it recognizes an indissoluble bond between the processes of economy–politics and illness; political and community participation is a strategy to promote health, and finally, the State and public health is the guarantor of universal access to health.
6. Click: local term which refers a kind of turning point.

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