Women and Drugs: case studies from Jamaica

MELANIE DREHER
University of Massachusetts School of Nursing, Amherst, MA 01003, USA

Introduction

The use and abuse of alcohol and drugs by women throughout the Caribbean and Latin America constitute a significant and expanding problem in the region (Caravano, 1994). Although alcohol, tobacco and psychotropic drugs continue to be the most commonly used drugs by women in the region, marijuana, cocaine and cocaine derivatives have increased dramatically in some populations. Even the limited research on this topic has identified the serious impact of female substance abuse—both on the women themselves and on their families and communities.

The observations and illustrative case studies that follow are drawn primarily from two studies of drug use in Jamaica: an ethnographic study of urban female crack users conducted by Dreher & Hudgins (1990) and a national ethnographic study of drug consumption and distribution, conducted in six Jamaican communities by Dreher et al. (1992). The naturalistic design selected for both projects attempted to: (1) overcome the potential mistrust of investigators that often accompanies research on illegal and socially disapproved activities; (2) permit a more longitudinal exploration of the lifestyles and drug careers of drug-using women; (3) capture the cultural meaning of drug-related behavior in women; and (4) through direct observations of drug use, compare the actual and reported drug-related behavior of women.

The Social Context of Female Drug Use in Jamaica

For decades, marijuana (or ‘ganja,’ as it is called in Jamaica) was the only illegal, psychoactive substance that enjoyed widespread use in Jamaica (Rubin & Comitas, 1975; Dreher, 1982). Since the early seventies, scientific reports have documented its cultural integration and for many Jamaicans, ganja has ritual and medicinal, as well as recreational functions. Traditionally, the smoking of ganja cigarettes (‘spliffs’) has been a male-dominated social activity while female participation in ganja activity was limited to the preparation and consumption of medicinal teas and tonics in a domestic context. This organization of ganja consumption based on sex was justified by an ethno-pharmacological explanation that ganja, when inhaled, goes directly to the brain where it induces psychoactive effects. When consumed as a tea or tonic, however, it is believed to ‘go directly to the blood’, where it produces physiological and health-rendering effects. Accordingly, only adult men were considered to have sufficient
mental capacity to handle the psychoactive properties of ganja. Women, on the other hand were ‘encouraged’ to abstain from smoking and restrict their ganja activity to the domestic preparation of teas and tonics which were consumed by themselves and their families for medicinal and preventative effects.

Women who ignored the sex-linked injunctions on ganja smoking were considered ‘brawling’ (disorderly) and unrespectable by smokers and nonsmokers alike. In addition to risking widespread community sanction in the form of censure and gossip, the woman who breached these norms essentially compromised her ability to attract a literate, steadily employed future mate, for whom the competition among women is intense. Since conjugal unions are the primary means by which rural, working class women acquire economic security and social status, the extent to which they conform to standards of respectability significantly influence their socioeconomic future. Consequently, women generally adhered to the gender specific norms related to ganja consumption and ganja smoking continued to be a male dominated activity.

More recently, however, the percentage of female ganja users has increased steadily in a downward cycling economy. Shifts in socioeconomic status and power occur as working class men become increasingly marginalized and more women necessarily assume the role of independent wage earners (Dreher, 1987).

Nevertheless, in spite of the statistical evidence that women constitute a greater percentage of ganja smokers than ever before, female use continues to be non-normative behavior and women tend to smoke less frequently and in smaller amounts than their male counterparts (Dreher, et al., 1994). Thus the institutionalized social rules that comprise the ganja ‘complex’, including the widespread sanctions on female smoking, continue to limit use among women and inhibit abuse.

In contrast to the culturally integrated ‘ganja complex’ in Jamaica, the recently introduced ‘crack/cocaine complex’, reveals a very different scenario—explosive rates of addiction, widespread social and economic dysfunction and the absence of culturally-generated parameters that channel and control consumption (Dreher & Hudgins, 1992). Similar to the use of ganja, crack use in Jamaica is a predominantly male activity. Current findings, however (Stone, 1989; Dreher et al., 1994), indicate that women are using the substance and that female use is increasing. Furthermore, although the statistical evidence is scant, the ethnographic findings, consisting of direct observations and informants’ reports, suggest that the rate of females among cocaine users may be higher than the rate of female users of other substances including cigarettes and tobacco as well as ganja. In one small coastal town, for example, seven of the 32 chronic crack/cocaine users were women.

While somewhat speculative, it appears that the potentially higher rate of female participation in crack consumption than ganja consumption may be attributed to differences in the manner in which the two substances entered and subsequently moved through Jamaican society, as well as the social context in which the two substances are consumed. Ganja came to Jamaica through indentured laborers from India and moved quickly into the Afro-Jamaican working classes, where it eventually became part of Rastafarian doctrine. Subsequently it moved, less visibly, into the intellectual and artistic communities and wealthy classes. In contrast, cocaine entered Jamaica predominantly through wealthy users—ex-patriots, tourists and entertainers and then spread to the lower socioeconomic groups in the form of crack. As cocaine and crack moved
from through the entertainment and tourism sectors, many exotic dancers and prostitutes were exposed to the drug by their clients. It is commonly believed that some ‘big (important) men’ and entertainers introduced literally hundreds of young women to crack/cocaine. Subsequently, women introduced it to their partners, friends and co-workers as they travelled throughout the country to dance at various clubs, bringing cocaine with them. As crack/cocaine became increasingly available, men began to use it to solicit and pay prostitutes.

Carmen

Carmen, 29 years old, was born in Montego Bay and attended school until she was 13, when she dropped out because she became pregnant. She had three more children before the age of 18, all but the last with the same man, from whom she is now estranged. She first drank beer and smoked cigarettes with friends. She does not like to drink very much and although she tried ganja, she did not like it. At age 19 she and her cousin were in Westmoreland at a go-go club and the owner asked them if they wanted to dance there for the weekend. Since they needed the money, they agreed to do it.

On their return to Montego Bay, they started dancing regularly. Approximately ten years ago, they were standing on the street when a ‘big man’ asked them if they wanted to go to a party. Everybody at the party was smoking crack and Carmen, who ‘knew nothin,’ was asked to hold the cocaine. Her cousin, who already was using crack, talked her into trying it. She passed out after a 2 minute rush and they had to throw water on her. A couple weeks later she asked her cousin for some more and claims that from that time she was addicted, ‘night and day for 3 years’. She worked as an exotic dancer and prostitute throughout Jamaica but finally stopped using crack because her boyfriend, whom she lived with in Negril, used to beat her when she smoked. He used to come home at the end of the week with his paycheck and ask Carmen what she wanted. She would say a couple of ‘lights’, he would give her the money for the cocaine, and then beat her after she came back from smoking. He is a recovered addict but now sells cocaine. Carmen believes that if her boyfriend, whom she says is now ‘very nice’ and no longer beats her, left her she would start using crack again.

Unlike ganja, which ordinarily is smoked in male work and social groups, crack routinely is consumed with members of the opposite sex, often in a pre-sex context. Thus, even women who are not, themselves, involved in entertainment and tourist industries are nevertheless at risk through their association with men in high exposure industries (entertainment, tourism, and drug trafficking). Taxi drivers, for example, often are asked by tourists to obtain crack/cocaine and then are invited to partake with their customers. They, in turn, may take some home for their girlfriends to try and may even turn to selling crack/cocaine, themselves, so that they can ‘keep their women looking good’.

The Women Who Use Crack

The oldest reported female cocaine users in Jamaica were in their forties while the majority ranged from late teens to early thirties. The longest history of
addiction was 19 years while most women ranged from 3 to 8 years of use, reflecting the more recent popularity of crack. One of the most remarkable findings from the Jamaican examples is the absence of special characteristics that would distinguish cocaine users from other women in Jamaica. They hailed from a range of family environments but a surprising number came from stable, two-parent households. All were literate, had some level of schooling and had an impressive ability to articulate and conceptualize their problems and their lifestyles. Typically, they left high school when they became pregnant for the first time and then engaged in a series of unsuccessful relationships with men—many of which resulted in pregnancy and childbearing. Even the crises that women reported to precipitate their initial experience with crack were not unique. Indeed, the probability exists for many, if not all, women to experience similar disappointments or losses such as the death of a parent, the termination of a relationship or the death of a child. Each of their stories, up to the time they became crack users, could be any working class Jamaican woman’s story.

Furthermore, in contrast to the widely held opinion that female crack users come mainly from the under- and unemployed, participation in high exposure industries (tourism, entertainment) often increased the risk for crack addiction. Women in legitimate jobs such as hotel workers, waitresses and musicians as well as exotic dancers, prostitutes and ‘hustlers’ are routinely recruited to procure drugs for tourists, thus increasing their own exposure. Many are enticed to try it themselves because ‘they are curious and don’t understand the danger’.

In Jamaica, it is women, in particular, who have suffered the ravages of crack/cocaine use. The devastating impact of crack on health and physical appearance are keenly felt by women who reported being robbed of their vitality and appearance with dry and thinning hair, skin lesions and blotches, burned and stained fingers and, perhaps most important in this population, severe weight loss. Many women reported a complete disregard for personal hygiene and grooming, losing interest in their hair, clothing and even bathing.

**Jolene**

Twenty-nine years old, Jolene had grown up in Montego Bay as one of ten children in a neighborhood that she describes as ‘poor’ or ‘ghetto class’. Her mother was very strict and she attended the Adventist Church regularly. She completed all of grade school but could not afford high school. At age 15 she became pregnant and had a miscarriage. She then became pregnant again with the same boyfriend and terminated the pregnancy. Her mother made her leave the house when she became pregnant the second time and then her boyfriend left her. Jolene started exotic dancing at Montego Bay club at age 18 and began drinking for the first time. Subsequently she was introduced to ganja and cocaine which she said had no effect. When she tried crack, however, she wanted to keep ‘doing it again and again’.

When dancing no longer provided enough money to procure drugs, she turned to prostitution. She used crack consistently for 11 years until she went into rehabilitation a year ago. The reason she stopped drinking, using crack and working as a prostitute was her health. Her ‘sicknesses just wouldn’t get better, especially VD’, she was ‘getting sores all over, skinny, but mostly it was constant sickness’. Shortly after
a successful drug rehabilitation, Jolene was diagnosed as HIV positive and died of meningitis a year and a half later.

The Jamaican experience is consistent with that of other countries in that the majority of female addicts become prostitutes in order to purchase crack. As prostitutes they are exposed to sexually transmitted diseases (including HIV infection) and to violent injury, including stabbings, beatings, and rape. The influence of drug intoxication places them at further risk as the exposure to danger occurs at the very time that the ability to avoid or manage risk is impaired. In general, female crack users suffer a life of danger and degradation that surpasses that of male crack users. Female crack addicts, working as prostitutes, for example, often engage in practices (fellatio, cunnilingus, voyeurism, anal sex) that are outside normative sexual behavior in Jamaica. Although the men who participate in these practices may be privately criticized, it is not unusual for the women to suffer public ridicule as they are called names ('whore', 'suck hood', 'lick him batty') and even stoned and beaten by young boys in the community. Thus in addition to the health risks associated with the ingestion of substances that are unregulated and potentially dangerous, crack using women further compromise their health and well-being through prostitution.

Although they have the potential to generate comparatively large sums of money through prostitution, crack using women reap no permanent benefits. Women lamented repeatedly that they will purchase crack until their money is gone, the need for the substance superseding all other needs including food, clothing, housing and all responsibilities including the care of their children. Since women in Jamaica are the primary family caregivers, the health and development of their children also may be compromised. Children whose mothers use drugs are exposed to abuse and neglect as the resources needed to clothe, feed and educate children are redirected to the procurement of crack. In Jamaican society, a woman who ignores the hungry cries of children and steals from her parents is much less forgivable than a man who does the same. The contempt that family and neighbors often express with regard to a woman's crack use augments her isolation and despair. After further discrediting themselves by stealing from and lying to friends and family members, many of the women in the study were banished from their parental homes and their children were turned against them. The combination of community distrust and repulsion re-enforced their social isolation and self-loathing.

Lois

It happened the first time at a Reggae Sunsplash. She was walking with a friend she considered a 'bigger' person. The friend asked if she wanted to meet some of the performers. Lois agreed and they went to the stage area where the other woman knew people. Everyone was drinking heavily and as the performances ended, they asked her if she wanted to go to a hotel for more partying. Lois agreed. The woman and one of the performers were whispering together and Lois wondered about it but didn't ask because it seemed like they were sharing some secret. Then her friend went to the bathroom and took out a pipe for a smoke. Lois had never seen crack or coke before and she was curious. The woman set up a pipe for her but since it was her first time, Lois exhaled rather than inhaled. The woman became angry but set up
another pipe and this time she held the smoke in for a long time. It felt so good that ‘immediately, I told her to put on another piece—a bigger piece’.

Lois soon learned how to acquire her own supply and asked permission to smoke at the bases. She soon lost interest in her work which was teaching physical education and after 2 months on crack, quit her job. She then started stealing from her family and especially remembers selling her mother’s clock. It was a very valuable wall clock but when she took it to a dealer, he gave her only $100 (3.00 in US currency) for it because she had told him ‘if I don’t get a fix, I’m going to get mad (crazy)’.

Her smoking has deeply affected her two sons, the older of whom stayed away from school to avoid the taunts of other children because of his mother’s crack use. ‘Mummy, why do you have to smoke crack? Why do people have to say “Mummy is a crackhead?” She became more depressed and eventually decided to enter a rehabilitation program. Within 4 weeks she was back on the street as a prostitute. She recalled a time when she was so desperate for money she went to see her sister who works for one of the government ministries. She stood outside the office calling her sister to come out, that she needed money to ‘get some smoke’, and that she had her sister’s jewelry and wanted more. Her sister called the police and told their mother.

Another time a girlfriend, who deals coke in Kingston, brought a supply from New York. They both smoked crack and drank alcohol for 7 days without eating. Eventually, Lois passed out and apparently began having seizures. As soon as she was up, she went back to her pipe and continued to smoke, without eating, for another 4 days until she eventually went into coronary failure and her ‘heart stopped beating’. Everyone thought she was dead and fled the house. Fortunately, the gardener, whom she had befriended earlier, came in and immediately took her to the hospital and saved her life.

Cultural Implications for Prevention

The success of programmatic efforts to control the use and distribution of dangerous drugs ultimately depends on the cultural meaning that a group assigns to substances and to the users of those substances, i.e. whether the group identifies itself as having a ‘drug problem’. According to many Jamaicans—particularly Rastafarians—ganja is not a drug. Rather it is a natural ‘herb’ that is believed to stimulate the appetite, enhance work, promote health, generate a calm, meditative approach to life, reduce violence and augment sexual performance. As such, it both symbolizes and promotes enduring values about health, behavior and relationships in Jamaica. Even heavy use is tolerated because it does not threaten the social fabric of the community.

Unlike ganja, which is grown and processed locally, cocaine is a ‘manufactured’ substance and ‘imported’ to Jamaica. Its use is considered not only a violation of the law, but indicative of an ‘undisciplined’, lazy and even unhygienic person. In a society that values ‘clear’ skin, fleshiness, sexual vigor, self control and family loyalty, the ‘mawga’ (thin), impotent and perverted crack user, unkempt and covered with sores, who disregards the needs of parents and
children, is seen as debauched, materialistic, self-serving and the antithesis of everything that is good and important in Jamaica. Users, frequently referred to as ‘cokeheads’ or ‘crackheads’, are despised and disrespected.

David

I have a friend who is spending sometime in rehab. This girl had everything going for her. Her parents are rich and powerful and she was a straight A student. She dropped out in her second year in U.W.I. all because of crack. This was her choice. We both tried it the same time and she liked it, I did not. So I guess it’s a matter of choice. I loved her very much but I am poor and maybe could not match up to her peers. Secondly, I am not sporty. I am not a straight A student but I have a good average. I have to work very hard. This girl does not even have to study—she is just bright. But she was not bright enough to keep away from cocaine. She is very spoiled and I guess only weak people really get hooked.

My girlfriend got mad with me because I won’t get high with her and watch blue movies and do those nasty oral sex acts. Those are the things that people want to do when they take crack and cocaine. Crack turns your inside out, it lets you forget your moral sense and cleanliness. Right now I don’t have a girlfriend and I do not believe I will want one for now because they all want oral sex and I am not into that. My girlfriend buys the cocaine, gets baking soda and I sit down with tears in my eyes and watch her destroy herself with it.

She cooks it with hot water then puts on cold water, and it becomes hard as glass then she cuts small bits and smokes it on a pipe she makes up with a pen and bottle cover. When she is not where she can get the stuff to smoke, she breaks open a cigarette and puts the pieces into it and rolls a spliff or gets some herb and does the same. This they say is seasoned herb. So you see Miss, all this is the reason why I hate all avenues that bring this wicked cocaine into our clean islands. When my girlfriend does this it smells up the room that I sometimes feel drunk and then she goes under the bed to hide saying I am going to kill her and only when she does that, she feels I am going to hurt her.

A few times I tried to hurt her but I don’t anymore because I find that she is very weak and dried out. She gets thirsty all the while, she says her mouth is dry, and her beautiful skin is not beautiful any more. One night, she was so high, that she ran away and went to a base, was taken away by someone else who gave her more crack and then three men had sex with her one time—doing all kinds of orals and then she wants me to do it to her. I tell you when I found out I held her on her neck and thought that I was going to stretch her neck and break it. I hated to see what my beautiful girl had become. We had plans to get married and go back to Trinidad, and now it’s like my whole life has turned around.

Indeed, Jamaicans reported the use of crack/cocaine as one of the most serious problems in their country and the statement by a Montego Bay resident that there were two evils in the world—politics and cocaine—was echoed throughout the study population, even by current crack users and traffickers of crack/cocaine. Theoretically, this universally expressed disdain toward crack use and
users in Jamaica should serve to reverse the increase in numbers of users. Unfortunately, however, the economic incentives created by an expansive, vibrant crack industry beg participation in it and the creation of a crack market. The need for convoluted and extensive series of middle persons and transactions between importer and consumer has resulted in a system that is extremely difficult to control and relatively easy to enter. This is especially true for women, who are regarded as the least suspect and therefore the most frequently recruited. One woman, for example, described the “deal” that she was offered to bring cocaine back from the United States: in addition to the round trip ticket and the visa, she would receive US$3000.00 when she returned and US$2000.00 ‘shopping money’ while she was there. For the Jamaican working class woman, who may earn from US$15.00 to US$30.00 per week as a domestic, and who could never hope to ‘travel to foreign’, such an offer is almost irresistible.

Given the number of women who live in Jamaica in impoverished circumstances, even modest inducements are sufficient to enter the distribution network. Thus even women who are former crack users and have experienced its devastating consequences, are likely to engage in distribution. One female crack base operator, who had been a former addict, claimed that being a seller actually prevented her from using the substance again, glibly adding ‘if you sell you can’t lose, but if you sell you can’t use’. When questioned as to why they would help to make such a profoundly damaging substance more available, many women responded that if they didn’t profit from it, someone else would.

Indeed, the commonly held contemptuous view of the cocaine user as amoral or weak actually permitted those involved in crack distribution to subvert ethical considerations to economic ones. Accordingly, cocaine itself does not generate decadence and violence. Rather it enhances or releases what is ‘already inside’ the person. For example, it was claimed that drugs will have a negative effect on family relationships only if the individuals are not ‘family-oriented’. The moralistic designation of crack users as essentially worthless degenerates into rationalized participation in the distribution of crack by persons who would never consume it themselves. This justifies the punitive posture toward users while maintaining a more conciliatory attitude toward traffickers.

The implications of this distinction between being a user and being a trafficker for prevention and demand reduction are profound for while crack/cocaine users are disdained, the glorification of cocaine profiteers compromises the anti-drug efforts. Furthermore, even the most well-designed drug education programs eventually must compete with the profitability, excitement and rewards of drug trafficking, including expensive cars and motorcycles, elaborate homes, gold jewelry, fancy clothing and, in general, an affluent and powerful lifestyle. Thus in Jamaica, while there was almost universal exposure to drug prevention messages and universal awareness of the problem, the constantly escalating importation of cocaine and other drugs through the ‘Corridor’ communities constantly expanded the market. This has made it impossible to assess the actual impact of these programs on demand reduction.

In addition, crack addicts readily acknowledged that expanding their network of addicts by introducing new users, is useful to increase the availability of a ‘lick’ of crack when they, themselves cannot afford it. Observations in Jamaica revealed that because of their comparatively limited access to resources, women, in particular, rely on others to get a ‘lick’ and that the role of the female user as a source of addiction may be under-estimated. Once addicted, crack use be-
comes a highly communicable disease and women are likely to ‘infect’ others. Indeed, one female crack addict in a small tourist community was commonly known as ‘Mama Rock’ because she was responsible for initiating scores of crack users, most of whom were men in their early twenties. The exposure to users, of course, is not random. Rather it is associated with presence in a high-usage environment, particularly through high-exposure economic activities, such as tourism and drug trafficking.

Tony

In Ocho Rios one night he met a girl, ‘nice chick (in that time me stay good, not like I am now)’ at a club. She invited him back to her house and he found a taxi. On the way to her home, she told the taxi to stop at a house. ‘After about 7 minutes she come back she tell the driver to drive’. He didn’t ask questions because he ‘wasn’t a man to sample, you know...When we reach her house now and do a t’ing at her place’. He went to take a shower and when he came out with a towel around his waist he said that ‘she make up a little something. She take off her shirt and me look pon her still. I ask, Wa’ ya do? She say ‘Feel nice. Wan try?’ He refused because he had never been involved in drugs and knew nothing about them.

The following week he came back ‘cause de t’ing (sex with her) nice so me go back again—same procedure like den. Me look pon her so she say me can try it. I ask, how it mek ya feel? She say, ya ha fe try yourself...So beginning of hell. So me try it and feel a little strange. The other week, me na go on because me skip out—try to make money’. Three weeks later he went by her gate and she was there. He asked her how much she spends on a piece of rock and gave her money to buy three pieces. ‘Me never hear nothing ‘bout coke—nothing, nothing, nothing at that time’. She made the purchase and returned to the house. ‘She set up sumt’ing and me say ‘gimmie first’. She gi’ me. Me gwa w. Me get wild. Me tek four...Me start work for it now’.

Summary

Typical of most cultures in the region, Jamaican society has more or less condoned the use of substances (both legal and illegal) by men, but negatively sanctioned their use by women. The recent increasing use of drugs by women in the Caribbean and Latin America have been attributed to various proximal antecedents such as simple exposure and access to the substance, lack of information or misinformation, peer and partner pressure, the need to escape from or cope with a reality of poverty, oppression, domestic violence and childhood sexual abuse. While all of these factors may have a bearing on the problem, each is linked in some manner to the changing roles and responsibilities of women. The traditional sex-linked norms pertaining to drug consumption by women can no longer be counted on to protect women from drug abuse. Neither can the traditional economic structure can no longer be counted on to insulate women against commercial drug activity.

The data from other areas of the region indicates that the phenomenon of women being put at risk through their involvement in drug production and distribution is not exclusive to Jamaica. Caravano (1994) cites evidence suggest-
ing that women involved in the production of cocaine derivatives in Colombia are likely to eventually abuse that drug. Similarly, she cites findings from Brazil indicating that women involved in drug trafficking are at increased risk from substance abuse. As the economic situation for women in Jamaica becomes increasingly difficult, it is likely that the cocaine and other illicit drug industry will grow; for inspite of the normative value that cocaine and cocaine users are unworthy, there is no doubt that the affluent lifestyle of the distributor and the prevailing economic conditions provide real incentives for Jamaican women to participate in the drug economy, promoting drug use and eventually damaging themselves. These changes call for new approaches to drug prevention and demand reduction that acknowledge the economic circumstances of women and the changing social norms that guide female behavior.

References


