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REDUCING HARM AND RISK: PUBLIC POLICIES FOR DRUG USERS IN BRAZIL AND FRANCE

INTRODUCTION

> Half of Injecting Drug Users (IDUs) are infected with the virus that causes AIDS, and 71% of them regularly share syringes in groups. This is the finding of a study conducted from 1994 to 1996 with backing from the Brazilian Ministry of Health, led by psychologist Regina Bueno, in the cities of Santos (SP), Rio de Janeiro (RJ), Salvador (BA), Itajaí (SC), Corumbá (MT), Cuiabá (MS), and Goiânia (GO). These eight cities have the highest rates of AIDS transmission via injectable drugs in the country. This study is the first to outline a profile of IDUs in Brazil, a population estimated at 500,000 drug-dependent individuals. (...) The biggest challenge in containing the spread of the disease among IDUs and their sexual partners is precisely reaching this population, situated on the margins of society, and doubly affected by prejudice. "It is essential to work with the general population to discourage and reduce drug use; *for those who continue to use drugs, however, syringe exchanges can help break the transmission chain*," states Pedro Chequer, coordinator of the Brazilian STD/AIDS program (Bernardes, 1997, free translation).

Published in the newspaper *Folha de S.Paulo* in the late 1990s, the above passage provides an insight into the catalytic nature of the public health approach identified as harm reduction (*redução de danos*) in Brazil and risk reduction (*réduction des risques*) in France[1]. Regardless of the term or country involved, it represents a set of public health strategies designed to reduce the physical, psychological, social, economic, and urban risks and harm associated with drug use, without demanding abstinence from the target public. As we can observe in the opening excerpt, this approach is fundamentally *pragmatic* (Rui, 2012; Porto, 2022)—since it includes those *who*

do not stop using drugs—and, in both countries, constitutes a response to a public problem (Gusfield 1963, 1981; Cefaï, 1996, 2009, 2017) of an *epidemiological* nature, aiming to *break the* [viral] *transmission chain*.

Although its origins can be traced back to the publication of the Rolleston Report in 1926 in the United Kingdom (O'Hare, 1994; Mesquita, 1994; Woodak, 1998), which already recommended the first Opioid Agonist Therapy (OAT)[2] for heroin addicts, this approach emerged in both Brazil and France as an initiative designed to contain the spread of the HIV epidemic in the 1980s. I argue that, at that moment, problems typically experienced by drug users, such as contracting and transmitting viral infections, went beyond "the circle of people immediately involved and affected a larger number of people" (Cefaï, 2017: 190, free translation), mobilizing different publics as a consequence (Gusfield, 1963, 1981; Cefaï, 2017). The same virus infecting the injecting drug users (IDU) population indirectly threatened the rest of the population via unprotected sexual relations—as the federal government's prevention campaigns from 1988 and 1990 made clear: "You can't tell if someone has AIDS just by looking at them," "If you don't take care, AIDS will get you"[3].

In 1986, the Brazilian Ministry of Health established the National STD/AIDS Program. In the following decade, this program would become an ally of harm reduction, rooted in a recognition common to both movements: the need to implement and develop Needle Exchange Programs (NEPs)—the first and most iconic initiative in harm reduction in Brazil and risk reduction in France. Despite this common origin, however, the development of these and other programs, their modes of operation and their institutional integration followed distinct paths in each country. Building on my previous research on France's risk reduction policy and my ongoing research on Brazil's harm reduction policy, the present study seeks to comprehend the broader processes influencing this public policy in distinct social and political contexts, as well as the distinctive features of their diverse local manifestations[4]. This inquiry will be undertaken along two analytical axes: a historiographical approach, which explores the trajectory of risk reduction and harm reduction separately, focusing particularly on the moral disputes and agreements regarding the political opening and institutionalization from the late 1980s to the early 2000s; and a contrastive approach, exploring the intersection of these sets of data, not with the intent of producing a comparative study per se, but rather as a preliminary step in a broader investigation into risk/harm reduction.

On the French side, empirical research was conducted in Paris from 2018 to 2020 via comprehensive interviews (Kaufmann, 2013) with key figures in the Parisian risk reduction scene, such as Fabrice Olivet, a historian and activist for drug policy reform and former president of the *Auto Support des Usagers de Drogues* (ASUD – Self-Support Association for Drug Users)—the first French organization representing this population, founded in 1992 with the

support of the *Agence Française de Lutte contre le Sida* (AFLS – French AIDS Control Agency) in response to the spread of the HIV epidemic among users of injectable drugs—and Olivier Doubre, a journalist for *Politis* magazine and former coordinator of the first French local participatory democracy initiative on drug-related issues, developed in the Stalingrad neighborhood[5] of the 19th arrondissement of Paris[6] in 2002 and 2003, in collaboration with sociologist Anne Coppel, with whom he co-authored the 2012 book *Drogues: sortir de l'impasse*. The research also involved an ethnographic study of risk reduction facilities run by the *Espoir Goutte d'Or* (EGO) association, including a *Centre d'Accueil et d'Accompagnement à la Réduction des Risques pour Usagers de Drogues* (CAARUD)[7]; a *Centre de Soins, d'Accompagnement et de Prévention en Addictologie* (CSAPA)[8]; and a NEP linked to CAARUD-EGO, known as STEP[9].

All these facilities are located in the *Goutte d'Or* neighborhood in the 18th arrondissement, where I attended as a volunteer, working alongside professionals during opening hours. There I also attended a week-long risk reduction training course, organized by EGO for its team of professionals, and participated in dozens of academic and technical events for researchers, professionals, and users of spaces such as CAARUDs, CSAPAs, and NEPs across France. From 2020 onwards, the research advanced through virtual participation in other events and training courses, including one offered by the Université Paris-Saclay and funded by the *Mission Interministérielle de Lutte contre les Drogues et les Conduites Addictives* (Mildeca)[10], held in March and April 2021, focusing on addictions. Since 2018 and continuing to the present, my research has also been developed via document analysis and another ethnographic study in Paris, as part of an international collaboration on crack use scenes in France and Brazil.

On the Brazilian side, the research has been developed via document analysis since 2022 and ethnographic study since April 2024 at a Psychosocial Care Center for Alcohol and Other Drugs (CAPSad) II in Rio de Janeiro[11]. Attending once a week, I followed patient cases, institutional consultations, team meetings, group dynamics, and events for service users both inside and outside the facility. I also conducted semi-structured interviews (Ferreira, 2014) with professionals and users of this service. The research includes yet an approximation with the *Projeto Seguir em Frente* (Moving Forward Program), aimed at the homeless population, primarily drug users, launched by the Rio de Janeiro city government in December 2023. The project has opened three facilities, visited by me and presented by the professionals from each service: the *Ponto de Apoio na Rua* (PAR *Carioca* – Street Support Point), a mobile support unit currently located in Maracanã, a district in Rio de Janeiro's North Zone, and CAPSad III *Dona Ivone Lara* and its ten integrated complexes of *Residência e Unidades de Acolhimento* (RUA *Sonho Meu* – Residences and Reception Units), situated in Cascadura, also in the North Zone. As the fieldwork itself announces, my analytical interest is focused on *state-run* facilities of harm and risk reduction *associated with drug use*, resulting from the institutionalization of this

approach in both countries in the wake of the HIV epidemic—albeit not exclusively, as I shall demonstrate below.

INTERNATIONAL PRELUDE

Evoking the expression *Les Trente Glorieuses* – in English, *The Thirty Glorious Years*, the title of Jean Fourastié's 1979 book on the economic growth experienced by France and other industrialized countries after the Second World War until the 1973 Oil Crisis—Chappard and Couteron (2013) describe this period as one of transformation in consumption patterns in Western Europe, centered on hedonism, transience, and pleasure, which would subsequently provoke what the authors call the *crusade* against drugs. The term invokes a religious dimension, previously highlighted by Gusfield (1963), that reflects a Protestant puritanism already present in the Temperance Movement and alcohol prohibition in the United States from the nineteenth century to the 1930s. In 1961, the United Nations (UN) would adopt the Single Convention on Narcotic Drugs, propagating a concern about drugs at a global scale:

> Concerned with the health and welfare of mankind, recognizing that the medical use of narcotic drugs continues to be indispensable for the relief of pain and suffering and that adequate provision must be made to ensure the availability of narcotic drugs for such purposes, [*the parties to the convention recognize*] that addiction to narcotic drugs constitutes a serious evil for the individual and is fraught with social and economic danger to mankind, [*and are*] conscious of their duty to prevent and combat this evil.

Following approval of the UN convention, the first measures for international substance control were instituted, defining which substances fell into this category—including marijuana, cocaine, codeine, fentanyl, heroin, methadone, and so on—via coordinated actions to limit the possession, use, trade, distribution, import, export, manufacture, and production of these drugs, restricting them exclusively to medical and scientific practices. However, despite the prohibition drive, opioid consumption, previously limited to travelers and artistic circles, began to spread among French youth over the course of the 1960s, becoming an integral part of the student and countercultural movements in the wake of May 1968.

The case of Martine, a 17-year-old girl found dead from a heroin overdose in the restroom of the Bandol casino, in the Toulon region of southern France, on 25 August 1969—"the terrible year of drugs" (*Paris-Presse*, 1969)—became a paradigmatic case of the perceived threat increasingly associated with the substance, prompting a review of drug laws. In 1971, the UN adopted the Convention on Psychotropic Substances, extending the control measures of the first convention to synthetic substances such as LSD, MDMA, mescaline (which opened *The Doors of Perception* for Aldous

Huxley in 1954), amphetamines (the drug of choice among the IDU population in Brazil from the 1950s to the 1970s), buprenorphine (currently used, alongside methadone, for OATs), clonazepam (widely prescribed and known by the brand name Rivotril), and diazepam (originally marketed as Valium), among others.

Amid the global outpouring of definitions, value judgments, and classifications of drug use as *deviant* behavior (Becker, 1963; García, Irala, & Pérez-Salazar, 2022), US President Richard Nixon declared a "War on Drugs" in 1971. Following this same logic of eradication, already widespread in France since the beginning of the decade, a decree issued in 1972 banned the sale of syringes and needles in pharmacies across the country, aiming to curb the "heroin epidemic" (Coppel & Doubre, 2012: 18) apparently taking root. As various professionals in the area have observed (Chappard & Couteron, 2013) and as I have shown in other works (Porto, 2021, 2022, 2025), one consequence of this public policy was the widespread adoption of syringe-sharing practices among French users, leading to a high rate of HIV transmission within this population.

As Mesquita (1992) pointed out, one of the outcomes of this public policy in Brazil was the influx of large quantities of cocaine into the country. Following repressive policies targeting coca-producing Andean nations in the 1970s, Brazil emerged as an alternative trafficking route for cocaine. The port city of Santos, located on the São Paulo state coast, became one of the primary hubs for the drug's shipment to North America and Europe (ibid). As the supply increased within Brazil, combined with the ban of amphetamine use from 1971 onwards, the country's IDU population adopted injectable cocaine in their consumption routines due to its similar stimulating effects on the central nervous system (Domanico, 2019). Not by chance, Santos would become known as the "AIDS capital of Brazil" in the following decade. In both national cases, therefore, the War on Drugs policy (Cf. Morellato & Reid dos Santos, 2020) ultimately contributed to the *epidemiological problem* (Porto, 2022, 2025) that harm and risk reduction policies would later seek to address.

At the height of the military dictatorship, Brazil experienced a reactionary technicism that defended the asylum system, medicalization, and electroconvulsive therapy, expressing a profound aversion to countercultural values (Petuco, 2020). Congruent with the movement observed in France and other Western countries, Law No. 6,388 of 1976 introduced measures to repress the illicit trafficking and misuse of narcotics or substances causing physical and psychological dependence. The law also instituted penalties ranging from 3 to 15 years of imprisonment for anyone who "induces, incites, or assists another person to use narcotics." Brazil in the 1980s and 1990s saw a series of health-related campaigns (Zihlmann & Barreiros, 2019) that emerged as attempts at social reorganization against the dictatorship (Silva & Tuon, 2020). Movements that had been active in France since the end of the Second World War began to flourish in Brazil,

where the asylum model had been questioned and rejected in favor of a therapeutic approach centered on listening to and including psychiatric patients in institutional life—establishing, in both countries, albeit at different times, the foundation for the later risk and harm reduction approaches to drug use.

HARM REDUCTION AND THE MENTAL HEALTH PROBLEM

Awareness of the problems of the hospital-centered and asylum-based model of mental healthcare began to take shape in Brazil in the late 1970s, emerging as a social movement for the rights of psychiatric patients initiated by the Mental Health Workers' Movement (MTSM)[12]. Formed in 1978 by members of the health movement, union activists, members of professional and family associations, and people with a history of psychiatric hospitalizations, the MTSM grew into a collective that formally adopted the name National Anti-Asylum Movement[13] at its Second National Congress, held in 1987 in Bauru, in inland São Paulo. The congress adopted the slogan "for a society without asylums" and the movement began to work formally towards this aim (Amarante & Nunes, 2018). This organization thus emerged alongside the popular mobilization for Brazil's return to democratic governance, converging with the establishment of the Brazilian Unified Health System (SUS), and culminating in the founding of the country's first Psychosocial Care Center (CAPS), named after Professor Luiz da Rocha Cerqueira, in the city of São Paulo, also in 1987.

Based on a day-service model, CAPS Luiz Cerqueira and the other CAPSs inspired by it operate on the premise that the subjective expressions of their target population and their clinical specificities require a broad and diverse range of care options. After two years, Telma de Souza, then mayor of Santos, directed the Municipal Health Department to intervene in the Casa de Saúde Anchieta psychiatric hospital, also known as the "House of Horrors," for functioning as a "warehouse of untreated sick people" (Souza, 2019). This initiative led to the implementation of a Mental Health Program organized around the newly created Psychosocial Care Nucleuses (NAPS)[14]—regionally-based facilities, open 24 hours, with various tools and care alternatives applicable to diverse needs with no minimum attendance requirements. Also converging with the HIV epidemic, the efforts of the anti-asylum movement merged with those of emerging harm reduction initiatives, defining some of the directions taken by Brazil's public policy in relation to drugs.

The experience in Santos clearly illustrates the confluence of both movements: in 1989, the mayor Telma de Souza not only ordered an intervention in the Santos asylum but also launched Brazil's first NEP to curb the epidemic among the IDU population (Bueno, 1994). However, this project was later shut down by the Public Prosecutor's Office and its organizers were criminally prosecuted for facilitating and promoting drug use[15]. Unable to

implement a NEP, the healthcare professionals involved in the initiative distributed sodium hypochlorite, popularly known as bleach, for users to disinfect syringes—a viable harm reduction strategy in the absence of disposable supplies for injectable drug consumption[16]. This was already a common practice among users to remove blood traces that could clot in the needle, although the guidance was seldom followed in full—the recommendation was to rinse the syringe twice with drinking water, followed by sodium hypochlorite and then two additional rinses with water—since the procedure was time-consuming and "left a taste" (Domanico, 2019).

Professionals working in harm reduction also faced the dilemma of informing users that the safest method of injection involved the then-prohibited needle exchange, since rinsing eliminated HIV but not hepatitis viruses. At the same time, scientific and empirical evidence of the effectiveness of NEPs became irrefutable worldwide, leading to the inclusion of harm reduction in the repertoire of the World Health Organization (WHO) initiatives for combating AIDS and its funding in various countries. In 1992, financial support reached Brazil, prompting the Ministry of Health's National STD/AIDS Coordination Group to create an HIV prevention project for drug users that included NEPs (Antunes, 2019). The first of these programs was launched in Salvador in 1994 by the Federal University of Bahia's Center for Drug Abuse Studies and Therapy (CETAD/UFBA)[17].

Also in 1992, the existing NAPSs and CAPSs were regulated, forming a public network of services designed to replace the asylum-based model. In 1997, the Brazilian Association of Harm Reduction Practitioners (ABORDA)[18] was founded at the Second Brazilian Congress on AIDS Prevention held in Brasília. The following year, the Brazilian Network for Harm Reduction and Human Rights (REDUC)[19] was established at the National Harm Reduction Meeting in São Paulo. Also in 1998, the São Paulo state government published, in the Official Gazette, the regulatory framework of the first state law permitting syringe distribution for the IDU population (Antunes, 2019), joining the roughly 200 Harm Reduction Programs (HRPs) created with federal government support (Raupp & Conte, 2020). However, following the arrival and expansion in crack use in the 1990s, the scope, strategies, and institutional integration of harm reduction policies would become significantly reconfigured.

In Salvador, the number of syringes exchanged by the aforementioned program in the Pelourinho neighborhood fell from 1,462 in 1996 to just five the following year, while workers reported cases of injectable cocaine users beginning to smoke crack (Antunes, 2019). With the decline in intravenous drug consumption and a lack of evidence connecting crack use to viral transmission risk, questions arose about the need for the Brazilian Ministry of Health to continue allocating AIDS prevention resources to harm reduction programs. It is no coincidence that Francisco Inácio Bastos et al. (2007) consider Brazil a paradigmatic case of decentralization in HIV-focused actions: although the Brazilian AIDS program was highly centralized at its inception, from 2000

onwards, organizations seeking funds in this field had to leave the federal sphere and compete for project funding at state and municipal levels. As a consequence, municipal and state administrators acquired the autonomy to decide whether or not to invest in harm reduction programs, which obliged the applicant organizations to rebuild spaces for negotiation and for technical and political engagement with local authorities, frequently forcing them to confront funding cuts and suspension of their activities, as Rui (2012) has shown.

With the approval of the Brazilian Ministry of Health's Policy for Comprehensive Care for Alcohol and Other Drug Users in 2003, harm reduction moved beyond the remit of STD/AIDS policies and became part of the National Mental Health Policy, constituting a guiding principle for the CAPSas in the country, created by a 2002 ordinance[20] that gave substance to the Psychiatric Reform Law, approved a year earlier (Antunes, 2019). Thus, while harm reduction was initially a response to an *epidemiological problem*, its later institutionalization was a response to a second *mental health problem* (Porto, 2025). According to Petuco (2019), the experiences developed through harm reduction programs implemented over the 1990s filled a gap in care techniques that psychiatric reform had not yet managed to address, just as mental healthcare provided harm reduction policies with an opportunity to extend beyond their purely preventive and instrumental dimension. Yet although I was able to witness the positive outcomes of this "fortunate encounter" (ibid) daily at CAPSad, the field research also enabled me to observe several challenges resulting from it, operating on the most recently created facilities aimed at this public in Rio de Janeiro.

These include the Street Support Point (PAR), which shelters homeless individuals for an indefinite period, providing small wooden benches for day and overnight stays without restricting outings, even to surroundings *cracolândias* (so called *cracklands*), as a professional told me; and CAPSad III *Dona Ivone Lara*, annexed to the RUA *Sonho Meu*, which accommodates up to 50 homeless individuals living with psychosocial suffering and/or drug abuse in each of its ten units. The ethnography revealed that these facilities, implemented within the sphere of Mental Health, are criticized for accommodating individuals without a diagnosis of mental disorder—"sleep on the street for two or three days, and then tell me if you don't experience mental distress", countered a representative of the *Projeto Seguir em Frente*—and are seen, therefore, as the responsibility of Social Assistance. Additionally, these facilities host far more than the maximum of 12 bed spaces permitted in CAPSad III centers, advocated by the Psychiatric Reform movement and opponents of the aforementioned "warehouse of untreated sick people" typical of earlier institutionalization in asylums. As I show in the following section, in France, risk reduction takes another form in the public policy sphere, offering a broader network of specialized services for drug users, a model which I see as a promising strategy for resolving the types of problems, conflicts, and internal contradictions encountered in Brazil.

RISK REDUCTION AND THE ADDICTION PROBLEM

Returning to our timeline, we head back to the 1980s France. Prompted by the idea that the high rate of HIV transmission among the IDU population represented "a real risk" because "they make love" (*Le Monde*, 1985), in 1987 the Minister of Health under Chirac's government, Michèle Barzach, issued the first non-repressive measure since approval of the 1970 Mazeud Law[21], suspending the provisions of the 1972 decree for one year. The dramatic circumstances of the HIV/AIDS epidemic resulted in a series of social and epidemiological inquiries, leading to experimental policies such as the new legislation, which temporarily allowed over-the-counter sale of syringes and needles in pharmacies across the country, contingent on scientific evaluation for its continuation after the trial period. This measure, dubbed the "Barzach Decree," is considered the founding act of the French approach to risk reduction (Jauffret-Roustide, 2017).

The promised evaluation was submitted in 1988, revealing a surprising outcome: contrary to the predictions of the policy's opponents, no increase in injectable drug use was observed following the legalization of syringe sales. Moreover, their commercialization was shown to significantly reduce needle sharing practices. A study conducted by the *Institut de Recherche en Épidémiologie de la Pharmacodépendance* (IREP)[22], presented by Rodolphe Ingold (1988), and another by the *Institut National de la Santé et de la Recherche Médicale* (INSERM)[23], presented by Françoise Facy (1989), indicated that 52% of users encountered on France's streets reported using only personal syringes purchased at pharmacies, compared to 71% who had previously reported sharing needles. As a result, drug users became increasingly seen as agents of their own health (Chappard & Couteron, 2013).

In 1989, while Mayor Telma de Souza was attempting to implement Brazil's first Needle Exchange Program (NEP) in the city of Santos, France launched its first three NEPs, experimentally set up in Paris and run by *Médecins du Monde*. Involved in this experience was the current director of the Gaïa Association, founded in 2005 and responsible since 2016 for managing the *Salle de Consommation à Moindre Risque* (SCMR)[24], a supervised injection site. This facility originally included an anteroom designated for orally inhaled drugs, which was suspended during the COVID-19 pandemic due to transmission risks and has remained closed since—as I was told during fieldwork in 2024, reportedly to pressure the opening of additional SCMRs in the city. A significant element in this process was the "contaminated blood scandal," a health crisis that impacted various countries in the 1980s and 1990s, including France, in 1991, when hundreds of people were revealed to have been infected with HIV and hepatitis C through blood transfusions. This led to the idea of *public responsibility* becoming a significant issue in the country (Lacoste, 2015).

Not by chance, in the same year, *Stéribox* kits containing disposable equipment for injecting drugs[25] began to be sold in participating pharmacies.

Also in 1991, a significant political movement emerged, led by members of the *Association Nationale des Intervenants en Toxicomanie* (ANIT)[26], who declared their support for the decriminalization of drug use. In 1992, this climate of social and political mobilization spurred the creation of the aforementioned ASUD. With the mission of supporting all individuals assisted by France's health and social systems in their drug consumption routines and advocating for "pragmatic and non-moralistic action" (Olivet, 2017), the association's creation reflected the recognition of these individuals as citizens. According to Lacoste (2015), this marked the second founding act of risk reduction in the country.

The Minister of Health, Bernard Kouchner[27], following in the footsteps of Michèle Barzach, helped introduce Opioid Agonist Therapy (OAT) in France and strengthened the approach as it developed. Until 1993, only three facilities in Paris—known as *Centres Spécialisés de Soins aux Toxicomanes* (CSST)[28]—were authorized to use methadone strictly for limited, experimental purposes in substitution treatments. From 1993, however, the number of available places increased from 52 to over 1,600 across 45 CSSTs distributed throughout France (Augé-Caumon, 2001). That year also saw the inauguration of *boutiques*, or 'shops,' as they were called by Simone Veil, Kouchner's successor, who envisioned them as places where "a door opens and users are welcomed" (Lacoste, 2015: 8), adopting a risk reduction approach even before its formal institutionalization. The first door opened in Marseille through the *Association Méditerranéenne de Prévention des Toxicomanies* (AMPT)[29].

In 1994, when Brazil finally launched its first NEP in a single city, the French Ministry of Health and the Order of Pharmacists formalized the sale of *Stéribox* kits in all pharmacies across France. That same year, the first automatic syringe dispensers were installed in public spaces. In 1995, NEPs were officially recognized in the Public Health Code and all CSSTs in France received authorization to prescribe and distribute methadone without any need for prior approval. As noted in circular DGS/SP3/95, the first and only text dedicated exclusively to OAT, published on 31 March 1995, the phenomenon of *drug dependence* was increasingly becoming a political issue referred to by specialists (Cf. Adès, 2001), and later by public officials in France, as *addiction*.

As early as 1990, US psychiatrist Aviel Goodman had developed a clinical definition of addiction as a condition in which a particular behavior becomes repetitive over time, leading to a loss of self-control that drives its continuation despite potentially negative consequences for the individual's physical, psychological, and social health, or even legal issues. This definition attributed an agentic meaning of a *loss of control* or a *loss of individual freedom*, a concept previously applied only to alcoholism (Fouquet, 1950; Jellinek, 1960). What this definition suggests is a surrender of individual agency to the substance (or a takeover of the person's agency by it, stripping away the individual's decision-making capacity in favor of a hedonistic logic—that is, pursuit of their own

pleasure). However, the model emphasizes that this pleasure-seeking does not necessarily intensify because of the user's desire, but because they are conditioned to do so, situating the origin of addictive behaviors in the strong agency of nature rather than in the strong agency of individuals. If users act as they do because they *lack control over themselves*, punishability can be turned into treatability—which, in this case, refers less to a curative process and more to a way of managing bodies and habits. In both instances, however, the intervention ultimately acts on their agency.

Based on the premise that all addictions share common characteristics and thus belong to the same category—including non-substance addictions, which do not directly impact nervous tissue but are produced by stimuli similar to those found in psychoactive substances, as recognized by the WHO and validated by discussions on the *spectrum* of addiction—,specialized and fragmented knowledge from the earlier medical fields of toxicology, alcoholism, and smoking was gradually integrated into a single field, known as *addictology*. This new medical specialty, emerging in the 1990s within the public health sector, enabled a *clinical* interpretation of consumption.

By the end of the decade, the addiction had ceased to be exclusively medical and turned into a category of public action, progressively shaped by concerns specific to the political and administrative spheres (Fortané, 2010). Taking on a triple role as a public issue, a scientific term, and a category of state intervention, the concept appeared for the first time in 1999 in a public health policy that unified measures designed to curb the consumption of alcohol, tobacco, and illicit drugs in the Three-Year Plan of the *Mission Interministérielle de la Lutte contre la Drogue et la Toxicomanie* (MILDT)[30] —French agency responsible for coordinating state actions on drug-related issues, renamed *Mission Interministerial de Lutte contre les Drogues et les Comportements Addictifs* (Mildeca), in 2014.

The substitution of the term *toxicomanie*[31] by *addiction* in the renaming of MILDT to Mildeca—also seen in the transition of the aforementioned *Association Méditerranéenne de Prévention des Toxicomanies* (AMPT) to *Association Méditerranéenne de Prévention et de Traitement des Addictions* (AMPTA), or from *Association Nationale des Intervenants en Toxicomanie* (ANIT) to *Association Nationale des Intervenants en Toxicomanie et Addictologie* (ANITEA)—illustrates this reframing (Goffman, 2012; Beraldo, 2021) of drug issues in terms of addictology. By grouping legal and illegal drugs under a single category within a unified public policy, the French state identified and began to address an *addiction problem* common to all drugs, which the risk reduction policy aims to address.

Although risk reduction and addictology originated from distinct movements, fields and debates, in France, as in Brazil, a "fortunate encounter" (Petuco, 2019) emerged at the institutional level to the benefit of both sides in the early 2000s: while addictology justified the existence of a risk reduction policy for addicted drug users—then recognized as having

a chronic illness and thus deserving of medical-social support—risk reduction allowed for the incorporation and practical application of addictology's principles and knowledge in the daily lives of the support facilities, fostering and contributing to its development. Not by chance, risk reduction obtained legislative recognition in 2004, becoming a public health policy and leading to the creation of two state-regulated and funded medico-social establishments cited earlier: the *Centres d'Accueil et d'Accompagnement en Réduction des Risques pour Usagers de Drogues* (CAARUD) and the *Centres de Soins, d'Accompagnement et de Prévention en Addictologie* (CSAPA), whose name clearly reflect this convergence.

The CSAPAs are currently responsible for providing and administering Opioid Agonist Therapy, working in close alignment with addictology's insights into brain circuits and other biopsychic phenomena that enable the substitution of one substance for another. This type of knowledge has developed within the country, supporting the creation of new substitution treatments, such as Electronic Smoking Devices (ESDs) for those seeking to quit smoking. These are also offered at these establishments, as I observed at CSAPA-EGO. Operating in a complementary manner to the CAARUDs—which provide attentive listening, primary care, food, donated clothing, items of personal hygiene, showers, workshops, cultural outings, administrative support, and so on—,the clinical/pharmacological support offered by these facilities enables the reduction of risks beyond consumption itself by integrating patients into other types of programs. These include *Un Chez Soi d'Abord* (Housing First), focused on residential integration, and the *Dispositif Premières Heures* (First Hours Scheme), focused on professional integration—initiatives also present in Rio de Janeiro's *Seguir em Frente* Program.

CONCLUSIONS

Based on my research conducted since 2018 in France and 2022 in Brazil, I set out from the premise that the Brazilian harm reduction approach responds to (1) an *epidemiological problem* among users of injectable drugs, identified during the 1980s HIV epidemic; (2) a *mental health problem* identified by professionals and users of these services in the late 1970s, which became consolidated as a social movement in the following decade, more specifically as the anti-asylum movement; and (3) an *urban ecology problem* (Joseph, 2004; Porto, 2022) identified by residents, passersby, and shopkeepers in regions occupied by drug trafficking and consumption in the 1990s, as a consequence of the arrival of crack at the end of the previous decade, which worsened in the twenty-first century (Alves & Pereira, 2021).

The French risk reduction approach similarly appears to respond to (1) an epidemiological problem among users of injectable drugs, identified in the 1980s (Porto, 2021); (2) an addiction problem among users of both legal and illegal psychoactive substances, identified in the 1990s with the rise of

addictology as a new medical specialty within the public health sector and thus within the sphere of state intervention; and (3) an urban ecology problem involving drug users and residents, passersby and shopkeepers in the neighborhoods most affected by the sale and consumption of these substances. The latter issue was already recognized in the 1970s with the emergence of open drug scenes, particularly for heroin and other injectable drugs, and intensified in subsequent decades with the arrival of crack in the country, becoming increasingly prominent in debates and in interventions within public space (Porto, 2025).

Although harm and risk reduction share a common origin and other similarities, the current implementation of this public policy differs significantly between Brazil and France. In Brazil, public security policies currently predominate in confronting the "drug issue," concomitantly with the weakening of harm reduction policy at a legislative level since the publication of the 'new' National Drug Policy in 2019 under former president Jair Bolsonaro and the resulting deterioration of CAPSad services (Costa & Rui, 2023). In France, by contrast, we can observe a predominance of health policies in response to the same issue, treating users as individuals responsible for their own care (Bergeron, 1999; Jauffret-Roustide, 2004, 2011; Quirion & Bellarose, 2007; Schmitt & Jauffret-Roustide, 2018), while also encouraging them to take care of themselves—and others who are or may be impacted by drug use.

This occurs through the strengthening existing risk reduction facilities (Beaulieu, 2021), such as the CAARUDs, CSAPAs, NEPs[32], *maraudes*[33], SCMRs, and Sleep-In facilities[34], as well as the proposal to open new spaces dedicated to supervised drug use (Tubiana-Rey, 2021), especially for crack (Belaïch, 2020). The prevalence of this substance among users in Paris, France's most important metropolis, has also led to the creation of new support spaces exclusively for this population, such as the *Espace de Repos* (Rest Space). I observed the implementation of the latter in 2019, including the idea of professionals involved to turn it into a SCMR (Porto, 2022). Political disagreements have so far prevented this change from happening, although alcohol can be consumed within the facility and crack can be used at its entrance, as I observed during fieldwork in 2024.

In my analysis, this discrepancy can be explained, among other factors, by the ways in which harm/risk reduction approaches have been institutionalized in each country. True enough, in both cases, the first two problems identified shift the drug issue from a securitarian framework, typical of the 1960s and 1970s, to a health-centered framework from the 1980s onward. However, this process has unfolded in distinct ways in Brazil and France: when the risk of HIV was no longer sufficient to justify harm/risk reduction and its underlying rationale, the former aligned with mental health, while, as I was able to observe in the studied facilities and in a risk reduction training course, the latter was closely aligned with addictology. There are

three groups of diseases, thus, responsible for the shift of the drug issue to the sphere of public health: HIV/AIDS and other Sexually Transmitted Diseases (STDs), Mental Disorders, and Addictive Disorders. Although the approach, in both cases, distances itself from one pathology and anchors itself in another—whether to survive, become institutionalized or evolve—,there are fundamental differences between the fields of mental health and addictology, which lend distinct contours, functions and perspectives to this public policy.

It is true that some risk reduction professionals and activists, including the former president of ASUD (Olivet, 2014; Rodrigues, 2023) with whom I had the chance to discuss the topic, interpret this clinical/medicalized approach to drug use as a regression, reintroducing much of what the movement had fought hard to reject—for instance, the categorizations of drug users in the 1970 Mazeud Law as either *criminals* deserving punishment or as *sick individuals* deserving treatment. A colleague of Carl Hart (2021), Olivet told me at the time that he agrees with the neuroscientist's premise that most users develop a "relationship" with drugs rather than a pathological "dependence" and that the war on drugs is racial because "justice has a color," the illegality of drugs being the greatest harm associated with their use. It is evidently beyond the scope of the present article to determine whether or not users commonly develop a pathology related to dependence, but following the pragmatist tradition from which I take inspiration, it is essential to observe the *effects* of this pathologization engendered by addictology.

The research highlights that basing risk reduction on the precepts of this field has allowed the creation a series of facilities in France since 2004, as mentioned throughout this article. CAARUDs and CSAPAs are good examples, as are the SCMRs, now called *Haltes Soin Addiction* or Addiction Care Stops (Jauffret-Roustide et al., 2023), which have become another establishment that carries addiction in its name and is expected to proliferate at the national level by 2025, according to former Minister of Health Olivier Verán (Tubiana-Rey, 2021). In my analysis, the importance of this field lies in the construction of clinical knowledge on addiction and its role in the motivation, desire, and associative learning of users, which justifies the need for strictly pragmatic interventions to attend a condition described by professionals as an *irrepressible* urge to consume.

Viewing addiction as a chronic and thus incurable disease, this field does not condemn users to the status of "*sick individuals* deserving treatment" but, rather, of *patients* worthy of ongoing support focused on symptom management—including their *craving*[35], or *fissura* in Brazilian Portuguese—reducing the epidemiological, health, psychological, social, familial, legal, financial, and other risks associated with the drug use and ensuring them a place within the public health system specialized to cater to their condition. In my view, framing risk reduction within this kind of perspective strengthens it as a public policy. Specifically, it enables what I have termed a *productive pessimism*: a view shared by professionals and authorities that,

despite the current repressive and prohibitionist legislation, the lack of supplies (which are easily improvised and thus riskier) and health recommendations, a sizeable portion of drug users not only can but probably *will* continue to use drugs.

In Brazil, this line of argument seems to hold less impact, particularly at a national level. Unlike France, which has an integrated network of state-regulated facilities with standardized, or at least similar, supplies and services distributed across the country, Brazil's equivalent facilities often offer conflicting services. As described to me in the field, the CAPSad units in the municipality of Rio de Janeiro operate as part of a collective, from which they ensure a harm reduction approach across all participating units, foregrounding the centrality of the individual in their own care, respecting their wishes and decisions (including the decision to consume), fostering their autonomy, and providing supplies for safer use in community-based actions. As Santos (2023) highlights, the same facility in Campos dos Goytacazes, in the northern region of Rio de Janeiro state, takes a more conservative approach and "fosters a certain civil subjection" (ibid: 17) among users of the service, contributing to the internalization of a condition of hypo sufficiency. This leads them to view themselves "not only as someone who lacks the resources to pursue their own needs and wishes without State support (...), but as someone who, deemed to be ignorant, is in no position to have a say about what would be best for them" (Cardoso de Oliveira, 2022), in a context of medicalization with a view to abstinence.

Also in Rio de Janeiro, difficulties have emerged in implementing a facility that assists drug users but straddles the debates and interventions focused on the homeless population (and thus Social Assistance) and people with mental distress (and thus Mental Health), generating internal dilemmas and contradictions since they belong to both categories, and, at the same time, to neither. Another particularity of Brazil, especially in Rio de Janeiro, that places users in a third space and undermines the advancement of harm reduction policies, concerns what Michel Misse (1999) calls the *social accumulation of violence*: a complex social and historical process involving the modification and superposition of practices and figures shaping the representation of "urban violence," which more recently (Werneck et al., 2021) includes the figure of the *cracudo* or crack user (Brandão, 2015; Veríssimo, 2015), redirecting the drug issue towards the public security sphere. If, for Michel Misse, certain individuals are generally treated by society as *bearers* of urban violence[36] in processes of *criminal subjection* (Misse, 2010; Prado, 2020), in France, certain users of crack and other drugs are treated as *bearers* of addiction, a kind of *pathological subjection* that tends to be *productive* since it demands the development of a public policy aimed at reducing the risks and harms of a practice thereby interpreted as inevitable. Despite the limits and weaknesses of an analytical model still under construction, what I propose

to call “productive pessimism” seems to me an important lead for thinking about the future developments of the approach in Brazil.

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NOTES

1 The semantic register of the policy studied here varies according to locality—the expression 'harm reduction' is used in Brazil, Canada, and Switzerland, for instance, whereas 'risk reduction' is used in France. In Pierre Brisson's view (1997), the term 'risk' evokes an immediate notion of danger, whereas 'harm' conveys a broader sense of injuries and issues. For an excellent analysis of these terms, their meanings and the implications of each of these models in Brazil and France, see Rodrigues (2023).

2 Aiming to assist patients who wish to reduce or quit their use of opioids—substances derived from opium, a milky liquid found in the plant *Papaver Somniferum*, commonly known as the oriental poppy, in both natural forms (like morphine) and semi-synthetic (like heroin)—OAT is administered via medical prescription of fully synthetic opioids. These substances, with effects similar to the original opiates, allow users to replace unsupervised use of illegal and often adulterated substances with regulated pharmaceuticals such as methadone and buprenorphine with controlled composition and dosages, thus avoiding withdrawal symptoms; however, I often heard opposing reports during my fieldwork.

3 In Brazilian Portuguese, "*Quem vê cara, não vê Aids*," "*Se você não se cuidar, a Aids vai te pegar*."

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5 A neighborhood where crack arrived in the late 1980s, the location of Paris's first crack house on rue de Tanger in 1989. More than 30 years later, the area remains "the European crack shrine" (*Le Monde*, 2021).

6 The Parisian arrondissements are administrative divisions that split the city into 20 districts arranged in a spiral (each neighborhood representing a step in the movement of 'circling,' *arrondir*, the city) starting from the center of the map, where the 1st arrondissement is located.

7 In English, Center for Welcome and Support of Risk Reduction for Drug Users.

8 In English, Addictology Care, Support and Prevention Center.

9 The acronym STEP stands for "*Seringues, Tampons, Eau et Préservatifs*," which translates into English as "Syringes, Swabs, Water and Condoms."

10 In English, Interministerial Mission for Combatting Drugs and Addictive Behaviors.

11 In Brazilian Portuguese, CAPSad stands for *Centro de Atenção Psicossocial Álcool e Drogas*. CAPS I, II, and III provide mental health services via the Brazilian Unified Health System (SUS) for adults experiencing mental distress or severe and persistent disorders. CAPS I and II are open to adults from 8 a.m. to 5 p.m., Monday through Friday, while CAPS III operates 24/7 all days of the week. CAPSad II serves the population using drugs, while CAPSad III provides continuous clinical care for this population, with each unit equipped with 12 beds for patient observation and monitoring.

12 In Brazilian Portuguese, *Movimento dos Trabalhadores em Saúde Mental*.

13 In Brazilian Portuguese, *Movimento Nacional de Luta Antimanicomial*.

14 In Brazilian Portuguese, *Núcleos de Atenção Psicossocial*.

15 Far from being a situation unique to Brazil, the former president of the French association Techno+, Jean-Marc Priez, was also legally charged in 2002 for distributing two flyers that provided risk reduction guidance on cocaine use to electronic music festival-goers (entitled "Clean Sniff") and on poly-drug use, that is, the simultaneous use of two or more drugs (entitled "Drug Mix"). These flyers warned about the risk of hepatitis B transmission through sharing straws for snorting cocaine and advised that mixing drugs is riskier than consuming just one. Facing a potential 10-year prison sentence, later converted into a €20,000 fine, Jean-Marc was eventually acquitted in 2005.

16 The same applies to risk reduction in France, which launched with the following message: "If possible, don't use drugs. If not, try nasal use instead of intravenous. If not, use a clean syringe. If not, reuse your own syringe. In the worst case and you have to share a syringe, clean it with bleach" (Jauffret-Roustide, 2017).

17 In Brazilian Portuguese, *Centro de Estudos e Terapia de Abuso de Drogas*. This movement reflects a certain porosity between science and politics (Buton, 2006), similar to what

was happening simultaneously in France, as I intend to show later.

18 In Brazilian Portuguese, *Associação Brasileira de Redutores de Danos*.

19 In Brazilian Portuguese, *Rede Brasileira de Redução de Danos e Direitos Humanos*.

20 Notably, in the same year, France instituted the so-called "Kouchner Law," named after the Minister of Health responsible for its implementation, Bernard Kouchner, who I present later. Developed with the consultation of patient associations in the context of the AIDS epidemic—and thus conceived and constructed over a span of nearly 20 years, especially until 1996, when treatments for the disease were still not available (Cardin, 2014)—this legislation formally expanded the rights of patients treated in health and medico-social institutions. It guaranteed their participation in decision-making processes related to both institutional matters and their own care, replacing the term 'patients' with 'users' of these services, including drug users—which closely mirrors developments concomitantly introduced in Brazil by the Psychiatric Reform movement.

21 The so-called "December 31 Law, concerning health measures to combat dependence and the repression of the trafficking and illicit use of harmful substances," left users with two options: incarceration or therapeutic intervention, which, according to the letter of the law, meant abstaining from drugs in a rehabilitation center.

22 In English, Institute for Research in Epidemiology of Drug Dependence.

23 In English, National Institute of Health and Medical Research.

24 In English, Paris's Safer Consumption Room.

25 The original kit contained a syringe, a *stéricup* (a small aluminum container for preparing the drug), WFI (water for injection), a few cotton pads with 70% alcohol, and cotton swabs. Although this kit is no longer distributed, users still refer to its name at Needle Exchange Programs when seeking supplies for intravenous drug use.

26 In English, National Association of Drug Dependence Specialists.

27 Co-founder of Médecins Sans Frontières and Médecins du Monde, Kouchner was responsible for commissioning the report titled "Access to Methadone in France," which demonstrated the effectiveness of Opioid Agonist Therapies in the 1990s, helping to strengthen and expand the emerging risk reduction infrastructure.

28 In English, Specialized Drug Dependence Treatment Centers.

29 In English, Mediterranean Association for the Prevention of Drug Dependence.

30 In English, Interministerial Mission for Combatting Drugs and Drug Dependence.

31 *Toxico* refers to narcotics, whereas *manie* translates as mania or obsession. With the emergence of the term *addiction* in official reports, scientific studies, public policy texts, and the names of associations and institutions, as illustrated below, attention shifted from the object—which surpasses the boundaries of legal/illegal, as well as uses with/without substances—to the behavior itself. As a result, *toxicomane* became obsolete as a term referring to illegal drug users and is no longer employed by risk reduction practitioners, as I could observe during fieldwork.

32 The Needle Exchange Programs offer more than their name suggests, providing disposable supplies for injecting drugs, as well as oral and nasal inhalation, water for injection (WFI), and other substances to dilute injectable drugs and thereby aid prevent vein obstruction, healing creams for hands and lips, as wounds caused by drug use can become entry points for infections, and so on.

33 The *maraudes* are operated by professionals from *Samusocial*—an urban social emergency and anti-exclusion initiative—through interventions in public space that provide medical and hygiene care, psychosocial support, food, social housing, and more to homeless individuals (Cefaï & Gardella, 2011). Risk reduction *maraudes* offer the same services to drug users, along with distributing disposable consumption supplies and referring users to risk reduction facilities.

34 Facilities that allow users to stay overnight for a €1.50 fee and permit drug use during their stay—a reason why users trying to quit addiction preferred to spend the nights on the streets, as they told me during my fieldwork.

35 The term, borrowed from English and adopted by the French—corresponding in everyday language to *être accro* (to be hooked, addicted)—refers to a regular symptom of psychoactive substances, marking the point when the *desire* for consumption becomes a *necessity*.

36 Understood here as a multiplicity of events linked to lifestyles and situations existing in large modern metropolises (Misse, 2002) and also as a public issue (Grillo & Martins, 2020).

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REDUCING HARM AND RISK: PUBLIC POLICIES FOR DRUG USERS IN BRAZIL AND FRANCE

Keywords
Harm reduction;
Risk reduction;
Drug use;
Public policies;
Consumption.

Abstract

Based on earlier research on the French approach to drug use called risk reduction (*réduction des risques*) and an on-going investigation into a Brazilian approach called harm reduction (*redução de danos*), the article aims to understand the broader processes that permeate this public policy area in distinct social and political contexts, as well as the features that distinguish their various local manifestations. Pursuing this aim, I develop two analytical axes: a historiographical approach, interested in understanding the trajectory of risk reduction and harm reduction separately, especially the moral disputes and agreements relating to political openness to the policy and its institutionalization in both countries from the late 1980s to the early 2000s; and a contrastive approach, exploring the intersection of these sets of data, as a preliminary step in a broader investigation into risk/harm reduction.

REDUZINDO DANOS E RISCOS: AS POLÍTICAS PÚBLICAS PARA USUÁRIOS DE DROGAS NO BRASIL E NA FRANÇA

Palavras-chave
Redução de danos;
Redução de riscos;
Uso de drogas;
Políticas públicas;
Consumo.

Resumo

Partindo de uma pesquisa anterior sobre a abordagem francesa de Redução de Riscos (RDR) e de uma pesquisa atual sobre a abordagem brasileira de Redução de Danos (RD), o objetivo deste trabalho é compreender os processos mais amplos que atravessam essa política pública em diferentes contextos sociais e políticos, bem como os traços distintivos de suas diversas manifestações locais. Para tanto, são desenvolvidos dois eixos analíticos: um historiográfico, interessado em compreender a trajetória da RD e da RDR separadamente, sobretudo as disputas morais e os acordos estabelecidos em torno da abertura política à abordagem e à sua institucionalização em ambos os países, entre o final da década de 1980 e o começo dos anos 2000; e um contrastivo, com vistas ao cruzamento dos dados, encarando como etapa seguinte de uma grande investigação sobre a redução de riscos/danos.