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Vietnam's policing in harm reduction: Has one decade seen changes in drug control?

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ABSTRACT

Alongside raising awareness and creating activities to develop a harm-reduction approach in the HIV/AIDS campaign since the end of the 2000s, broader harm-reduction interventions in Vietnam were also deployed that included several positive steps. Police forces, a fundamental sector in reducing the supply of illicit drugs, were also involved, partly to concretize this approach. As the first paper to examine the role of police in harm-reduction interventions in Vietnam, the current study utilizes qualitative approaches relying on in-depth interviews conducted with multiple key informants from government and its related bodies, United Nations personnel, and non-government organizations (NGOs), as well as police officers. We uncover noticeable progress in changing minds and approaches to apply harm reduction in drug policy, particularly within policing. However, major barriers in regulations, slow acceptance by police forces, and a lack of curriculum and courses in police training have limited harm-reduction approaches. As the first study to review and assess the policy of harm reduction after one decade, the paper contributes to a deeper understanding of the nature of Vietnam's police provisions to balance and improve harm reduction in drug control.

Key Words Harm reduction; law enforcement; policing; decriminalization of drug use; Vietnam

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INTRODUCTION

Due to the proximity of the Golden Triangle—one of the world's largest illicit drug production regions—and a porous border with neighbouring countries (Cambodia along the South, China along the North, and Laos along the centre), Vietnam has, in recent times, been considered a primary demand destination and transnational hub for illicit drugs in Southeast Asia. Most traffickers take advantage of difficult geographical, topographical, and climatic conditions across Vietnam's other borders—with China to the north and Cambodia to the south—which provide many official as well as unofficial pathways to transport illegal drugs to and/or through Vietnam and beyond (Hai, 2019a, 2019b). Meanwhile, the drug transportation and drug use situations have reached alarming levels. The percentage of drug-addicted persons in the whole country is also a serious concern, impacting negatively on social order, economic development, and public health. Police detect and arrest an annual average of nearly 20,000 cases and more than 25,000 drug offenders, respectively. In the first quarter of 2019 alone, they investigated 6,552 drug-related crimes and seized more than six tons of illegal drugs—more than the number of cases and quantities seized in all of 2018. Meanwhile, Vietnam also admits that there are at least 225,099 drug addicts registered by authorities, and about 1,600 people die of drug overdoses in Vietnam each year (MOLISA, 2018; MPS, 2018).

Drug control measures between the post-revolution period (*Doi Moi* in Vietnamese) in 1986 and the decriminalization of drug use in 2009 have almost all involved policies and strategies focused on supply and demand reduction. Quite similar to the situation in developing countries in mainland Southeast Asia, such as Cambodia, Laos, and Myanmar, Vietnam was slower than the rest of the countries in the ASEAN region (such as Thailand, Malaysia, the Philippines, and Singapore) to use harm-reduction interventions. The harm-reduction approach to drug control in Vietnam was derived from its symbiotic relationship with HIV/AIDS. In other words, it is only since the harm-reduction practices used in HIV/AIDS programs and policies were introduced and implemented in the mid-2000s that applying similar practices to drug control policies has been encouraged and promoted. One of the main reasons for this situation is that the two affected groups, HIV/AIDS and people who inject

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drugs (PWID), are strongly interlinked, as around 30% of the HIV-positive population are PWID. There are an estimated 250,000 adults and children living with HIV and 226,900 PWID (Tam et al., 2018; UNAIDS, 2018). In contrast, there has been no notable change in policing to apply harm-reduction interventions, particularly with anti-narcotics police (ANP) and administrative management of social order police (AMSOP) forces, except for some minor cooperation, collaboration, and supports in the form of projects conducted by the Ministry of Health (MOH), the Ministry of Labour, Invalids, and Social Affairs (MOLISA), and the United Nations Office on Drugs and Crimes (UNODC) (Jardine, Crofts, et al., 2012; Vuong, 2012). According to Hong et al. (2012), police officers often focus on preventing and controlling drug use as their highest priority rather than supporting harm reduction. This has led to a practical irony in that, although they are leaders and operators of harm reduction in their own field, not all ANP and AMSOP officers actually understand it, which has limited the scope of the contributions of law enforcement agents (LEAs) to harm reduction in drug use at the local community level. Yet, in some cases, they have also exhibited a more common pattern of seeking drug addicts and pushing them into compulsory detoxification centres (CDCs) rather than advising those addicts to go to voluntary treatment communities (Dung, 2019; Thu et al., 2017). The main aim of the current paper is therefore to review and assess changes and adjustments in policing intended to align with harm-reduction interventions during the decade since drug use was decriminalized in Vietnam in 2009. Additionally, sharing the findings of interviews also provides inside stories and showcases the dilemmas and hesitations of the interviewees, with a view to explaining why expanding harm reduction among Vietnamese police remains slow and inconsistent.

METHODS

Interviews were conducted at multiple levels. First, the authors consulted and examined the Office of Government, including activities at the Prime Minister level relating to social welfare and community affairs and including harm-reduction interventions based on concerns for drug-user health. Secondly, three pillar sectors in Vietnam's national strategy on preventing and combating drug concerns were examined: the Ministry of Public Security's (MPS's) ANP department, which is the permanent lead on monitoring; the department responsible for addressing social evils (MOLISA), and the department focused on HIV/AIDS (MOH), which, together, intervene to prevent and treat transmission of HIV/AIDS in connection with drug policies. Thirdly, purposive interviews among representatives of hot-spot drug-related areas in Hanoi and Nghean province were also conducted to clarify and assess their current understanding of and approaches to harm-reduction interventions. Ten interviewees were selected and invited to share their opinions in interviews lasting 45 to 60 minutes. In accordance with the People's Police Academy of Vietnam's Ethical Approval Statement, respect for personal confidentiality and the rights of law enforcement and government officers, these interviews were not recorded. Almost all handwritten notes taken during the interviews were jotted down in Vietnamese language first. Transcripts of interviews were prepared and analyzed using thematic analysis after double checking by all authors and then translated into English before entry for analysis. These descriptive transcripts were analyzed using NVivo 12 for Mac. All section headings used below were repeated among interviewees, and original quotations are shared as faithfully as possible to respect the valuable contributions made to this study.

RESULTS

Decriminalized Drug Use is One of the Most Important Triggers of Harm-Reductions Interventions

Although the legal documentation related to drug treatments has been revised and supplemented several times, from the *Ordinance on Handling of Administrative Violations* in 1995 to the *Law on Drug Prevention and Control* in 2000 (LDPC) and the *Law on HIV/AIDS Prevention and Control* in 2006, harm reduction in drug policies in Vietnam has not yet been applied regularly to the process of drug detoxification. In 2009, the first countries in Southeast Asia began to decriminalize drug use, while almost all countries in the entire ASEAN state still pursued a campaign of rhetoric with the goal of being a drug-free zone by 2015. Vietnam has also been making a critical change to build up its national strategy in drug control by implementing harm-reduction interventions alongside supply-and-demand reduction approaches. This change is still a slow transition from social evil to harm reduction, as Windle (2016) has argued, but an important one:

> It is not only proof of a considerable milestone in Government drug policy but also shows tremendous effort on the part of all related authorities and the social public towards viewing the drug user/addict as a chronic patient rather than an offender. (Interviewee 1)

The amendment of the law on drug prevention and control passed in 2008 marks the first time harm reduction was recognized as a priority method for drug control (at article 34a).[1] Accordingly, as of the 2009 Vietnam Penal Code, the illegal use of drugs is no longer "subject to criminal prosecution" but is only "administratively handled," with fines under certain conditions; otherwise, addicts may be sent to CDCs. The fact that the illegal use of narcotics is not considered a crime does not mean simply tolerating such acts but requires more effective and sustainable handling measures, such as medical treatment combined with labour, home, and community education as well as CDCs.

> In addition to decriminalizing the illegal use of drugs, in society, the consensus in conducting harm-reduction solutions is increasing. Many seminars given by MOLISA,

[1] According to article 34a, interventions to reduce the harms of drug addiction are measures to reduce the harmful effects related to drug-use behaviours of drug addicts, which cause harm to themselves, family, and community. Interventions to reduce the harmful effects of drug addiction are implemented among drug addicts through prevention programs suitable to socio-economic conditions. The Government shall specify interventions to reduce the harms of drug addiction and organize the implementation thereof.

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> MOH, and MPS on this topic have been organized to recognize the importance and share the experience of harm-reduction implementation. (Interviewee 3)

> In our view, cooperation with the health sector is the most achievable milestone to make a connection between harm reduction and public health in drug policies, and it can also build a bridge to law enforcement for cooperating and collaborating in utilizing methadone maintenance therapy (MMT) in drug detoxification. (Interviewee 4)

To support and deploy this important change, the Government permitted the pilot application of the MMT model in 2008 in Hai Phong and Ho Chi Minh City before starting it in Hanoi at the end of 2009. It was extended to 12 cities and provinces as of 30 June 2012 to treat nearly 10,000 patients, who have experienced reduced harms caused by using opioids, including HIV, hepatitis B and C resulting from needle sharing, death from overdose and related criminal activities, and a reduction in illicit drug use and injection that has improved the quality of life of addicts (Tam, Long, Manh, Hoang, & Mulvey, 2012). Notably, in 2015, five years after drug use was decriminalized, the Phu Son Prison in Thainguyen province, with support from UNODC Vietnam, launched the first MMT service unit for prisoners in Vietnam to offer adequate treatment to prisoners affected by drugs, who account for over 30% of prisoner population. A retired senior police officer made the following observation:

> As you can see, with positive changes in policies for drug addiction, which now view drug users as patients in need of treatment, almost all drug users in society, even if they are imprisoned, have the right to access an MMT service. I consider this to be a remarkable record in our policing approaches since decriminalizing drug use in 2009. (Interviewee 2)

To Begin, We Did Not Really Recognize the Nature of Harm Reduction in Drug Policy

Although the 2008 LDPC provided support for harm-reduction measures as well as decriminalizing drug use in the new penal code in 2009, the 2012 *Law on Handling Administrative Violations* (LHAV) continues to categorize drug use as an administrative violation, and users are still frequently sent to CDCs, under certain conditions. Yet these legislative documents also contain contradictory regulations with regard to handling drug users and/or addicts that lead to "disconcerting and confusing information regarding an integrated implementation among local authorities and other functional agencies" (Interviewee 5). As the ANP officer who covers legal matters in terms of drug policies of the MPS noted:

> Clause 1, Article 27, and Clause 2, Article 28, of the 2008 LDPC stipulates that in cases where drug addicts do not voluntarily enter detoxification, the CDCs shall be applied in the community under decisions of the presidents of commune-level People's Committees. However, I can point out that the 2012 LHAV has not specified this content; unless otherwise stated, the authority to make a decision and direct those addicts into CDCs will belong to the district court. Also, the 2008 LDPC regulates the time limit for compulsory detoxification as one to two years, but Clause 2, Article 95, of the 2012 LHAV requires between six months and two years. (Interviewee 7)

Several conflicting regulations in drug laws have also led to barriers and difficulties in solving drug addiction after decriminalization in 2009. As well, the situation with drug addicts is increasingly complicated. According to statistics as of November 2008, the number of drug addicts nationwide was 120,455. In 2018, the number of addicts nationwide was 225,099, an increase of 87% compared with 2008. This unexpected figure "has introduced more pressure to our duties: protecting community safety as well as trying to detoxify drug users in our areas" (Interviewee 6). Consequently, local police forces have actively carried out investigations, grasped the situation of drug addicts, and coordinated with relevant actors, including AMSOP officers, to compile and open documents on managing drug users, while also consigning drug addicts to CDCs. In terms of sharing among AMSOP officers in Hanoi after the first years of decriminalizing drug use, Interviewee 9 made the following comment:

> Although the decriminalization of drug use took effect on 1 January 2010, we had puzzled about what to do with them [addicts]. Frankly, we did not exactly know what were the best ways to deal with them if they were not criminalized and without prisons. Alternatively, before the new national detoxification scheme [in 2014], we elected to send them into CDCs as one of the more flexible solutions at that time, where at least they were under the continuing control of the authorities.

Accordingly, in 2010, the ANP cooperated with grassroots police groups to gather and send 10,000 drug addicts to CDCs. These numbers were then reduced to 7,705 in 2011 and 1,894 in 2015 (MPS, 2019). This specific reduction arose from updated adjustments made by the Government in the period of 2011 to 2015, which proclaimed the National Strategy Plan on Drug Prevention, Combating and Control through 2020, and Towards 2030, which called for actions that are "closely combined with combat, supply reduction, demand reduction and harm reduction." At that time, most drug users and addicts were encouraged to choose admission into centers for treatment—education—social labour (TESL), rather than CDCs, to concretize their patient's rights, though these two centers are quite similar in their applications of "cold turkey" methods (Aldhous, 2005). However, while both MOH and MOLISA bodies and agencies endeavoured to support many positive pathways in terms of healthcare and social welfare to help those patients, the police force had not yet learned to deploy these changes in advanced ways (Hong et al., 2012; Jardine, Anh, & Hong, 2012).

In contrast, as stated by Interviewee 8,

> for us [ward police], it is one of the practical challenges we must face without sufficient knowledge about harm reduction in policing, dealing with drug addictions and

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> collaborating with health sectors to apply MMT for them [addicts] at our local communities.

Clearly, it is reasonable to assume that many police officers, including ANP and AMSOP, feel perhaps too much emphasis is placed on "harm reduction" and not enough on "supply reduction" as per their usual duties. As a result, the role of the police in harm-reduction intervention in the first five years of decriminalizing drug use, in reality, is still at the very least being questioned. As the AMSOP of Nghean confessed:

> On the one hand, we must meet the criteria to bring drug addicts into CDCs, but on the other hand, we also encounter obstacles from conflicts of policies in terms of HIV, drug-related crime, and harm reduction, as well as obstacles from the families of drug addicts, and the pressure of keeping the community safe and clean. This has pushed our team into the situation of being between the hammer and the anvil. (Interviewee 10)

There Is a Need to Change Attitudes and Actions to Implement Harm-Reduction Approaches in Policing

In 2012, over 5,000 law-enforcement signatures from all over the world were obtained in support of harm reduction. Vietnam's police delegation also joined and signed this Statement of Support, leading to one Vietnamese translation version provided alongside versions in five official languages, which were presented at the inaugural meeting of the International Police Advisory Group in Melbourne. In August 2013, five senior officers from the Cambodia police force together with six first pioneers of Vietnam's representatives from the People's Police Academy were invited to Australia to undertake public-health leadership training in a three-week course to focus on Police as Collaborative Leaders in the HIV Response (LEAHN, 2013).[2] On that occasion, one of them shared their thoughts about their expectations in applying this harm-reduction knowledge in policing:

> Harm reduction is an important part of drug prevention, so a new perspective on this is needed. In our opinion, the use of harm reduction measures in drug prevention is not a compromise with drug enforcement but is rather a complement to this work, especially in the work of drug detoxification. However, which measures should be selected to ensure high effectiveness and avoid misunderstanding about social awareness needs to be clarified and assessed as carefully and as practically as possible in our police force.

Traditionally, within the scope of the internal emphasis among police on an abstinence approach, harm reduction is conceptualized as a form of propagative education to share and warn of the many negative impacts of drugs to help people avoid them, and even never try them (Dung, 2019). "If you ask me about the nature of this intervention [harm reduction], I can only think that I do the best to protect myself and be as careful as possible when in contact with addicts, particularly if they are HIV/AIDS" (Interviewee 5). Ironically, while ward police officers often play an important role in monitoring, filtering, and selecting which inject drug users (IDUs) will be nominated for an MMT program, they have still been using their personal experience and internal criteria to clarify "good" vs "bad" IDUs and applying this to their decisions since the first pilot deployed in 2009 (Hong et al., 2012; Jardine, Anh, et al., 2012). This has led to an ineffective effort between police and health and social affairs sectors to cooperate, consult, and decide on the specific criteria to use to implement harm-reduction interventions at the local community level. As an ANP officer of Hanoi pointed out:

> Most police ward officers in my district management are armed with the knowledge that PWIDs are disproportionately affected by HIV, with high prevalence rates. Many of them are often reluctant to confess that they don't understand the link between policing and HIV risk. Therefore, I think we need to change our attitudes, behaviours, and also knowledge about harm reduction and should perhaps be re-educated, supplementing these new experiences to us in police training institutions. (Interviewee 7)

DISCUSSION

In this first study to review what has changed in harm reduction among Vietnam's police since drug use was decriminalized in 2009, the current findings show that, while police play many roles in the fight against drug crimes, they often assume that their duty in drug prevention is in conflict with supporting harm-reduction activities, which leads to stress at work and in their relationship with the community. In a situation similar to that of the Australian police two decades ago, when harm minimization was introduced there, despite being a force that directs and conducts harm-reduction activities, not all police are aware of it, and some still have doubts and think it contradicts their drug-combating responsibilities (Lough, 1997; Maher & Dixon, 1999). Accordingly, both needle exchange and methadone treatment are believed by some police officers to be in conflict with their main task of supporting the operation of rehabilitation centres. This even leads to stigma in terms of their community's expectations when citizens think the police give clean syringes or methadone to addicts (Hong et al., 2012). To bridge this gap, they must not be judgmental and must forget their moral prejudices against illicit drug-taking, as the cost is just too great to miss the opportunity for reducing the amount of drug use; reducing the harm that drug users experience per unit of drug used; reducing the harms that drug users impose on others; and reducing the harms caused by production, trafficking, and distribution of drugs (Caulkins & Reuter, 2009). Twenty years

[2] This program was hosted by the Law Enforcement and HIV Network (LEAHN) and the Nossal Institute for Global Health, University of Melbourne, and included practical sessions from practitioners in family-based methadone, community harm-reduction services, and police from Victoria and New South Wales. It provided an opportunity for aspiring leaders and trainers within policing institutions in Vietnam and Cambodia to build their own, and, by extension, their respective police forces', capacity to work collaboratively to respond to HIV among Key Affected Populations.

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ago, when the Australian Police approach to "harm minimization" campaign began, Lough (1997, p. 172) recommended that "local operational police must become both pragmatic and rational; then, and only then, will law enforcement become truly mutually compatible with harm minimization rather than mutually exclusive." To some extent, therefore, in Vietnam, it is necessary to set up a multiple police team, between ANP officers, who focus on detecting drug trafficking cases and look for groups/organizations involved in drug use, and AMSOP officers, who control and monitor local citizens, including addicts and drug users, at their hosted management sites. The head of a team should assign police officers to coordinate with health clinics, population leaders, village heads, neighbours, families, and social organizations to supervise and manage drug addicts and offenders in the community.

Ten years after the first four-year research project (2009–2012), the Law Enforcement, Harm Reduction, Nossal Institute project (LEHRN), funded by the Australian Development Research Awards and implemented by the Nossal Institute for Global Health at the University of Melbourne in mainland Southeast Asia, including Cambodia, Laos, and Vietnam, there are no further similar projects to encourage LEAs in Vietnam to continue this paradigm (Thomson, Moore, & Crofts, 2012). One of the most achievable impacts of this project is to support some MMT pilots in these countries, such as in the Tu Liem district, Hanoi, with leading clinics to serve PWID through methadone treatment. However, the program's expectations of treating, consulting, and assisting the addicts during pre- and post-detoxification has suffered from limited knowledge and insufficient training in how to approach these MMT interventions within police forces, including ANP and AMSOP officers—limits which have become key barriers to deployment (Jardine, Anh, et al., 2012). Meanwhile, there is a need for more specific evidence and effective activities to promote the application of harm-reduction interventions by police in drug control as one of three "pillar" policies (supply-demand-harm reduction) since the decriminalization of drug use in 2009. Most high-ranking representatives of MPS tend to be cautious and approach this trend as slowly as practically possible. It is one of the specific reasons that explains why, even though the first pioneering delegates of Vietnam were invited to attend the leadership program for policing in harm reduction in Melbourne more than five years ago, the expected vision to implement a harm-reduction curriculum in police institutions is still under discussion and not underway, as the international community had hoped. This in spite of the fact that senior delegations of MPS joined and signed the Amsterdam Declaration on Police Partnerships for Harm Reduction in October 2014 in Amsterdam (LEAHN, 2013, 2014). Unlocking the potential of police and community partnerships in harm-reduction responses is urgently needed. It is an issue that must be prioritized at this stage to insist on the important role of police in changing drug policies in Vietnam. Specifically, rather than focusing solely on arrest campaigns, police (ANP and AMSOP) should join forces with public health and build up their new evidence-based perspectives on treatment with MMT and NSPs by changing and updating current police training courses to link with improved public health knowledge.

CONCLUSIONS

Harm reduction is an important part of drug prevention, and a new perspective on this is needed. The use of harm-reduction measures in drug prevention and control is not a compromise with drug-use reduction efforts but rather a complement to this work, especially in the area of drug detoxification. However, questions remain about which measures should be selected to ensure high effectiveness and avoid misunderstanding about social awareness. Therefore, harm-reduction measures must have the same strict legal regulations as those for reducing drug supply and demand. Furthermore, it is necessary to also create a stronger consensus among ministries, departments, and agencies on harm reduction so that all localities and industries can firmly apply and implement these solutions.

The current research also shows that, in Vietnam's social context, police involvement in harm-reduction interventions is necessary. However, in order for police to adequately assume this role, they need to be equipped with knowledge about harm-reduction approaches and related procedures. Awareness-raising activities for police to reduce their prejudice towards drug users should be implemented immediately. Laws and policies also need to be further improved to reduce conflicts between drug laws and HIV laws, and guidelines on harm reduction for police and other partners need to be widely disseminated and supported to promote more effective cooperation between sectors. Coalitions across sectors can furthermore improve the capacity to better contribute to the common goal. Last but not least, regarding training, only when Vietnam's police accept to add a community-based health curriculum into their current training courses will true community-based policing, and the effective contributions of policing in harm reduction, become a reality.

CONFLICT OF INTEREST DISCLOSURES

The authors declare that there are no conflicts of interest.

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