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Harm reduction programmes for people who inject drugs in Nigeria: Challenges in implementation and sustainability

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KEY POINTS

- Harm reduction services need to be responsive to the needs and concerns of people who inject drugs for there to be optimal utilization.
- Existing harm reduction services in Nigeria focus mostly on health needs, and do not adequately address the social, economic, and legal problems faced by people who inject drugs.
- There is currently a dearth of services addressing the peculiar needs of women who inject drugs, including sexual and reproductive health services.
- Lack of counterpart domestic funding, due to low prioritization of harm reduction programmes compared to law enforcement, threatens the sustainability of existing services.
- Limited recognition of the expertise of people with lived experience of drug use in policy-making processes results in a missed opportunity to de-stigmatize people who use drugs at the policy level.
- Law enforcement strategies (e.g., confiscation of drugs and injecting equipment) contribute to low uptake of services and encourage high-risk behaviours such as sharing of needles-syringes.
- Inefficient procurement processes and non-adoption of a community-based approach to service delivery hampers the provision of life-saving services such as naloxone for overdose.

INTRODUCTION

Injecting is a high-risk method of drug administration owing to the likelihood of infection with blood-borne diseases such as HIV and viral hepatitis, fatal and non-fatal overdose, vein damage, and bacterial infections. People who inject drugs (PWID) have a twenty-eight times higher risk of being infected with HIV compared to the general population[1]. This high risk of HIV infection is linked to sharing injecting equipment (e.g., needles-syringes), and is exacerbated by 'risk environment' factors including criminalization, marginalization, poverty and homelessness[2]. Injecting drug use is a major facilitator of HIV and HCV transmission in Eastern Europe and Central Asia[3]. In the sub-Saharan African region, it has been linked to emerging epidemics of HIV and viral hepatitis[4,5]. It is estimated that 6.5% of PWID living in Central and West Africa have HIV[6].

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Harm reduction services, a set of public health interventions that aim to reduce health and social harms linked to drug use, has shown potential for mitigating the harms associated with injecting drug use. However, findings from assessments of these interventions highlight different challenges in implementation. These include limited scope of available services, particularly lack of services addressing the socioeconomic needs of PWID[7], as well as limited participation and stakeholdership of PWID in programs, including value for their knowledge and lived experiences[8]. Similarly, Marshall et al.[9] identified multi-level barriers to involving PWID in harm reduction programmes, including criminalization and stigmatization of drug use, favouring enforcement over harm reduction, inadequate training and support for peer workers, exclusionary attitudes and policies, and not grounding interventions in the lived experiences of people who use drugs (PWUD). The sustainability of harm reduction services has been linked to both internal and external factors. The former includes resourcing, engagement and willingness of implementers, while the latter includes service-friendly law enforcement, community support and funding[10].

In sub-Saharan Africa, harm reduction programmes for PWID have emerged in some countries as the region transitions from what has been described as a 'consensus position on prohibition' towards approaches to drug policy that are aligned with the global drug policy reform movement[11]. However, the scope of services is limited in most countries and implementation faces many challenges. In this context, country-specific assessments could help to identify the challenges facing implementation in order to inform constructive policy and programmatic responses. This Policy Brief reports on a preliminary assessment of harm reduction programmes for PWID in Nigeria, drawing on interviews with key informants (programme managers, policy makers, PWID) and visits to service facilities. Interviews focused on the scope of available services, acceptability, accessibility and sustainability of services, PWID participation in the design and implementation of services and other challenges in programme implementation. Primary data is complemented by information from secondary sources, including relevant reports from local and international NGOs. The rest of this paper is divided as follows; 1) epidemiology of injecting drug use; 2) harm reduction services; 3) implementation and sustainability challenges, and; 4) conclusion.

INJECTING DRUG USE IN NIGERIA

Nigeria has long been listed among sub-Saharan African countries with an increasing prevalence of injecting drug use[12]. According to a 2018 national survey of drug use, there were an estimated 80, 000 PWID in Nigeria[13] (see Table 1 for regional distribution of PWID). This is reported to be one of the highest PWID populations in the sub-region[14]. Nearly 17% of PWID are women. The survey also found that the drugs most commonly injected were pharmaceutical opioids (e.g., tramadol, codeine, morphine) followed by cocaine, heroin and tranquilizers. Over 50% of PWID injected drugs daily or nearly daily in the 6 months preceding the survey, with women slightly more likely than men to inject daily or nearly daily (58% of women compared to 54% of men). Injecting often occurred within a social context, involving injecting with friends and acquaintances, sexual partners and within semi-public drug use spaces known locally as bunks. Women are more likely than men to inject drugs with their sexual partners, often injecting after their partners and sharing injecting equipment[15].

Table 1: Injecting drug use as a proportion of high-risk drug use

Nigeria Drug Use Profile		
Drug user	**High Risk Drug Users**	**Injecting Drug Users**
14.4% (14,300,000 people)	0.4% (376,000 people)	0.08% (80,000 people)
Drug Use Profile of Assessed States		
Region	**State**	
North Central		10.0%
	FCT	10.0%
	Plateau	11.0%
North East		13.6%
	Gombe	21.2%
North West		12.0%
	Kano	16.0%
South East		13.8%
	Abia	11.3%
South South		16.6%
	Akwa Ibom	12.5%
	Cross River	11.8%
	Rivers	15.0%
South West		22.4%
	Lagos	33.0%
	Oyo	23.0%

*** High risk drug users are defined as those who had used opioid, crack/cocaine or amphetamines in the past 12 months as well as used for at least 5 times in the past thirty days**

The survey further indicated that unsafe injecting practices were common, with nearly half of PWID reporting that they had used a needle or syringe after someone else had used it or that another person had injected with their used needle or syringe. The reason for sharing needles-syringes included trust among friends and sexual partners, low availability of sterile needles-syringes at the time of injecting, having an urgent need to inject drugs to prevent withdrawal symptoms and injecting or being injected by someone else. Further, fear of being frisked by law enforcement officers also prevents PWID from carrying sterile needles-syringes and encouraged injecting with contaminated equipment[16]. Other unsafe practices include sharing drugs from the same cooker, using the same cotton swab, and using previously used water to clean injecting equipment. High-risk sexual behaviours, including sex without a condom and having sex with multiple sexual partners, are also common among PWID.

An estimated 9% of all new HIV infections occur among PWID. HIV prevalence among PWID is estimated at 3.4% compared to 1.3% in the general population. The prevalence of HCV and HBV is estimated at 5.8% and 6.7% respectively[17]. It has been contended that these estimates underrepresent the prevalence of blood-borne diseases among PWID, which may be significantly higher[18]. The available evidence has informed a public health response aiming to reduce drug-related harms among PWID. This includes Needle and Syringe Programs (NSP) that ensures access to sterile injecting equipment, Opioid Substitution Therapy (OST) and Naloxone to address opioid dependence and overdose.

HARM REDUCTION SERVICES

Essential harm reduction services for PWID are available through a multi-sectoral response established to address treatment and care gaps by ensuring availability and accessibility of NSP, OST and Naloxone for opioid overdose for PWID. In 2019, the National Programme on Demand Reduction and Harm Reduction (NPDDHR) was established by the Federal Ministry of Health (FMOH) to coordinate the health sector response to drug use. The National Harm Reduction Technical Working Group (NHRTWG) was also formed to oversee and guide the implementation of harm reduction programmes. In 2020, the National Guidelines on NSP was developed

and pilot services were implemented in three states (Gombe, Abia and Oyo). The pilot study, which assessed the feasibility, effectiveness and quality of NSP services for PWID to inform the scaling-up of intervention, has been controverted and questions have been raised about the collection and handling of data[19].

NSP has been scaled up from the initial 3 pilot states to 10 (Abia, Akwa Ibom, Cross River, Federal Capital Territory (FCT), Gombe, Kano, Lagos, Oyo, Plateau and Rivers). The number of PWID enrolled also increased from 2,731 to 70,738[20]. NSP and other harm reduction services are provided through public and private health facilities, one-stop-shops, drop-in centres and community-based organizations[21]. Implementation is through fixed site and community outreach models, the later anchored by trained peer outreach workers. Community outreach provides health education and condom distribution along with the supply of sterile injecting equipment and retrieval of used ones. An estimated 32% of PWID have been tested for HIV, and 25% of sero-positive PWID accessed Anti-Retroviral Therapy (ART)[22]. Between January 2020 and September 2021, about 8,190 HIV zero-negative PWID were screened for Preexposure Prophylaxis (PrEP) eligibility. Of these, 2,661 were eligible and received oral PrEP along with risk reduction counselling and other services[23]

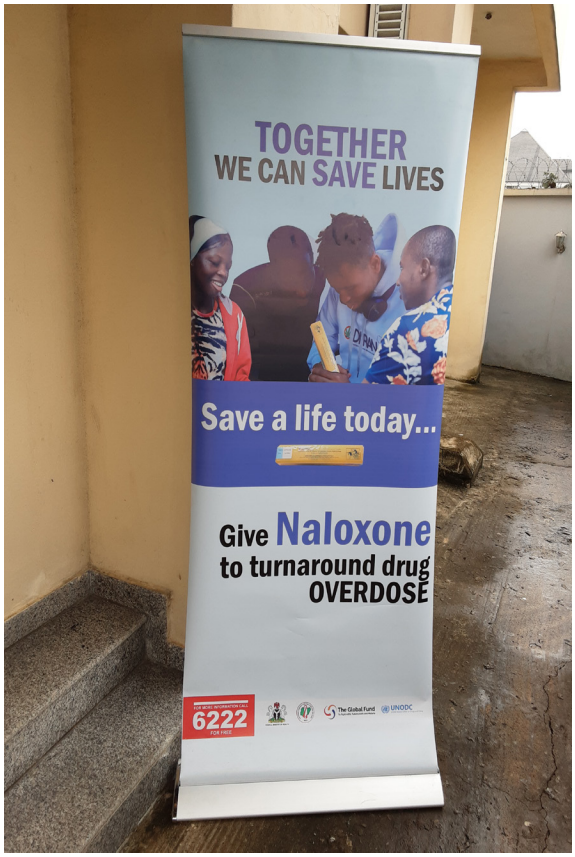

Figure 1: Banner located in front of a service facility carrying message about naloxone

A ministerial approval through the FMOH for the implementation of all major components of harm reduction services in 2022 enabled the commencement of OST provision as well as management of opioid overdose with naloxone. Between January and May 2023, the OST guidelines and Standard Operating Procedures (SOP) were launched, OST feasibility study was completed and selected health facilities were approved for implementation of services. The target beneficiaries were also expanded to include pentazocine and tramadol consumers. Procurement process for methadone has long commenced and there are plans to train personnel in the provision of OST. Naloxone is currently distributed through one-stop-shop facilities for key populations, but plans are reported to be in place to commence community distribution[24]. A recent assessment shows that naloxone and methadone were out-of-stock in many of the service facilities and processes for the procurement for these medications have been hampered by bureaucratic hurdles.

Acceptance of harm reduction services (especially NSP and OST) for PWID among health professionals (e.g., psychiatrists, who were previously resistant to these services), has been highlighted as an indication of progress. Other indicators of progress include development of national guidelines, federal approval for all components of harm reduction services for PWID as well as an administrative policy of non-prosecution by law enforcement agencies of persons caught in possession of small amounts of drugs for personal use[25]. However, cooperation

on the part of law enforcement officials remains suboptimal and repressive policing practices continue to create structural barriers to service implementation and uptake. At the community-level, the provision of essential services has contributed to improving the health status of PWID accessing these services. Further, the participation of PWID communities in the design and implementation of services has helped to improve uptake as well as contribute to reduction of stigma. It has also fostered collective action aimed at addressing social inequities through PWID self-organizing and participation in national and transnational networks. Nevertheless, several factors pose challenges to the implementation and sustainability of these services.

ADAPTABILITY OF SERVICES

Harm reduction services help to reduce harms associated with drug use by addressing the macro and micro-level factors driving harms in drug-using populations. For example, macro and micro-level factors intersect to shape harms through low access to sterile needles and syringes and high-risk behaviours such as sharing of needles-syringes. In this context, harm reduction involves distributing sterile needles-syringes and retrieving used ones. However, the availability of sterile needles-syringes does not automatically translate to uptake. Services need to be responsive to the needs and concerns of PWID for there to be optimal uptake. For example, the type of injecting equipment distributed should be suitable for PWID. Otherwise, they will be under-utilized while most PWID seek out suitable syringes, even if they are contaminated.

According to key informants (including PWID), the available syringes are single milligrams. These syringes have not been well-received in most settings by PWID, most of whom prefer larger sizes. Smaller-size syringes are said to contribute to drug wastage[26]. Apart from discouraging the utilization of syringes, it has also encouraged using a single syringe several times and sharing of syringes. Similarly, practices such as the sharing of drugs among friends and associates has also undermined the effectiveness of needle-syringe services. This practice involves pooling funds together to procure and prepare drugs, each contributor drawing from the cooker with her or his syringe to inject[27]. Concerned about maximizing the utility of scarce and expensive drugs, PWID takes to drug-using practices such as using the same cooker, which while addressing their concerns, increased the risk of infection with blood-borne diseases. This issue, which has fortunately been identified by service providers, highlights the importance of tailoring services to the contextual drivers of harms in drug-using populations, including, as in this case, the concerns that shape drug consumption practices.

The importance of tailoring interventions to contextual peculiarities is further illustrated by naloxone administration. Globally, there has been a shift towards making naloxone (and the relevant skills and competency) more widely available in settings where overdose is known to occur[28]. Described as 'take-home naloxone', this involves the administration of naloxone in community settings by non-clinical responders (e.g., peer workers, police officers) as an end-point intervention in which responders help because of their proximity to the person at the time of overdose. In Nigeria, however, policy makers have expressed concerns about the possession of controlled drugs by non-clinical responders, including concerns about safety and the risk of diversion[29]. This has led to a preference for the administration of naloxone through facilities, despite the implication for timely overdose intervention. Nevertheless, civil society groups and networks of PWUD have continued to advocate for community-based distribution of naloxone. Some programs have gone ahead to adopt this approach to improve access to naloxone for people who use opioids. In Lagos, for example, community-based distribution of naloxone through peers has reportedly led to increased utilization[30].

LIMITED SCOPE OF EXISTING SERVICES

Harm reduction services for PWID in Nigeria are based on the HIV prevention model for key populations (e.g., PWUD, commercial sex workers, men who have sex with men), a PEPFAR-funded programme implemented across the country. This approach involves the provision of health services (HIV testing and treatment, condom distribution) to the target population through both fixed site and community outreach models of service delivery[31]. Core harm reduction services for PWID (naloxone, NSP, and OST), funded through the Global Fund project, is an adjunct to the broader HIV prevention program. In other words, these services were incorporated into an existing intervention for key populations to fill the gaps in essential harm reduction services specifically for PWID.

The result is that current harm reduction services for PWID are framed within a healthcare service model of intervention – what a key informant described as a 'silo approach'. The focus is mostly on physical health harms. The programme does not adequately address the social and legal harms experienced by PWID (homelessness, stigma, police violence) as well as their mental and sexual/reproductive health needs. The paucity of women-specific services (e.g., provision of sanitary towels, intimate partner violence mitigation) in most existing programmes also contributes to the exclusion of women who inject drugs from existing services. Further, as many key informants explained, service delivery (e.g., needle-syringe distribution) is mostly oriented towards meeting service targets, with little

Table 2: WHO recommended package of care for people who inject drugs

Essential for impact: enabling interventions	Essential for impact: health interventions	Essential for broader health: health interventions
° Removing punitive laws, policies and practices ° Reducing stigma and discrimination ° Community empowerment ° Addressing violence	**Prevention of HIV, VH and STIs** ° Harm reduction (needle and syringe programmes, opioid agonist maintenance therapy and naloxone for overdose management) ° Condoms and lubricant ° PrEP for HIV ° PEP for HIV and STIs ° Prevention of vertical transmission of HIV, syphilis and HBV ° HBV vaccination ° Addressing chemsex **Diagnosis** ° HIV testing services ° STI testing ° HBV and HCV testing **Treatment** ° HIV treatment ° Screening, diagnosis, treatment and prevention of HIV-associated tuberculosis (TB) ° STI treatment ° HBV and HCV treatment	° Conception and pregnancy care ° Contraception ° Anal health ° Mental health ° Prevention, assessment and treatment of cervical cancer ° Safe abortion ° Screening and treatment for hazardous and harmful alcohol and other substance use ° Tuberculosis prevention, screening, diagnosis and treatment

effort made to integrate existing services through effective referral mechanisms. This is seen, for example, in the dexterity with which peer outreach workers are said to distribute sterile needles-syringes and to retrieve used ones. They, however, do not show the same diligence in connecting PWID to available social services within the community, such as those offered by philanthropists and faith-based organizations[32].

Although weak linkages to secondary and tertiary healthcare services have been put down to limited funding, little attempts have been made by programme implementers to scope-out and leverage health and social care provided through other civil society organizations that are not working under the Global Fund project[33]. Inadequate linkages to existing social services (e.g., housing, economic support) have implications for the utilization of health services such as NSP. For example, key informants explained that most PWID engages in economic activities such as loading commercial buses and panhandling to earn income to meet personal needs, including purchasing drugs. Economic activities intersect with housing instability and drug use criminalization to produce a highly mobile population that is often difficult to reach effectively with NSP. In this context, addressing the socioeconomic needs of PWID could potentially improve their uptake of Health services.

INADEQUATE FUNDING AND SUSTAINABILITY QUESTIONS

A major reason for the limited range of services currently being provided is inadequate funding. As pointed out in the previous section, the Global Fund project covers basic health-related harm reduction interventions (NSP, OST and naloxone services). Inadequate funding has impeded the provision of comprehensive services that respond to the social, economic, legal and health problems experienced by PWID. It has also hampered referral to secondary and tertiary level care through lack of funds to cover these services[34]. Also, the one-stop-shop approach, involving the provision of services from the same facility, has resulted in a dearth of specialized services (e.g., mental and reproductive health services). This approach has also contributed to increased stress among the workforce, resulting in a high turn-over rate of project staff. Outreach workers complained of being overworked and underpaid, and some have taken on other 'hustles' to supplement what a peer outreach worker described as 'meagre pay from the project'[35].

A key aspect of the funding challenge is the lack of counterpart financial investment by the Nigerian government. This problem, which may reflect low prioritization and commitment to a public health response to drug use, casts doubt on the sustainability of current services. The expiration of a large supply of methadone procured under the Drug Revolving Fund scheme operated by the FMOH, while the agency was seeking for donor support for the implementation of substitution treatment[36], is also concerning. Over-reliance on external funding for public health programs is by no means a new issue in Nigeria. The community-based intervention for PWUD, which offered outpatient, psychosocial services for problem drug users through selected community-based organizations, was funded by the European Union (EU) under the project 'Response to drugs and related organized crime in Nigeria', and implemented by the United Nations Office on Drugs and Crime (UNODC). This crucial service, which filled an important gap in current interventions for PWUD, only existed as long as the EU funding subsisted. The winding up of these services following the ending of the EU-funded project, mostly due to lack of domestic funding, is tragic to say the least. This is more so because investments in enforcement-based responses to drug use has increased concomitantly with the disappearance of these

crucial services. This speaks volumes about the direction of drug policy in Nigeria, showing political priorities to be a major impediment to the sustainability of a public health response to drug use in Nigeria. This trajectory raises questions about the future of harm reduction beyond the Global Fund project cycle.

In addition to political commitment, the efficiency of current services is hampered by daunting bureaucratic processes, especially within the FMOH. Key informants spoke about low prioritization of harm reduction services for PWID among top-level policy makers, which some saw as being rooted in a preference for criminalization of drug use. They also referred to cumbersome administrative processes that constrain the procurement of essentials (e.g., naloxone), as well as in-fighting between and within Ministries, Departments and Agencies (MDAs) of Government (e.g., FMOH) over roles and jurisdictions. For example, it took a lot of efforts to advocate for naloxone to be included in the essential medicines list approved by the FMOH. Another round of advocacy was needed to secure the ministry's approval for a community distribution model. Sadly, at the time approval was granted, a large portion of the available supply of naloxone had expired[37]. Wastage of essential supplies seems to be a recurring problem in the current program, apparently an indication of the inefficiency that stems from a morbid bureaucracy.

ISSUES OF PARTICIPATION AND INCLUSION OF PWID

The participation of drug-using populations was identified as a key contributor to the success of current harm reduction programmes. According to some of the policy makers I interviewed, the project was designed to thrive on the participation and stakeholdership of PWID. It strategically mobilized PWID-led organizations, which emerged as part of the self-organizing impetus provided by the EU/UNODC project in Nigeria[38]. These organizations have gained significant visibility and relevance under the Global Fund-supported harm reduction programme for PWID, including having representation in the national technical working committee and participating in programme design and budget development as well as in decision-making at all levels (national, state and community levels). This view was corroborated by PWID who serve as peer outreach workers under the programme. They explained how these roles have made them feel useful, contributing to the mitigation of the felt stigma associated with the drug user identity.

However, participation in project design and implementation, although laudable, has not translated into substantive inclusion and equity for PWID. Policy making is characterized by discursive practices that contribute to the 'othering' of PWID, reinforcing social differences between them and other actors in the policy space (e.g., government officials and medical professionals). For example, referring to medical professionals as 'experts' [39], without also recognizing the expertise of PWID, results in marginalization of the expertise of people with lived experiences which serves to position PWID on the fringes of policy making. This results in a missed opportunity to advance the de-stigmatization of PWUD at a structural level.

Further, concerns were expressed within drug-using communities about a selective participation approach that perpetuates inequality by recognizing those with social and political capital, while excluding the vast majority of PWID. Key informants described how individual PWID, often those with requisite education and social connections, are able to participate at various levels in the design and implementation of projects, while the wider drug-using community engages only as beneficiary. They explained how this can result in lack of cooperation that could hamper service implementation. Drug consumption spaces (known colloquially as 'bunks') play a crucial

role in harm reduction service provision, and their integration into project design through institutionalizing a system of recognition for key community gatekeepers (e.g., bunk owners) was identified as important in enhancing inclusion and leveraging community support for service implementation.

LAW ENFORCEMENT CHALLENGES

Law enforcement remains a major challenge to effective implementation of harm reduction services for PWID, even though law enforcement agencies are represented in the technical committees at all levels and collaborate with implementing organizations at the community level. Law enforcement agents have participated in trainings designed to inculcate skills as a step towards involving them in programme implementation. They have also been targeted for services that address rising levels of substance use in the workforce as well as to create awareness and build support for services. Despite these measures, police crackdowns on drug consumption spaces are known to be common occurrences[40]. Raids serve as a pretext for extortion of PWUD and peer outreach workers by rank-and-file officers.

Policing strategies such as raids on drug consumption spaces, frisking, confiscation of drugs and injecting equipment, as well as arrest of PWUD are known to contribute to low uptake of services, deter possession of sterile injecting equipment and encourage high-risk behaviours such as rushing injection and sharing of needles-syringes[41,42]. As key informants explained, policing practices on the ground constantly undermine service uptake regardless of formal partnerships between implementing organizations and law enforcement agencies. Such practices have their roots in a culture of violent extortion and predation on vulnerable groups that thrive within the Nigerian police[43]. Policing practices directed towards PWUD are upheld and sustained by legal frameworks and societal attitudes that criminalize and stigmatize drug use.

CONCLUSION

This Policy Brief present findings from a preliminary assessment of harm reduction services for PWID in Nigeria. Corroborating previous assessments conducted in other parts of the world, it shows that while a range of services are available to address the needs of PWID, implementation and sustainability are blighted by challenges including limited scope of existing services, inadequate funding, bureaucratic hurdles, lack of substantive inclusion of PWID as well as legal framework and enforcement practices that undermine the uptake of services. While these challenges are broadly similar to those reported in previous works, they nonetheless highlight the peculiar structural factors that undermine the effectiveness and sustainability of public health programmes, especially those addressing the needs of structurally vulnerable populations. This has to do with low political commitment to a public health response to drug use as reflected in poor prioritization, administrative inefficiencies, lack of domestic funding and a failure to create an enabling legal environment for existing programmes. The Nigerian government is to be commended for supporting public health interventions to reduce harms to PWID. Nevertheless, harm reduction for a population facing social and material disadvantages calls for more than mere political support. It also requires a sustained commitment to addressing marginalization and fostering inclusion. While the former has been demonstrated, the latter remains to be seen.

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