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AVAILABILITY OF AND BARRIERS TO THE UTILIZATION OF HARM REDUCTION SERVICES IN ENUGU, SOUTH-EASTERN NIGERIA: SERVICE PROVIDERS' PERSPECTIVE

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ABSTRACT

The study aimed to determine the availability and barriers to the utilization of three Harm Reduction Strategies (HRS) in Nigeria from service providers' perspective. This study was a descriptive survey using questions adapted from the harm reduction questionnaire. Eight institutions involved in the drug treatment services in Enugu, South-Eastern Nigeria participated. Only 25% of the agencies did not practice HRS in any form. The commonest internal and external barriers were lack of funding and community resistance, respectively. The heads of the agencies rated themselves and the community unfavorable to accepting HRS generally. However, with regards to specific HRS, they were more favorable to methadone replacement therapy, controlled drinking and condom sharing. The findings of this study enriched our understanding of the various impediments to the utilization of HRS in Enugu, Nigeria.

Keywords: Availability; barriers; utilization; harm reduction; services; service providers, Nigeria

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INTRODUCTION

There is burgeoning data on the usefulness of Harm Reduction Services (HRS) in the reduction of drug use, disease, crime, unsafe injection behaviors, related deaths and improvement in employment and interpersonal relationships among drug users (Margolin, Avants, Warburton, Hawkins & Shi, 2003; Hawks & Lenton, 1995; Hope et al., 2001). Harm reduction programs and services has been defined "as policies, programs and practices designed to reduce negative physical, social, and economic consequences resulting from substance use without requiring abstinence as a primary treatment goal" (Carlberg-Racich, 2016). The burden of substance use disorders globally, is huge and could be considered together with suicide and depression as an emerging epidemic with myriad consequences in the various domains of the society (Unaogu, Onu, Iteke, Tukur & Oka, 2017; Bates, 2018). Despite its implications for the individuals and their families and the country at large, there is a large unmet need for treatment, as majority of those who have the problem do not access the available services (World Health Organization, 2008). This situation is even made worse by the moral views held by many Africans with respect to drug-related problems.

HRS is generally lacking in most countries in the sub-Saharan Africa (Ogunrombi, 2018). A number of factors such as community resistance, lack of clarity of governmental policies, poor political support and perceived immorality of HRS have been reported in the literature as being responsible for the poor utilization of HRS worldwide (Ghiasi, Farahbakhsh & Hekmatpour, 2013; Bobrova et al., 2008; Ravaghi et al., 2017; Reid & Aiken; Magee & Huriaux, 2008; Kimber, Dolan, Van, Hedrich & Zurhold, 2003).

However, a recent global report from the Harm Reduction International indicates that the sub-region has made some progress in the HRS with about 10 countries in the region having explicit policy documents supporting harm reduction in 2018 (Ogunrombi, 2018). At the continental level, the African Union plan of action on drug control was endorsed at its ministerial conference in 2012 (African Union, 2013). This document sought to implement the United Nations' comprehensive package of nine interventions on harm reduction (African Union, 2013). Nigeria, the most populous nation in the sub-region continues to be resistant to HRS until recently, despite the huge burden of substance use disorder among its population (Ogunrombi, 2018). Over the years, the focus of drug policy in Nigeria centered on drug supply reduction leading to incarceration of offenders without any form of treatment. However, in 2018, the Federal Ministry of Health began a consultation on the development of guidelines on the use of methadone for drug rehabilitation treatment (United Nations Office on Drugs and Crime, 2018). Similarly, the National Drug Control Master Plan (NDCMP) entrenched a paradigm shift from over concentration on the supply reduction centered activities to demand reduction activities (National Drug and Law Enforcement Agency, 2014). This is due to the increasing global outcry that substance use problems should be viewed in the light of public health.

Despite the numerous benefits of HRS and some shift in policies towards the public health approach to drug use, there is paucity of data on the availability and

barriers to the implementation of HRS in Nigeria from the stakeholders. Hence, this study was done to examine the following objectives:

1. To determine the availability of HRS in Enugu, South-Eastern Nigeria.
2. To determine the acceptability of HRS by the service providers.
3. To determine the barriers to the implementation of HRS from the perspectives of the service providers.

METHOD

The study was carried out among eight heads of agencies involved in the treatment and rehabilitation of drug abusers in Enugu. There were a total of 11 institutions identified with some services for drug treatment and rehabilitation. Of the 11, two were Teaching Hospitals of Tertiary Institutions. One is a standalone Psychiatric Hospital, whereas the remaining eight were owned by either the Government or Non-governmental organizations. A total population sampling technique was used to recruit all consenting heads of agencies involved in the treatment and rehabilitation of drug abusers. Two heads of agencies declined consent to participate and the remaining one was not available during the period of the study. Enugu State is the capital of the defunct Eastern region of Nigeria. It is a mainland state with an area of 7,161 square kilometers, located in the South East Nigeria, with a population of over 3 million. All the interviews were conducted from June 2018 to June, 2019. The ethical approval for the study was obtained from the Ethics and Research Committee of the major psychiatric facility in Enugu.

This was a descriptive survey using the harm reduction questionnaire (Hobden & Cunninghan, 2006). The harm reduction questionnaire was designed by Hobden & Cunninghan (2006) from a qualitative study of service providers. It is a 55-item questionnaire which assesses the availability, acceptability and barriers to four harm reduction services namely: needle exchange program, free condom sharing, methadone replacement, and moderate drinking. In addition, the survey also assesses general understanding of harm reduction. The questionnaire was pretested for suitability among specialist in substance use disorder treatment unit of the Federal Neuropsychiatric Hospital, Enugu. After considering all the questions and options of the original survey; some modifications were made. The team of specialist expunged the section on methadone replacement as the policy on its implementation is yet to be issued by the Federal Government and as such it is not practiced yet anywhere in the country. However, the section on rating of the respondent's disposition for future use was left to assess for possible acceptability. Also expunged was the option "negative reaction from the Alcohol Anonymous (AA) community". This is because there were no such organizations in the study setting.

Each respondent assessed the availability of three harm reduction services in their centers, reasons for its availability, internal and external barriers to its implementation. The respondents were asked to rate themselves, their colleagues and the community on an 11-point scale (0-very unfavorable, 10-very favorable) how they felt about non-abstinence as a treatment goal in some drug users. In addition, they were asked to proffer solutions

on how HRS can be made more available and acceptable. For each question asked despite having options, the participants were allowed to provide other answers not available in the outlined options in the section of others. All the agencies were contacted and eight of them indicated interest to participate (two hospitals, three other non-hospital based governmental agencies and two non-governmental organization). The questionnaire was given to them in their various offices to fill, and all returned their completed questionnaire. Data were entered into the Statistical Package of Social Sciences (IBM-SPSS) version 20. Categorical questions were described using frequency tables while the 11-point rating was summarized using the mean and median.

RESULTS

All the agencies that responded had heard of HRS. Controlled drinking and free condom sharing were known by all the respondents while opioid substitution therapy was the least known as shown in Table 1. The proportion of the agencies that practiced needle and syringe exchange, moderate drinking and condom sharing were 25%, 50%, and 25%, respectively (Tables 1 and 2).

Respondents rated themselves unfavorable to non-abstinence-based treatment goal with a mean score of 2.7. Similarly, respondents rated the community unfavorable to accepting non-abstinence-based treatment goal. With regards to specific HRS, most respondents rated themselves and the community unfavorable to accepting needle and syringe exchange programs. However, respondents rated themselves and the community more favorable to methadone replacement, controlled drinking and free condom sharing as shown in Table 3. The definition of harm reduction by respondents varied with half of them agreeing that reducing the harm from substance use by the individual without necessarily reducing the use of the substance is the best definition. A majority (62.5%) of the respondents agree that reducing the negative consequences associated with drug/alcohol use was the most important component whereas providing the gateway/bridge into treatment was the most appealing as shown in Table 4.

All the participants agree that clear government policies/legal framework is needed for effective implementation of HRS. Similarly, 75% of the respondents advocated improved community and staff educational awareness on the usefulness of HRS and improved funding. (Table 4).

DISCUSSION

The main aim of this study was to describe the HRS available in Enugu, South-Eastern, Nigeria, and highlight the barriers to the utilization of HRS from the perspective of the service providers.

The finding that all heads of agencies were aware of the HRS is consistent with a previous observation in Ontario, Canada (Hobden & Cunninghan, 2006), who reported that service providers in Ontario Canada are fully aware of HRS. The increase in awareness among service providers in the South-Eastern Nigeria may be related to the robust campaign by many non-governmental organization and other stakeholders to decriminalize drug abuse and the increasing perception of drug use problems as a public health

Table 1. Availability of HRS, needle exchange program and barriers to its implementation

Variables	Frequency (%)
Ever heard of harm reduction strategies	
Yes	8(100.0)
No	0(0.0)
Which harm reduction strategy do you know?	
Needle exchange	6(75.0)
Methadone replacement	5(62.5)
Controlled drinking	8(100.0)
Free condom	8(100.0)
Does your institution practice it in any form?	
Yes	7(87.5)
No	1(12.5)
Would you like to practice it?	
Yes	8(100.0)
No	0(25.0)
Does your institution practice needle exchange program? (n=8)	
Yes	2(25.0)
No	6(75.0)
Have your agency considered needle exchange program? (n=6)	
Yes	1(16.7)
No	5(83.3)
Reasons for not considering needle exchange (n=5)	
Little or no perceived need or demand	2(40.0)
Services available locally	1(20.0)
Staff resistance	1(20.0)
Anticipated community opposition	2(40.0)
Negative client opposition	0(0.0)
Lack of funding	2(40.0)
No legal framework/clear government policies	3(60.0)
Internal barriers to setting up needle exchange services (n=8)	
No perceived need	2(25.0)
Lack of medical staff	1(12.5)
Lack of funding	4(50.0)
Services already provided locally	1(12.5)
Staff resistance	0(0.0)
Contravenes agency policy	0(0.0)
Outside agency mandate	0(0.0)
No clear legal framework	2(25.0)
External barriers to setting up needle exchange services (n=8)	
Community resistance/culturally inappropriate	1(12.5)
Lack of political support	2(25.0)
Funding	3(37.5)
Seen as promoting drug use	6(75.0)

issue. Before now, drug use control activities in Nigeria was hinged on supply reduction. However, with the recent shift to improve demand reduction, international partners (e.g., United Nations Office on Drug and Crime) have increased their sensitization of the service providers through seminars and workshops with regards to the various treatment options including HRS. These activities with concurrent improvement in the awareness of mental health issues in Nigeria may

Table 2. Availability of moderate drinking and condom sharing programs and barriers to its implementation

Variables	Frequency (%)
Does your institution allow for moderate drinking goal? (n=8)	
Yes	4(50.0)
No	4(50.0)
Have your agency considered moderate drinking as a therapeutic goal? (n=4)	
Yes	4(100.0)
No	0(0.0)
Internal barriers to moderate drinking as a treatment goal (n=8)	
Not appropriate for their clientele	4(50.0)
Staff resistance	1(12.5)
Contravenes agency policy/philosophy	2(25.0)
External barriers to setting up needle exchange services (n=8)	
Community resistance/culturally inappropriate	1(12.5)
No clear government policies	7(87.5)
Does your institution offer free condom to clients? (n=8)	
Yes	2(25.0)
No	6(75.0)
Have your agency considered offering free condom? (n=6)	
Yes	0(0.0)
No	8(100.0)
Internal barriers to offering free condom services (n=8)	
Resistance from staff	4(50.0)
Resistance from board	4(50.0)
Fear of negative community reaction	8(100.0)
Lack of funding	8(100.0)
External barriers to offering free condom services (n=8)	
Community resistance/culturally inappropriate	8(100.0)
Services locally available	4(50.0)
Benefits of offering free condom services (n=8)	
Reduction of HIV/STDs	6(75.0)
Reduction of unwanted pregnancy	4(50.0)
Opportunity to provide information	3(37.5)

explain the magnitude of knowledge of HRS as demonstrated in this study.

Of the HRS programs (i.e., moderate drinking, needle exchange program and condom sharing) available in the South-Eastern Nigeria, moderate drinking as a treatment option is the most widely practiced. This is consistent with a previous report which found high availability of moderate drinking and condom sharing and less of needle exchange and methadone replacement programs (Hobden & Cunninghan, 2006). This finding is understandable in the line of the following considerations: First, drinking in the traditional South-Eastern society is culturally appropriate whereas other substances of abuse are abhorred. The participants of this study are members of this culture and acceptance of moderate drinking as a treatment option and its implementation may just be a reflection of their cultural bias. Second, the implementation of moderate drinking does not necessarily require additional funding. Since, funding is a major internal barrier to other HRS, it

Table 3. Rating of the various harm reduction programs by the heads of the agencies

N=8

Variables	Mean (median) score
How do you feel about non-abstinence as a treatment goal for some drug users?	2.7(0.0)
How do other therapist in your institution feel about non-abstinence as a therapeutic goal for drug users?	2.5(1.0)
How do you think non-abstinence for drug users would be viewed by your community?	1.7(0.0)
How do you feel about providing clean needles to drug users?	3.8(2.5)
How do you think other colleagues in your facility feel about providing clean needles to drug users?	3.8(2.5)
How do you think needle exchange for drug users would be viewed by your community?	2.5(2.0)
How do you feel about offering methadone replacement as a treatment option to drug users?	8.0(10.0)
How do other therapist in your institution feel about methadone replacement?	6.7(9.0)
How do you think methadone replacement for drug users would be viewed by your community?	5.5(6.5)
How do you feel about providing free condom to drug users?	7.7(9.0)
How do you think your colleagues in your facility feel about providing free condoms to drug users?	7.3(9.0)
How do you think providing free condoms to drug users would be viewed by your community?	5.2(6.5)

Rating is a scale of: 0=not at all favorable to 10=extremely favorable

is possible that the non-capital intensive nature of moderate drinking would have made it more practical for implementation across agencies.

The commonly identified internal barriers to the implementation of HRS in South-Eastern Nigeria were those related to the fear of promoting drug use, funding, staff resistance, poorly trained/ inadequate staff and no perceived need. Whereas, the commonly reported external barriers were community resistance, lack of clarity of government policies and poor political support. These findings are consistent with previous reports (Ghiasi et al., 2013; Bobrova et al., 2008; Ravaghi et al., 2017; Reid & Aitken, 2009; Magee & Huriaux, 2008). For example, Ravaghi et al., (2017) reported that in Iran, the main barriers to the implementation of HRS were the misunderstanding and misperception that HRS is encouraging or condoning substance abuse, lack of policy clarity and transparency in political position regarding HRS and community resistance. The similarities between the findings of the present study and that of Ravaghi and colleagues may be explained by the conservative and largely religious nature of these two societies.

The heads agencies rated themselves and the community unfavorable to accepting HRS generally. However, with regards to specific HRS, they were more favorably disposed to accepting methadone replacement therapy, controlled drinking and condom sharing. The finding of general non-acceptance of HRS as reported by the participants may be explained by negative opinions expressed by some persons towards the program. Kimber et al., (2003) reported that the predominant negative opinions in their survey was perceived immoral-

Table 4. Service providers' knowledge of harm reduction strategies

Variables	N=8 Frequency (%)
Definition of harm reduction	
Reducing harm from substance use incurred by the individual by reducing or eliminating the use of that substance	1(12.5)
Reducing the harm from substance use incurred by the individual and reducing their use of that substance	1(12.5)
Reducing the harm from substance use incurred by the individual without necessarily reducing their use of that substance	4(50.0)
Reducing the harm associated with substance use to the community or society as a whole	1(12.5)
Don't know	0(0.0)
Most important elements of harm reduction	
Disease reduction	3(37.5)
Empowering clients	3(37.5)
Improving the quality of life of clients	4(50.0)
Reducing negative consequences associated with drug/alcohol use	5(62.5)
Flexibility	1(12.5)
Education/awareness on the part of client	2(25.0)
Education/awareness on the part of the community	1(12.5)
Client choice	2(25.0)
Empathy	2(25.0)
Accurate assessment	1(12.5)
Don't know	0(0.0)
Most appealing aspects of harm reduction	
Disease reduction	2(25.0)
Reduced health costs	0(0.0)
May provide a gateway/bridge into treatment	4(50.0)
It's more palatable to clients than abstinence	2(25.0)
Clients choice	1(12.5)
It's non-judgmental	2(25.0)
It's client centered	1(12.5)
It's appropriate for some clients	2(25.0)
It's pragmatic/practical	2(25.0)
It provides flexibility/options	1(12.5)
It empowers clients	1(12.5)
Don't know	1(12.5
Proffering Solutions	
Government should be clear in their policies and legal framework	8(100.0)
Community education	6(75.0%)
Improved Funding	6(75.0%)

ity of providing HRS. Common arguments among their participants were that HRS promotes drug use, attract many people to use drugs and destroy the community. These opinions were similarly expressed by our participants. The people of South-Eastern Nigeria just like most Africans have strong traditional values. Substance use problems are commonly perceived as originating from moral weakness of the individual involved. Therefore, many people judge them harshly such that many family members in clinical practice are non-receptive to any other treatment options other than abstinence. This perception by family members may have informed the above ratings. Contrary to the ratings in general non-acceptance of

non-abstinence-based treatment options and needle exchange program, the participants were more favorable to moderate drinking and free condom sharing. This is probably due to the initially stated acceptance of alcohol in the traditional Igbo society and the part that the society has been properly educated about condom use with regards to the prevention of Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome (HIV/AIDS).

Limitations: The relatively small sample number of agencies that responded (8 out of 11) in our study may have limited the diversity of opinions.

Conclusion: The findings of this study show low availability and acceptability of HRS as a treatment option in Nigeria among service providers. Community resistance to the HRS calls for a comprehensive action by policy makers and clinicians towards demystifying the myths held by the community against HRS. This has become necessary to enhance the availability and utilization of HRS to improve access to services to drug abusers.

STATEMENT OF AUTHORSHIP

The authors contributed to the study design, analysis and interpretation of data. Drafting of the manuscript was by the first author. All authors read and approved the manuscript.

CONFLICT OF INTEREST

The authors declare no conflict of interest

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