Opportunities to address the growing “syndemics” of HIV, sexually transmitted infection, stigma, violence and substance abuse among people who inject drugs in Nigeria.

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<td>Civil-Society Led Organizations</td>
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<td>FMoH</td>
<td>Federal Ministry Of Health</td>
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<td>HAV</td>
<td>Hepatitis A Virus</td>
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<td>HTS</td>
<td>HIV Testing Services</td>
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<td>IBBSS</td>
<td>Integrated Biological And Behavioral Surveillance Survey</td>
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<td>IMHIPP</td>
<td>The Integrated Most-At-Risk Population Hiv/Aids Prevention Program</td>
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<td>INL</td>
<td>Bureau Of International Narcotics And Law Enforcement</td>
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<td>KP</td>
<td>Key Populations</td>
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<td>LP's</td>
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<td>MHPSS</td>
<td>Mental Health And Psychosocial Support</td>
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<td>NACA</td>
<td>National Agency For The Control Of AIDS</td>
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<td>NDLEA</td>
<td>National Drug Law Enforcement Agency</td>
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<td>NENDU</td>
<td>National Epidemiological Network On Drug Use</td>
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<td>NSP</td>
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<td>OSF</td>
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<td>OSS</td>
<td>One-Stop Shops</td>
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<td>People Who Inject Drugs</td>
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<td>Trauma-Informed Mental Health And Psychosocial Support</td>
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<td>ToT</td>
<td>Training Of Trainers</td>
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<td>UNODC</td>
<td>United Nations Office On Drugs And Crime</td>
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ABSTRACT

Background

Studies among persons who inject drugs (PWID) worldwide have indicated high rates of HIV, hepatitis, tuberculosis (TB), experiences of violence and abuse in childhood and adulthood before and after initiating substance misuse via injection and severe mental health and psychosocial distress. The quantitative associations between these factors and sexual risk and non-adherence to HIV treatment have been labelled “syndemics”.

International guidelines based on over thirty years of research recommend a “harm-reduction” approach integrating needle and syringe programs (NSP), opioid substitution therapy and overdose prevention with naloxone as the key tools to prevent transmission of infectious disease among PWID, but these remain unavailable in Nigeria.

Methods

In November 2017, Heartland Alliance International (HAI), which provides services to over 12,000 PWID in 7 states, conducted a review of the literature and program data, visits to each state program, meetings with Nigerian authorities and focus groups with PWID in order to analyze needs and gaps.

Results

Nigeria has among the highest rates of drug trafficking and drug use in West Africa as well as HIV, hepatitis and TB, suggesting significant increased risk for PWID and an important contribution of injection drug use to epidemics of infectious diseases.

HAI program data from 2016 to 2017 suggest an increasing HIV epidemic among PWID: HIV positivity was three times higher among PWID: 11%: (women: 20%; men: 8%) than in the most recent IBBSS (2014) study: 3.4% (women: 13.6%; men: 2.9%). PWID and service providers reported almost universal sharing of injection equipment, opioid overdoses as well as emotional, physical and sexual violence. New national policy now endorses comprehensive harm-reduction programming, but the services remain unavailable.

Conclusions

Available indicators point to alarming high-risk injecting behaviors and incidence of multiple, related diagnoses (syndemics) calling for a more effective public health response. NSP, opioid substitution therapy (OST) and overdose prevention with Naloxone must be initiated and scaled up. Trauma-informed mental health and psychosocial approaches are needed to address high levels of violence, discrimination and comorbid conditions. Further research and surveillance are critical to better inform health policy, strategy and service delivery for PWID in Nigeria.
EXECUTIVE SUMMARY

Introduction/Background

The concept of “syndemics” in public health refers to the coexistence of two or more diseases and “synergistic interaction of diseases and social conditions at the biological and population levels.” (Singer, 2003, p.423). Studies among persons who inject drugs (PWID) worldwide have indicated syndemics of high rates of HIV (Mathers, 2008) experiences of violence and abuse in childhood, adolescence and adulthood both before and after initiating drug use and drug injection (Covington, 2008) Dube, 2012; Wechsberg, 2006, 2010). In addition, many PWID experience severe mental health and psychosocial (MHPS) disease and distress (Brooner, 1997; Lipstz, 1994; Najavits, 2013). Recent studies have quantitatively measured the associations between these factors and labelled the PWID epidemics as “syndemics”. For example, Mizuno (2014) found that the presence of each factor significantly increased the odds of reporting others: drug abuse, injection, sexual risk factors, trauma, mental health and psychosocial (MHPS) problems, and HIV treatment nonadherence and failure.

Heartland Alliance International (HAI) implements the Integrated Most-At-Risk Population HIV/AIDS Prevention Program (IMHIPP) with USAID-PEPFAR funding in seven (7) states in Nigeria to mitigate the impact of HIV/AIDS among key populations (KP) and their partners. IMHIPP is a nine-year project implemented between 2009 and 2018 which treats the HIV epidemic among PWID as a syndemic of HIV, STIs, violence and trauma, MHPS problems and substance abuse. Thus, it provides targeted and high-quality HIV prevention, STI diagnosis and management, HIV testing services, referrals for HIV treatment and other related activities through One Stop Shop centers (OSS), working with KP-led civil society organizations (CSOs). These activities include trauma-informed mental health and psychosocial support (TI-MHPSS) (SAMHSA, 2014). Much of this programming is implemented by KP-led civil society groups that are strengthened by HAI.

Methodology

In October and November, 2017, two (2) two-week long multi-faceted exercises took place. The first was an assessment by HAI-Headquarters and HAI-Nigeria of the continuum of care for all KP groups in all 7 of HAI states and consisted of (i) analysis of the prevention-testing-treatment cascade data for all states, (ii) Site visits to OSS and (iii) focus groups with different KP groups including three (3) with PWID.

The second was a PWID-focused assessment by an international PWID expert and HAI-Nigeria staff consisting of (i) a needs assessment and gap analysis of the current policy landscape examining the wider systemic and structural barriers in reducing drug-related harm; (ii) training to HAI and CSO staff on evidence-based harm-reduction interventions and effective response to enable behavior change at the individual level; (iii) policy level advocacy for evidence-based approaches for PWID and (iv) site visits to OSS and (v) focus groups with PWID at various sites. As a result, the exercise strived to generate critical information relating to the prevalence and patterns around injecting drug use, increase capacity among HAI and CSO frontline staff in delivering evidence-based harm-reduction interventions and support a more enabling environment for harm-reduction at both the policy and implementation levels identifying any socio-cultural, economic, political and legal barriers which may undermine future scale-up efforts.
Results

These results were compiled and analyzed through the literature review, needs mapping, focus group discussions with PWID and meetings with staff and community and government stakeholders. The results are well aligned and salient:

High HIV burden among PWID in Nigeria  
HAI program cascade data from 2016 to 2017 reveals that HIV-positive yield is three times higher among PWID accessing their services: 11%: (women: 20%; men: 8%) than in the most recent IBBSS study: 3.4% (women: 13.6%; men: 2.9%) (Government of Nigeria, 2014). Testing program HIV prevalence is usually lower not higher than that found in population studies, because individuals who already know they are HIV-positive are much less likely to seek out HIV testing. This could suggest that the epidemic has expanded significantly since 2014.

New policy windows for harm-reduction in Nigeria  
In October and November of 2017, new policy windows at the federal level had opened that suggested greater openness to comprehensive harm-reduction services for PWID in Nigeria than previously. The Government of Nigeria is committed in policy documents to supporting a scale-up of harm-reduction services. New national guidelines on HIV/AIDS prevention, treatment and care, hepatitis and drug control equally acknowledge and recommend the need for evidence-based harm-reduction interventions in line with the comprehensive package (Government of Nigeria 2016a; 2016b; 2016c). However, evidence-based harm-reduction services such as NSP, OST and overdose management with Naloxone currently remained unavailable. However, Methadone for future OST programming was procured in early 2017, although there is still no policy nor guidelines in place for OST nor for any other harm-reduction interventions.

High presence of syndemic risk factors among PWID in Nigeria

1. Most PWID do not have access to sterile injecting equipment thus share used needles and syringes repeatedly and are unaware of how best to clean dirty equipment when they cannot obtain clean needles and syringes.
2. ‘Blood sharing’ is practiced by male and female PWID in all seven states. This high risk injecting practice describes an individual injecting themselves with a syringe full of blood from a peer who has just used drugs intravenously themselves in order to obtain an indirect hit, to reduce opioid withdrawal and / or as a gesture of altruism, reciprocity and obligation.
3. Drugs, commonly opioid-based painkillers, are often sold by dealers in pre-prepared needle and syringes. This unit will then be shared between peers and safe frontloading /backloading practices are uncommon. Generally, PWID are unaware if dealers have prepared drugs using sterile equipment.
4. Many pharmacies refuse to sell sterile needles and syringes to known drug users which means PWID have to travel further afield to procure equipment for safe injecting or resort to sharing.
5. PWID are at risk of arrest or extortion by law enforcement agencies if injecting equipment and other drug paraphernalia is found in their possession thus they are unlikely to travel far from their ‘bunks’ or ‘jungle’ to procure clean equipment.
6. Opioid overdose happens regularly, especially among tramadol users. Members of the PWID community and peers seldom contact health agencies in fear of reprisals from law enforcement agencies.
7. Unlawful and abusive treatment of PWID occurs regularly with incidents of extortion, violence, sexual assault and unlawful arrest by law enforcement actors which drives PWID further underground hindering access to health services

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1 Also referred to by peers as flashblood and love sharing
Recommendations – in brief

**Policy and legal:** HAI and CSOs have an integral role to play in advocating for a legal framework for harm-reduction interventions which replaces existing repressive drug policy. OSSs have started providing advice and information to PWID on safer injecting practices and injection-related health. However, a comprehensive HIV prevention, treatment and care response places NSP, OST and Naloxone at the core of service provision for PWID. In light of the shifting political landscape in support of harm-reduction, civil society has a unique opportunity to build political will through targeted advocacy with government structures and the media.

**Implementing the scale-up of harm-reduction through pilots:** HAI and CSOs have showcased positive results in HIV prevention, treatment, care and other health services to hard-to-reach KPs over a nine-year period through their OSS, outreach and green-housing mechanisms. As a result, HAI is optimally placed to pilot NSP, OST and other interventions for PWID. Government institutions may require further evidence to endorse CSO-led harm-reduction programming. A suggested step forward is for HAI to develop proposals for 12-month pilots of OST, NSP and overdose management with Naloxone which include a robust plan for monitoring, evaluation and research as well as clinical management and quality assurance.

**Resource mobilization:** As well as building on existing partnerships with IMHIPP donors and partners, potential new funding options include UNODC, WHO, OSIWA, OSF, NIDA, Colombo Plan, INL and Médecins du Monde.

**Capacity building in evidence-based harm-reduction:** In late 2017, HAI rolled out the first ever Training of Trainers (ToT) on evidence-based harm-reduction approaches and interventions. Designated harm-reduction leads within HAI and CSOs should be supported to ensure they have all the resources necessary to ensure all other staff and community members receive the training via cascade methods by the end of quarter 2 in 2018. Harm-reduction leads should be supported to access all training around substance misuse and harm-reduction in line with the resources available.

**Monitoring, evaluation and research:** Routine and robust data collection around high-risk drug-related patterns, trends and in other health areas will generate critical information on the specific needs of PWID in order for programs to be designed and developed appropriately. Demonstrable outcomes and empirically validated results can only strengthen the case further for the sustainability of harm-reduction programming as well as wider coverage nationally.
FULL REPORT

Report on harm-reduction in Nigeria: needs, gaps and response to ensure access to effective HIV prevention, treatment and care for people who inject drugs

The current state of harm-reduction in Nigeria: a needs assessment

1.0 Background

The concept of “syndemics” in public health refers to the coexistence of two or more diseases and “synergistic interaction of diseases and social conditions at the biological and population levels.” (Singer, 2003, p.423). Studies among persons who inject drugs (PWID) worldwide have indicated syndemics of high rates of HIV infection (Mathers, 2008), violence and abuse in childhood, adolescence and adulthood both before and after initiating drug use and drug injection (Covington, 2008; Dube, 2012; Wechsberg, 2006, 2010), and severe mental health and psychosocial (MHPS) disease and distress (Brooner, 1997; Lipstz, 1994; Najavits, 2013). Recent studies have quantitatively measured the associations between these factors and labelled PWID epidemics as “syndemics”. For example, Mizuno (2014) found that each of these factors significantly increased the odds of reporting others: drug abuse, injection, sexual risk factors, trauma, MHPS problems, and HIV treatment nonadherence and failure.

Given the health risks associated with unsafe injecting practices coupled with the stigma associated with drug use, PWID are among the most marginalized KP subgroups. They experience widespread discrimination, stigma, vulnerability to premature death and poor health outcomes, as emphasized recently by global expert epidemiologists in the fields of harm-reduction, HIV/AIDS and substance misuse public health following a multistage systematic review into PWID prevalence and patterns in PWID related public health:

“There is an imperative to invest in blood-borne virus prevention activities, such as needle and syringe programs and opioid substitution therapy, and to provide treatment and care for those who are living with HIV and HCV. […] Simultaneously other drivers of vulnerability, risk, and harm among this key population need to be addressed. Our review of existing characteristics of PWID suggests that there is considerable cause for concern across multiple indicators about the level of exposure to high-risk environments that PWID face and the level of engagement in risk behaviors that occurs among PWID in some countries.” (Depenhardt, 2017) p. 1204.

A concentrated injection-driven HIV epidemic requires a prompt and targeted response at both the policy and implementation levels, including the timely scale-up of human rights-informed harm-reduction interventions. Furthermore, there is an abundance of evidence which supports how harm-reduction programming can significantly increase adherence to antiretroviral therapy (Low et al. 2016; Bouhnik et al. 2002; Nosyk et al. 2016).

Heartland Alliance International (HAI) implements the Integrated Most-At-Risk Population HIV/AIDS Prevention Program (IMHIPP) with USAID-PEPFAR funding in seven states in Nigeria to mitigate the impact of HIV/AIDS among key populations (KPs) and their partners. IMHIPP treats the HIV epidemic among PWID as a syndemic of HIV, STIs, violence and trauma, mental health and psychosocial problems and substance abuse. Thus it provides targeted and high-quality HIV prevention, STI diagnosis and
management, HIV testing services, referrals for HIV treatment and other related activities through One Stop Shop centers (OSS), working with KP-led civil society organizations (CSOs). These activities include trauma-informed mental health and psychosocial support (TI-MHPSS) (SAMHSA, 2014).

2.0 Objectives and methods

This needs assessment forms part of a wider strategy for Heartland Alliance International (HAI) to inform the future implementation of HIV prevention, treatment and care services in Nigeria specifically for the key affected population (KP): people who inject drugs (PWID).

It provides an up-to-date picture of drug-related harm suggesting how it can be addressed through existing programming under the Integrated Most-At-Risk Populations HIV/AIDS Prevention Program (IMHIPP). It allows HAI to demonstrate the effectiveness of the current existing treatment system as well as highlight any gaps in current service provision and additionally at the policy level.

IMHIPP is a nine-year project implemented between 2009 and 2018 to mitigate the impact of HIV/AIDS on KPs and their partners. The project provides targeted, high-quality HIV prevention, STI diagnosis and management, HIV testing services, referrals for HIV treatment and other related activities through One Stop Shop centers (OSS). Much of this programming is provided by KP-led civil society groups that are strengthened by HAI.

1.2 Methods

In October and November, 2017, two two-week long multi-faceted exercises took place.

The first was an assessment by HAI-Chicago and HAI-Nigeria of the continuum of care for all KP groups in all 7 of HAI states and consisted of

- Analysis of cascade data for all states,
- Site visits/observations to OSS and LPs in all states
- Focus groups with different KP groups including three (3) with PWIDs.
- Detailed discussion and planning with HAI-Nigeria senior leadership and program staff
- Analysis of HAI program data

The second was a PWID-focused assessment led by an international expert including HAI-Nigeria staff which was conducted between November and December 2017 with support from HAI Head Office and Nigeria Country Office, drawing on a variety of data sources as follows:

- Desk review of available literature at the epidemiological, policy and implementation levels
- Meetings with key staff from HAI Head Office and Nigeria Country Office
- Meetings with key government officials from NACA and FMoH
- Meetings with UNODC DDR team
- Meetings and focus group discussions (FGDs) with local implementing partners (LPs) and community members (including PWIDs) in four states (Abuja FCT, Cross Rivers, Akwa Ibom and Benue)
- Results from the pre-training and post-training capacity assessment on harm-reduction
- In-training presentations and feedback received from LPs and HAI programme staff
Site visit observations in three states and an additional videoconference with staff from one state (Benue)
Analysis of HAI program data

2.0 Findings

2.1 Epidemiology

In the last decade, the United Nations (INCB 2012, UNODC 2013) purported Nigeria as having the highest levels of drug trafficking and drug use in West Africa. Although there is a paucity of recent and reliable data around injecting drug use prevalence, patterns and trends, available indicators suggest that PWID are at increasing risk of life threatening diseases such as HIV, viral hepatitis and tuberculosis (TB) (Deiss et al. 2009; Getahun et al. 2012). Nigeria has a high burden of hepatitis B and C at a prevalence rate of 12.2% and 2.2% respectively (Olayinka et al. 2016 and FMOH 2013 respectively). WHO (2017) reporting on TB indicators from previous year data revealed that among 219,000 cases of TB reported in 2016, 16% were HIV infected (n=34,000). Of the 100,433 new TB cases notified, 94% knew their HIV status. Of those newly notified, 14,794 (16%) were HIV positive, 81% of whom were on antiretroviral therapy (n=11,934). A mere 29% of all people living with HIV who had been recently enrolled in at least one form of HIV treatment or care had commenced preventative treatment for TB. 2014 data revealed 3.4% of PWID were living with HIV in Nigeria (women: 13.6%; men: 2.9%) (Government of Nigeria, 2014).

Evidence from the Integrated Biological and Behavioral Surveillance Survey (IBBSS) published by the Government of Nigeria in 2014 provides evidence on the burden of HIV infection among PWID and other KPs identifying the likely drivers of risk, determinants of behavior and other factors predisposing KP to increased risk of HIV.

According to National Agency for the Control of AIDS (NACA), almost 3.5 million Nigerians are living with HIV, the second largest population in the world (NHEIA 2014a). The IBBSS reveals around 3.4% of PWID were living with HIV indicative of a downward trend from earlier 2007 and 2010 estimates (5.6% and 4.2% respectively). Equally, as many as 9% of new HIV infections annually are among PWID according to the Global AIDS Response: Country Progress Report 2015 (GARPR) by NACA.

High-risk injecting practices remains high. The IBBSS 2014 reported that 33% of PWID living with HIV shared injecting equipment such as needles and syringes and of those testing negative for HIV, a further 68% shared equipment. Results from the GARPR 2015 indicate similar levels of high-risk injecting behavior reporting 53% of PWID sharing injecting equipment of which 43% shared needles frequently or occasionally. Only 54% of PWID had been tested for HIV according to the IBBSS 2014. Less than half of all PWID respondents were aware of HIV/AIDS prevention methods as stipulated by UNAIDS best practice. Among all KP, the PWID cohort demonstrated the highest levels of misconceptions around HIV transmission with one quarter of PWID believing HIV could be transmitted through sharing meals. Excluding television and radio based HIV messaging; under 40% of PWID had received HIV/AIDS prevention information via other channels such as through peers and health workers. Barely a quarter of PWID felt they were a group at increased risk of HIV and less than half consistently used condoms with sexual partners. Women who inject drugs are thought to be more vulnerable to HIV transmission with UNAIDS (2016) reporting that women are seven times more at risk of transmitting HIV compared to men. Conservative IBBSS 2014 estimates suggest that 13.6% of female PWID lived with HIV compared with 2.9% of men.
HAI program cascade data from 2016 to 2017 revealed that HIV-positive yield two to three times higher among PWID accessing their services: 11% (women: 20%; men: 8%) than in the most recent IBBSS study: 3.4% (women: 13.6%; men: 2.9%) (Government of Nigeria, 2014). Testing program HIV prevalence is usually lower not higher than that found in population studies, because individuals who already know they are HIV-positive are included in the latter and individuals who know they are positive are unlikely to seek out HIV testing. This could suggest that the epidemic has expanded significantly since 2014.

Nigeria also has a high burden of viral hepatitis with a HBV prevalence of 11 - 13.7% (20 million) and HCV 2.2% (3.6 million) (FMoH 2013).

WHO (2012) reported alarming levels of TB in the general population, declaring Nigeria having the fourth highest of prevalence globally with an estimated incidence of 338 cases of TB per 100,000 population (FMoH 2010). WHO (2017) reporting on TB indicators from previous year data reveals that among 219,000 cases of TB reported in 2016, 16% were HIV infected (n=34,000). Of the 100,433 new TB cases notified, 94% knew their HIV status. Of those newly notified, 14,794 (16%) were HIV-positive, 81% of whom were on antiretroviral therapy (n=11,934). A mere 29% of all people living with HIV who had been enrolled in HIV treatment and care had commenced isoniazid preventative treatment for TB.

2.2 Drug supply and demand

There is a paucity of recent data relating to drug use prevalence and drug-related high-risk injecting behaviors in Nigeria. The country’s first comprehensive drug use survey is currently underway with support from UNODC and funded by the European Union (EU). Preliminary results are expected during the second quarter of 2018. Available indicators point to an abundance of narcotics and illicit pharmaceutical drugs destined for the growing local market in addition to being trafficked overseas.

In 2012, the International Narcotics Control Board purported Nigeria as having the highest levels of drug trafficking and drug use in West Africa. UNODC (2013) identifies three principal cocaine shipment hubs in the West Africa region with Nigeria acting as a key actor for cocaine receipt and redistribution within the southern hub of West Africa. The same UNODC report alleges that the vast majority of drug traffickers in West Africa are Nigerians, particularly from the southeast of the country. The National Drug Law Enforcement Agency (NDLEA, 2014) reports increasing levels of trafficking of heroin and cocaine as well as cannabis cultivation in northern states. Nigeria acts as a regional hub for heroin and cocaine trafficking with large quantities of the narcotics reaching a local consumer market.

Nigeria has a poorly regulated pharmaceutical industry and serves as a transit hub for prescription drugs to be diverted elsewhere. Opioid-based painkillers, such as tramadol, are regularly seized by customs officials in Nigeria. Illicit methamphetamine manufacturing laboratories are now functional in the country. The NDLEA and other law enforcement agencies have reported the detection and dismantling of laboratories, precursor chemical seizures and seizures ofamphetamine-type stimulants themselves (UNODC 2016). The West African Commission on Drugs (2014) reported that Nigeria had discovered 10 laboratories since 2010 with Mexican drug cartels playing a key role in the country’s methamphetamine ‘super lab’ industry and UNODC (2013) reported an over ten-fold increase in seizures of psychotropic substances in Nigeria over ten years between 2000 (238 seizures) and 2010 (2,551 seizures).
There is a scarcity of empirically validated data around drug use patterns and trends although all available indicators suggest there are high levels of narcotic and pharmaceutical misuse around the country. The 2014 IBBSS reported that heroin and polydrug cocaine and heroin were the most commonly used drugs. Other drugs and substances were used by 3% per cent or less of all respondents. Among PWID, 52% use cocaine and 49% use heroin and cocaine together.

NDLEA-supported psychiatric centers in Nigeria report increasing levels of substance abuse in general and particularly among the youth. The agency further reported Nigeria’s prevalence rate of cannabis use to be 13.8%, heroin and cocaine at 2% and prescription pharmaceutical abuse at 7%. UNODC (2017) reports increasing numbers of drug users entering treatment centers in Nigeria with primary drug opioid dependency.

Nigeria is currently piloting a National Epidemiological Network on Drug Use (NENDU) in 11 treatment centers nationally and with UNODC financial and technical support. Of the 969 clients entering structured drug treatment centers during 2016, 37% cited opioids as their primary drug of choice (n=355). Among the overall sample, 3.2% were PWID (n=31) (UNODC, 2015).

A policy brief by International Alert (2017) described the widespread use of narcotics and misuse of licit pharmaceuticals particularly opioid-based painkillers. The report links increasing levels of drug use with conflict and corruption in five Nigerian states as well as linkages between drug use and extortion during election political campaigning. In the southern states, the use of narcotics such as cocaine and heroin is widespread with pharmaceuticals such as tramadol, codeine, Exol, pentazocine and Rohypnol commonly misused countrywide.

Nigeria is faced with the challenges of limited access to safe, quality and efficacious psychotropic substances and narcotics for licit use. Access to pain relief medicines is especially inadequate for patients with infectious diseases, post-operative care or at terminal stages of disease.

2.3 Policy and the legal framework

To effectively guide a multi-sectoral response in HIV/AIDS prevention, treatment and care, Nigeria has enacted a number of policies and legal instruments including a commitment to universal access and comprehensive HIV prevention treatment and care.

2.3.1 Drug control

Building on its 1935 Dangerous Drugs Act, Nigeria has been a party to all UN international conventions on narcotic drugs and psychotropic substances. As a result, national policies in drug control are developed with consideration for the following international conventions to which Nigeria is a Party:

- 1961 Single Convention on Narcotic Drugs (as amended by 1972 protocol), ratified in 1972;
- 1971 Convention on Psychotropic Substances, acceded to in 1981;

Nigerian Decrees:

Decree 15 of 1993 established NAFDAC, a parastatal under the Federal Ministry of Health to control the importation and uses of controlled drugs limited to medical and scientific purposes. NAFDAC is further mandated to collaborate with NDLEA in measures to control substance misuse.

The use of illicit narcotics and misuse of licit drugs in Nigeria is heavily criminalised carrying lengthy penalties of between 15 and 25 years for possession. As a result, PWID face additional barriers in accessing HIV prevention, treatment and care placing them at increased risk of infectious diseases and overdose.

In 1999, a joint European Union and United States Government assessment mission, with civil society support, recommended for the drug demand reduction and supply functions to be separated and for an independent agency to be established to provide drug treatment, prevention and education. In 2012, the EU provided EUR 35 million of financial assistance to the Government of Nigeria through UNODC to provide technical support and increased capacity to the Government and civil society to further support drug supply and drug demand reduction activities nationally.

2.3.2 National guidelines as they relate to reducing HIV/AIDS and other blood-borne viruses among PWID

The following three recent national level guidelines highlight commitment at the policy level to improving health related outcomes specifically for PWID, including using effective harm-reduction interventions:

2016 National Hepatitis Guidelines, National AIDS/STIs Control Programme, Federal Ministry of Health

- Stresses the need for prevention to reduce Hepatitis C Virus (HCV) and HCV-related diseases, primary prevention methods (reduce the risks of contracting the infection), secondary (identify disease at the earliest opportunity and reduce the impact of the disease after it has occurred, and tertiary prevention (aims to reduce the impact of on-going illness)
- Sets out multifaceted approaches to reducing the prevalence of hepatitis infection among PWID through ‘precautionary methods’: never sharing IV drug needles or other drug equipment, counselling and education to prevent initiation of inject drug use or risky sexual practices. Individuals using illegal drugs should be advised to: stop using and injecting drugs, enter drug treatment, never share injecting equipment, use sterile equipment and clean the site of injection, get vaccinated against Hepatitis A Virus (HAV) and Hepatitis B Virus (HBV) and offer peer education interventions to PWID

2016 National Guidelines for HIV Prevention, Treatment and Care, National AIDS and STIs Control Programme, Federal Ministry of Health

- Recognizes high disproportionally high prevalence of HIV among KPs citing IBBSS 2014 of 3.4% per cent HIV infection among PWID
- Requires targeted and tailored HIV Testing Services (HTS) for KP
- Recommends for all drug using (injecting and non-injecting) individuals: “innovative interventions such as opioid substitution therapy (OST) and needle and syringe programs (NSP) should be considered as prevention interventions”

National Drug Control Master Plan 2016 – 2020, Inter-ministerial Committee on Drug Control (IMC), NDLEA
• Drug demand reduction strategy focuses on four pillars of: (1) Sensitization, advocacy and prevention (2) Treatment and continuing care (3) Drug use and HIV and AIDS (4) Establishment of a national drug monitoring system
• Regards PWID as a target priority population for HIV prevention interventions and commits to establishing models of ‘comprehensive, accessible, affordable and evidence-based HIV prevention, treatment and care services…with a focus on PWID’ (p. 38)
• Commits to including interventions under the comprehensive package for PWID included in the National HIV and AIDS strategic plan

3.0 Current HIV/AIDS activities and services for PWID

3.1 General HIV/AIDS and other services for PWID
National guidelines on HIV/AIDS Prevention, Treatment and Care, Hepatitis and Drug Control all acknowledge and recommend the need for increased efforts and interventions to reduce the harms associated with injecting drug use. Yet at the implementation level, evidence-based interventions such as needle syringe programs (NSP), opioid substitution therapy (OST) and overdose management remain unavailable.

4.0 Heartland Alliance Program Results

4.1 High HAI HIV program prevalence compared with 2014 IBBS
As shown in Table 1, the ISBBS (2014) revealed 3.4% (women: 13.6%; men: 2.9%) of PWID were living with HIV in Nigeria yet IMHIPP cascade data from July 1, 2016 to December 31, 2017 (FY 2016 Q4-FY 2018 Q4) reveals that HIV positive yield was three times higher among PWID accessing their services: 11% (women: 20%; men:8%). Testing program HIV prevalence is usually lower not higher than that found in population studies, because individuals who already know they are HIV-positive are much less likely to seek out HIV testing. This could suggest that the epidemic has expanded significantly since 2014. Also, HAI data show increases in HIV prevalence among all age groups. The composition of HAI’s PWID pool in testing services had a higher proportion of women than the ISBS (25.4% vs. 7%) but the two samples were very similar in terms of age groups.
### Table 1. Comparison between IBBBS 2014 and HAI 2017

<table>
<thead>
<tr>
<th>Disaggregation</th>
<th>IBBBS-2014</th>
<th>HAI 2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>% HIV+</td>
<td>3.4%</td>
<td>10.8%</td>
</tr>
<tr>
<td>% HIV Male</td>
<td>2.9%</td>
<td>8.0%</td>
</tr>
<tr>
<td>% HIV+ Female</td>
<td>13.6%</td>
<td>19.3%</td>
</tr>
<tr>
<td>% HIV+ 15-19</td>
<td>3.1%</td>
<td>6.1%</td>
</tr>
<tr>
<td>% HIV+ 20-24</td>
<td>2.3%</td>
<td>5.7%</td>
</tr>
<tr>
<td>% HIV+ 25-49</td>
<td>3.9%</td>
<td>12.2%</td>
</tr>
<tr>
<td>% HIV+ 50+</td>
<td>ND</td>
<td>12.6%</td>
</tr>
<tr>
<td>Female</td>
<td>7.0%</td>
<td>25.4%</td>
</tr>
<tr>
<td>Male</td>
<td>93.0%</td>
<td>74.6%</td>
</tr>
<tr>
<td>15-19</td>
<td>5.4%</td>
<td>5.8%</td>
</tr>
<tr>
<td>20-24</td>
<td>26.0%</td>
<td>28.1%</td>
</tr>
<tr>
<td>25-49</td>
<td>68.69%</td>
<td>64.3%</td>
</tr>
<tr>
<td>50+</td>
<td>0</td>
<td>1.8%</td>
</tr>
</tbody>
</table>

### 4.2 HAI Program HIV prevalence by sex and age groups

As shown in Table 2, HIV-positivity in HAI’s program was quite higher among women (19.5% n=3,563) than among men (8.0% n=10,456). For both men and women, the age breakdowns with the highest HIV prevalence were 25-49 years and 50+. In addition, in every age group, women had an HIV prevalence that was twice that of men.

### Table 2. HAI 2017 HIV Positivity by Sex and Age

<table>
<thead>
<tr>
<th>Age Group</th>
<th># HTS M</th>
<th># HTS F</th>
<th>Total HTS</th>
<th># + M</th>
<th># + F</th>
<th>Total +</th>
<th>% HIV+ M</th>
<th>% HIV+ F</th>
<th>% HIV+ Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-19</td>
<td>518</td>
<td>291</td>
<td>809</td>
<td>17</td>
<td>32</td>
<td>49</td>
<td>3.3%</td>
<td>11.0%</td>
<td>6.1%</td>
</tr>
<tr>
<td>20-24</td>
<td>2720</td>
<td>1217</td>
<td>3937</td>
<td>79</td>
<td>146</td>
<td>225</td>
<td>2.9%</td>
<td>12.0%</td>
<td>5.7%</td>
</tr>
<tr>
<td>25-49</td>
<td>7008</td>
<td>2012</td>
<td>9020</td>
<td>713</td>
<td>501</td>
<td>1214</td>
<td>10.2%</td>
<td>24.9%</td>
<td>13.5%</td>
</tr>
<tr>
<td>50+</td>
<td>210</td>
<td>43</td>
<td>253</td>
<td>23</td>
<td>9</td>
<td>32</td>
<td>11.0%</td>
<td>20.9%</td>
<td>12.6%</td>
</tr>
<tr>
<td>Total</td>
<td>10456</td>
<td>3563</td>
<td>14019</td>
<td>832</td>
<td>688</td>
<td>1520</td>
<td>8.0%</td>
<td>19.3%</td>
<td>10.8%</td>
</tr>
</tbody>
</table>
4.3 HAI HIV testing program positivity by state

Among men, HIV prevalence was highest in Rivers, Akwa Ibom, Benue and Cross Rivers. (Table 3)

<table>
<thead>
<tr>
<th>State</th>
<th>HTS</th>
<th>#+</th>
<th>%+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Akwa Ibom State</td>
<td>2032</td>
<td>220</td>
<td>10.8%</td>
</tr>
<tr>
<td>Benue State</td>
<td>1810</td>
<td>179</td>
<td>9.9%</td>
</tr>
<tr>
<td>Cross River State</td>
<td>1999</td>
<td>198</td>
<td>9.9%</td>
</tr>
<tr>
<td>Federal Capital Territory</td>
<td>1338</td>
<td>41</td>
<td>3.1%</td>
</tr>
<tr>
<td>Lagos State</td>
<td>544</td>
<td>10</td>
<td>1.8%</td>
</tr>
<tr>
<td>Nassarawa State</td>
<td>2221</td>
<td>87</td>
<td>3.9%</td>
</tr>
<tr>
<td>Rivers State</td>
<td>512</td>
<td>99</td>
<td>19.3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>10456</strong></td>
<td><strong>834</strong></td>
<td><strong>8.0%</strong></td>
</tr>
</tbody>
</table>

Among men, HAI registered higher HIV+ yield in Q2 and Q3 in all states. Rivers, Akwa Ibom, Cross Rivers and Benue had consistently high HIV positivity.

**Figure 1.** HAI State and Total HIV+ yield All Male - Q1 17 - Q1 18 (5 quarters)
Among women, HIV prevalence among women was highest in Benue, Akwa Ibom and Cross-Rivers state. In Rivers state, the program had not yet reached female PWID by this time. (Table 4)

<table>
<thead>
<tr>
<th>State</th>
<th>HTS</th>
<th>#+</th>
<th>%+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Akwa Ibom State</td>
<td>513</td>
<td>133</td>
<td>25.9%</td>
</tr>
<tr>
<td>Benue State</td>
<td>318</td>
<td>110</td>
<td>34.6%</td>
</tr>
<tr>
<td>Cross River State</td>
<td>942</td>
<td>238</td>
<td>25.3%</td>
</tr>
<tr>
<td>Federal Capital Territory</td>
<td>761</td>
<td>73</td>
<td>9.6%</td>
</tr>
<tr>
<td>Lagos State</td>
<td>410</td>
<td>40</td>
<td>9.8%</td>
</tr>
<tr>
<td>Nassarawa State</td>
<td>649</td>
<td>94</td>
<td>14.5%</td>
</tr>
<tr>
<td>Rivers State</td>
<td>0</td>
<td>0</td>
<td>#DIV/0!</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>3593</td>
<td>688</td>
<td>19.1%</td>
</tr>
</tbody>
</table>

Among women, HIV positivity was high consistently over all quarters among HAI’s testing program participants, unlike men. FTC and Benue had increasing trends while Cross River, Nasawara and Lagos had decreasing trends.

Figure 2. HAI State and Total HIV+ yield Female PWID - Q1 17 - Q1 18 (5 quarters)
4.4 HAI Overall Cascade Results for PWID

Figure 3 shows HAI’s overall performance by quarter on each step of the prevention-treatment cascade. Note that in Q1, all PWID who had been reached the previous year are considered new again for the purposes of reporting, but within the program year, each cascade indicator refers to number of individuals and they are not double counted quarter to quarter. The most difficult cascade step is linking positives to treatment. Large majorities who had started ART also stayed in treatment for at least the first three months.

5.0 Recommendations

The data collected from service users, service providers, key stakeholders, and feedback from training and epidemiological sources is well aligned which has made it possible to identify the unmet harm-reduction needs of PWID in several key communities in Nigeria, and to make recommendations to address these needs.

There is overwhelming evidence for harm-reduction to be promoted at the earliest opportunity as part of the core package of interventions for PWID at risk of, or living with HIV. Through the One Stop Shop (OSS) and ‘greenhousing’ mechanisms, HAI currently possesses a wealth of trained and experienced staff as well as the stable infrastructure, effective outreach systems and access to communities in order to extend the reach of harm-reduction interventions to PWID.

To support a scale-up of harm-reduction interventions under the current OSS model, the following recommendations can be considered.

5.1 Implementation

- Support local PWID-led organizations to appoint harm-reduction champions who act as a single point of contact within their OSS on technical and capacity-building related matters relating to harm-reduction.
• Support harm-reduction trained trainers to cascade harm-reduction knowledge to staff members, community members and peer educators.

• Develop Information, Education and Communication (IEC) materials which provide essential harm messages around safer injecting as well as overdose prevention and management.

• Support local PWID-led organizations to deliver sensitization sessions on harm-reduction and drug use for local stakeholders such as law enforcement agencies, emergency medical health workers and health workers providing screening and treatment for hepatitis and tuberculosis.

5.2 Policy

• Ensure NGO and service user presence and participation at key national level working groups in the areas of drug demand reduction and harm-reduction

• Continue to advocate for essential harm-reduction interventions such as needle syringe programs (NSP), opioid substitution therapy (OST) and overdose management with naloxone

• Position and promote HAI and local NGOs as viable future partners to undertake pilots on OST, NSP and overdose in the future through the development of three proposals to implement 12 month pilots of (1) OST (2) NSP and (3) Overdose management with naloxone, to include the following:
  - Evidence base which supports urgent need for increased interventions for PWID (epidemiology, HAI needs assessment)
  - Expertise, results and impact of IMHIPP service provision for KPs
  - Prospective sites for pilots following rapid assessments of LPs
  - Existing partnerships with key local partners
  - Rigorous monitoring, evaluation and longitudinal research studies
  - Robust management systems

• Position HAI and local NGOs as key technical partners of FMoH, NASCP and NAFDAC attending the relevant working groups for the development of national guidelines for OST (and other harm-reduction interventions in the future).

5.3 Resource mobilization

• Internally, prepare budget forecasts for the scale-up of OST, NSP and overdose treatment with naloxone.

• Supply proposals for future OST, NSP and Naloxone to potential donors. For example, UNODC headquarters and Nigeria Country Office may be interested in financing the NSP with WHO or UNAIDS providing the commodities required for NSP as well as naloxone. Open Society / OSIWA may be interested in funding the pilots and possibly the research studies.

5.4 Capacity building

• Develop a harm-reduction workforce development strategy to ensure all HAI and local NGO staff possess a baseline level of harm-reduction awareness.

• There is an urgent need for staff to be trained in behavior change strategies and basic psychosocial interventions such as motivational interviewing. Two HAI psychologists have a good level of knowledge of these and can be utilised by HAI to develop and deliver a ToT training package on evidence-based psychosocial interventions.
• UNODC offers trainings on drug dependence treatment and care. HAI can frequently reach out to UNODC drug demand reduction (DDR) teams in Abuja and Lagos to maintain this collaboration and partnership.
• Consider supporting harm-reduction leads to attend key international harm-reduction conferences.

5.5 Monitoring and evaluation

• Establish a more robust approach to PWID specific Monitoring and Evaluation (M&E) which will enable HAI and LPs to provide critical information on the needs of this KP as well as on the effectiveness of the activities. Indicators, data collection tools and other mechanisms will more effectively capture data relating to high risk injecting practices, prevalence of fatal and non-fatal overdose, basic drug use prevalence, patterns and trends (Annex 2). These should be aligned with the three national strategies as well as with PEPFAR, UNAIDS, WHO and UNODC recommendations. Where appropriate, all data should be disaggregated by gender and age in order to monitor the breadth and depth of the response to HIV, access to activities, equity of access and the appropriateness of focusing resources and interventions for PWID. HAI should aim for the harm-reduction monitoring system to be in operation from June 2018.
• Develop the necessary research protocol for the three prospective pilots of OST, NSP and overdose management with naloxone, which will effectively monitor and evaluate impact of the pilots along with demonstrable outcomes thus proving the effectiveness of such harm-reduction scale-up efforts. The protocols will assist HAI and LPs with setting longer term targets which can be aligned with future national level indicators.

Annex 1. Meetings and advocacy for harm-reduction with key stakeholders

A.1. Meetings with Government Stakeholders

Meeting with Drug Demand Reduction Department, Federal Ministry of Health (November 30, 2017)

• A new department for drug demand reduction (DDR) within the FMoH has been established recently, committing towards the scale-up of both low-threshold and structured treatment for PWID.
• 11 model drug treatment centers have been established so far in collaboration with five civil society partners, the NDLEA and with technical and financial assistance provided by UNODC/EU.
• The FMoH intends to establish a pilot for OST at two current drug treatment centers in psychiatric hospital settings. During this critical first phase of OST programming, the FMoH require the pilot is implemented in a government-regulated clinical setting to reduce the risks of methadone diversion. The two possible locations discussed are Enugu and Kaduna where UNODC is already supporting civil society organizations to carry out low-threshold interventions for drug users. The FMoH recognise the value in civil society collaboration particularly for the implementation of the OST pilots. The methadone has been procured and is currently in storage in Lagos. UNODC will be providing technical assistance to support the FMoH and NDLEA in producing clinical guidelines for OST.
• The FMoH will be starting a vetting process of all civil society organizations involved in delivering interventions to drug users to gauge levels of operational, technical and operational capacity. The results will enable the FMoH to identify viable partners for collaborative programs for drug users in the future.

• The FMoH recognised there is a need for NSP and naloxone in Nigeria and recommend that further discussions take place with NASCP and NAFDAC respectively leading discussions around future implementation of NSP as part of a wider efforts in viral hepatitis harm-reduction.

• The FMoH offered to share treatment data from their WENDU pilot with HAI and welcomed future collaboration with HAI and their LPs.

Meeting with the National Agency for the Control of AIDS (NACA) (December 2, 2017)

• NACA is committed and involved in HIV prevention and treatment programming specifically for PWID and both support and welcome the introduction of interventions such as OST, NSP and overdose management with naloxone.

• NACA feels there is currently increasing support for a scale-up of selected harm-reduction interventions to commence although the NDLEA Act remains a barrier to the introduction of NSP and OST. NDLEA are becoming increasingly supportive of harm-reduction interventions and NACA further recommend civil society conduct sensitisation and advocacy to policymakers as the Law relates to drug use / possession

• A new interagency and civil society led meeting witnessed a significant shift towards a more comprehensive treatment approach for government agencies such as NDLEA

• NACA currently undertaking an epidemiological study into HIV prevalence and feels current data underrepresents HIV prevalence estimates particularly among key populations

A1.2 Meeting with UNODC (December 4, 2017)

• Increased collaboration between UNODC and HAI-N regarding PWID issues will be welcome (Mr. Folusho focal point);

• UNODC EU project looking for further NGOs to deliver drug treatment and possibly harm-reduction activities;

• UNODC conducting national drug use prevalence (and risk) survey, results available Spring 2018;

• UNODC supporting Government OST guidelines, to start in next few months;

• UNODC recommendation for HAI-N to involve NASCP in harm-reduction scale-up as they may be the ‘driving force’ behind NSP for hepatitis harm-reduction;

• UNODC may be able to support HAI for NSP scale-up (commodities, training);

• UNODC will support government led OST but government (FMoH) currently see OST as form of drug treatment, not harm-reduction intervention (hence the need for HAI-N to open dialogue with NASCP);

• UNODC currently completing NGO capacity assessment (45/60 completed). Results should be persuasive in allowing more NGOs to deliver increased levels of services for drug users / PWID;

• UNODC planning to establish drug treatment at IDP camps next year. UNODC will keep HAI-N updated on tender notices and progress;

• UNODC announcing small-scale research project funding, deadline February 2018;

Summary of actions: Increased information sharing (Folusho and Dr Emmanuel), HAI-N access to UNODC led technical training (Folusho to coordinate), more regular meetings and closer collaboration between UNODC and HAI-N
A1.2 Meetings with One Stop Shops (OSS) Local Implementing Partners (LPs), field visits and focus groups

Field visit to OSS, Uyo, Akwa Ibom State (October 16, 2017)
LP: IHR
Meetings with Staff:

Summary and Key Points

- PWID Bunks frequently raided by police leading to high mobility of PWID population, which is a key barrier for linkage and retention
- Most KPs are in the “denial stage” when first testing positive for HIV, which is a challenge for linkage to care and retention
- Religious leaders claiming cures for HIV common, impacts linkage and retention

Field Visit to OSS, Abuja FCT (October 22, 2017)
LP: Youtrise CBO
Meetings with staff:

Summary and key points

- Prevalence of drug use: heroin, cocaine, cannabis and pharmaceutical drugs are commonly used. Occasionally heroin and cocaine is unavailable but other opioids can be acquired very easily.
- Patterns of injecting drug use: the sharing of injecting equipment is widespread for a number of reasons. For some PWID the practice of sharing symbolises trust between peers, further demonstrated through the ritual of ‘blood sharing’ when peers withdraw another’s blood and inject for added intoxication.
- Many will not purchase needles and syringes from pharmacies as many pharmacists refuse to provide them to PWID or make stigmatising comments. Some PWID pretend to be diabetic for this purpose. Pharmacies also threaten to report them to law enforcement agencies. Many PWID live or use drugs in ‘bunks’ or ‘jungles’: drug hotspots further away from pharmacies. Many drugs, particularly pharmaceuticals, are pre-prepared in syringes by drug dealers and eventually shared. Pre-prepared syringes of drugs can also be bought freely in the market.
- Law enforcement agencies frequently raid the bunks and jungles and are often violent. They almost always ask for bribes regardless of whether drugs are found in one’s possession. They often make arrests in the event drug paraphernalia such as pipes, needles and syringes are found. Female PWID are often sexually assaulted and sometimes raped unless they pay the bribe. PWID are often detained for days in the police station with no charges brought against them.
- The rate of overdose is high with the OSS hearing of overdose cases on a near daily basis. Clients will not go to the hospital in overdose emergencies in fear of stigmatization from health providers and by the possible legal ramifications. Currently, in the event of overdose, basic first aid is provided by peers as well as herbal medicines or condensed milk, which are believed to help bring someone out of an opioid overdose. Occasionally peers and bunk owners will request support from a doctor of tribal / non-pharmaceutical medicine.
- Staff felt services such as NSP, OST and overdose management with naloxone would be invaluable. Some staff suggested both fixed-site and mobile outreach models for NSP given many of the PWID community are entrenched in distant
bunks. One staff member suggested that bunk owners are provided with the NSP kits and commodities along with naloxone.

**Videoconference with OSS, Makurdi, Benue State (November 23, 2017)**

**LP:** CYDI CBO

**Meetings with staff:** Executive Director, Programme Staff x2 and Outreach Coordinator

**Summary and key points**

- Opioid-based painkillers are the most commonly used substances among their PWID community: morphine, pentazocine, tramadol, pethidine, Exol as well as benzodiazepines and sedatives such as diazepam, bromazepam and lorazepam. Variations of these are injected together.
- Many pharmaceutical drugs are already pre-prepared in syringes by drug dealers (vendors). ‘Love sharing’ is a common practice and refusing to shoot up by ‘love sharing’ erodes bonds and loyalties between peers.
- Most Female PWID are involved in sex and anecdotally, prevalence of HIV very high among this group. CYDI are conducting research to try and deepen understanding of the particular needs of this group as some of the women have had unplanned pregnancies and give birth in the bunk. Some babies have been sold on to traffickers. These women are deeply traumatised and have many health and mental health issues. The drug use was a way of coping and has become problematic and they are dependent on opioids as a result.
- Due to the high incidence among PWID participants, the absence of NSP and other harm-reduction interventions is a major challenge for CYDI. Because of this, many clients are disengaging from the OSS or are hard to engage in the first place. These clients are often uncontactable by phone and are in and out of the criminal justice system therefore it is difficult to reengage them.
- There are some positive relationships with law enforcement agencies at the higher levels but this does not cascade down to behavior at the ground level. As a result, NDLEA and police bribe many drug users and go so far to ‘plant’ drugs on their possession, framing them for drug offences. Advocacy efforts by CYDI are often lost owing to high turnover of NDLEA officers. Raids are often unofficial and orchestrated for the purpose of bribery.
- Overdose prevalence is high and sometimes the emergency services are involved. PWID are reluctant to discuss the occurrence of overdose as some were involuntarily taken to NDLEA drug treatment centers as a result of their overdose. They are fearful of reprisals from the NDLEA hence much of the overdose is unreported.

**Field Visit to OSS, Calabar, Cross Rivers State (November 24, 2017)**

**LP:** HASI CBO

**Meetings with staff:**

**Summary and key points**

- HASI has been able to attend some training around low-threshold drug treatment and harm-reduction provided by UNODC so they can deliver some effective interventions to PWID but they feel they need increased training around drugs and drug use, effective approaches and psychosocial interventions.
- Heroin, tramadol, cocaine and crack cocaine are in high demand and widely available. Primary opioid users will also snowball or smoke crack cocaine thus placing them at increased risk of overdose and other health problems.
- HASI staff are frustrated they are unable to provide services such as NSP and naloxone to clients especially as sharing of injecting equipment is high. ‘Blood
flashing’ (love sharing) practices common between users for an increased level of intoxication and also as a bonding and trust ritual. Among HIV negative clients, they struggle to retain PWID clients engaged in the OSS as they feel there is little on offer to help them remain free from HIV. HASI staff have been asked to provide sterile needles and syringes.

- Through outreach, HASI staff try to cover 18 known drug-using hotspots (bunks and jungle) and estimate roughly 20-30 PWID regulars at each site. PWID rarely leave their bunks to access services thus the outreach model is especially significant. If the OSS could offer more health interventions for PWID specifically, perhaps increased numbers of community members would access the OSS.
- HASI has strong linkages with other local healthcare providers who are becoming more accepting of PWIDs for treatment. Volunteer doctors attend the OSS offering satellite based support services, primary care for abscesses and injecting-related skin problems. HBV and HCV screening is free and available but treatment is costly.
- HASI staff suspect a high number of their PWID community have comorbidities such as mental health issues. PWID with dual diagnosis make it challenging to deliver interventions for HIV prevention, treatment and care but do not have access to mental health services for appropriate treatment.

A1.3 Focus Group Discussions with Community Members

Akwa Ibom (Uyo) (October 16, 2017) Focus Group Discussion, community members, IHR (ten HIV-negative community members)

Summary and key points

- PWID reported that in this location it is not difficult to get needles from pharmacy.
- PWID felt that many community members accessing services.
- PWID reported that although needles are cheap, needle sharing is still very common. Might do it because they don’t have time to go to the pharmacy. Also share needles to “build a sense of brotherhood”.
- The felt that HIV testing is available at the bunks (through HAI) but many PWID do not test because of fear.
- The PWID reported that they all use Facebook, WhatsApp, Instagram and other social media. They think it would be a good way to share prevention and treatment information.

Cross River (Calabar) (October 14, 2017) Focus Group Discussion, HIV-negative community members,

Summary and key points

- A great deal of needle sharing occurs because of lack of money. PWID will ask for drugs from a friend who has money but that person will only have one needle. In addition, they are in a rush to get the drug due to withdrawal symptoms.
- Difficult to ask for drugs in pharmacy due to stigmatization.
- PWID inject twice per day (morning and evening)
- Many PWID expect incentives to participate in services.
- Some PWID sterilize needles themselves with hot water and/or bleach.
- Expressed need for income generating activities.
FCT (Abuja) Focus Group Discussion: community members, Youthrise (seven male, three female) (November 22, 2017)

Summary and key points

- Nine out of ten community members used an opioid as their primary problem drug and all members were polydrug users. The most commonly used drugs and pharmaceuticals were (in order of prevalence: codeine, tramadol, heroin, cocaine, crack cocaine, cannabis, diazepam (and other benzodiazepines), pentazocine (Fortwin), Exol (Rohypnol, Fentanyl). One PWID injects ketamine and a form of frog venom. During election times, drug use increases with political campaigners paying drug users to recruit a further voting base.
- Community members stated most pharmaceutical drugs came pre-prepared in syringes from dealers or from the markets while heroin and crack users would prepare their drugs for injection themselves. Clean needles and syringes are cheap but sometimes hard to access from pharmacies. Many pharmacists won’t sell them to PWID. Some PWID claim to be diabetic to buy needles and syringes. Otherwise they will reuse their own unshared equipment for a long time. Some community members said this may have caused them an abscess. Others were sharing equipment until recently. When pharmaceutical drugs are pre-prepared in syringes there is no option but to share that syringe although most community members said they would only share with their partners or close peers. For opiate cooking, spoons are used, sometimes shared and filters (toilet paper) used. Vitamin C sugar sachets and vinegar used as acidifiers and water from any source, all possibly shared. ‘Love sharing’ is practiced but mainly between male-male or male-female partners.
- Overdose is common and the tramadol-induced overdose is especially deadly. Basic first aid is carried out by peers and bunk owners and ‘setting and washing’ practices which involves stimulation and giving an herbal medicine.
- Female PWID face gender based violence (GBV) issues particularly with law enforcement agencies, bunk owners and dealers. This forces them further deeper underground to buy and use their drugs and often there is no alternative but to share injecting equipment.
- Many community members are unaware of the HBV and HCV status. There was some debate among the group whether screening for HBV and HCV was free but treatment was expensive as many PWID do not feel they can access mainstream services in health clinics and hospitals in the fear stigmatisation and legal reprisals.
- Two community members have accessed drug treatment and both had relapsed. All the community members felt that treatment options were ineffective and coercive. Some male community members had been in prison many times and continued to use drugs but had not injected while in prison.

Cross-Rivers (Calabar) Focus Group Discussion: community members, HASI (eight male, two female) (November 24, 2017)

Summary and key points

(Due to unforeseen delays, the FGD was cut short lasting 25 minutes rather than the full 50 minutes)

- In terms of drug supply, ‘Everything and anything at any time is available here in Cross Rivers if you want it and you can pay for it’ (Male community member)
- Heroin, cocaine powder, crack cocaine and tramadol appear to be the most commonly used and widely available drugs. Amphetamine-type stimulants such
as methamphetamine and ephedrine are entering the market. One community member injects methamphetamine for his stimulant and heroin to come down and was in a severe state of withdrawal during the focus group discussion.

- PWID prefer to remain in their close-knit hotspots for all their requirements but find the OSS a very useful and welcoming place when they do attend. Injecting frequency is high among most PWID. The group participants inject an average of two times daily. Half of them were sharing injecting equipment with a partner or close peers and the other half use their own. Pharmaceutical drugs are prepared in syringes and some dealers are trusted to prepare this in sterile syringes. However lately, there are many new dealers around. Health is not their priority. Otherwise, sterile injecting equipment can be bought cheaply from pharmacies however some PWID do / will not leave their bunks.
- GBV in the bunks and other drug using hotpots is a significant problem. All community members know at least one PWID who was raped after using or overdosing on drugs. Sometimes the drugs can be stronger than usual or have unexpected side effects or be mixed with additional substances placing people at increased risk of adverse reactions and overdose.
- Overdose practices are basic. Basic first aid can be given but emergency services are never contacted.
### Annex 2. Monitoring Indicators

**Recommended indicators for the monitoring of harm reduction interventions (source reporting frequency monthly)**

<table>
<thead>
<tr>
<th>No.</th>
<th>Indicator</th>
<th>Numerator</th>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>PWID-1</td>
<td>Number of PWID</td>
<td>PWID reached with OSS and Outreach</td>
<td>Outreach record + OSS record</td>
</tr>
<tr>
<td>PWID-2</td>
<td>Number of PWID in OSS</td>
<td>PWID reached by OSS</td>
<td>OSS record</td>
</tr>
<tr>
<td>PWID-3</td>
<td>Number of PWID on outreach</td>
<td>PWID reached by Outreach</td>
<td>Outreach record</td>
</tr>
<tr>
<td>PWID-4</td>
<td>Number of condoms distributed to PWID</td>
<td>Only counted distribution to beneficiaries</td>
<td>Condom distribution records OSS + Outreach</td>
</tr>
<tr>
<td>PWID-5</td>
<td>Number of PWID who received an HIV test and know the result</td>
<td>Count those PWID who come back for their post-test of HIV counselling after testing</td>
<td>Service delivery record</td>
</tr>
<tr>
<td>PWID-6</td>
<td>Number of PWID who received STI treatment</td>
<td>Only reported once in six month timeframe</td>
<td>Service delivery record</td>
</tr>
<tr>
<td>PWID-7</td>
<td>Number of PWID who received HBV test</td>
<td>Number of PWID who received HBV test</td>
<td>Service delivery record</td>
</tr>
<tr>
<td>PWID-8</td>
<td>Number of PWID vaccinated with rapid schedule for HBV</td>
<td>Number PWID that tested HBV negative that received HBV vaccination according to WHO rapid schedule (0, 7, 21 days)</td>
<td>Service delivery record</td>
</tr>
<tr>
<td>PWID-9</td>
<td>Number of PWID who received HCV test</td>
<td>Number of PWID who received HCV test</td>
<td>Service delivery record</td>
</tr>
</tbody>
</table>
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