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OPINION PIECE

Supply control, demand reduction or harm reduction? Developments and directions for drug policy in Nigeria

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ABSTRACT

Nigeria is the most populous country in Africa, and it is a transit country for the passage of drugs to Western countries. This has among other factors, led to an increasing level of illicit drug use despite a long history of punitive measures of drug control. Nigeria boasts of very punitive laws against both drug use and drug trafficking, which has been endorsed by external bodies such as the US DEA, but there are no harm reduction policies or services and very limited availability of treatment services. There is a need to legislate for demand reduction measures in the country to complement possession and trafficking legislation and the develop treatment services nationally before there is a large increase in HIV and other blood borne diseases. A model of community level treatment services is proposed to deliver services at a local accessible level using existing NGOs and volunteers.

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Introduction

Nigeria has a population of over 140 million people, which makes it the most populous country in West Africa. The country has acquired notoriety for the scale of its developmental failures and the ironies surrounding its malaise (Lewis 2006). Nigeria's condition is full of disturbing contradictions. Although endowed with abundant human and natural resources, the country ranks high in poverty and other indices of under-development. Governance is poor and the state is 'conspicuous by its regulatory absence' (Klein 2009: 383). The country's major problems (economic decline, corruption, political instability and social conflicts) are not peculiar, but they are remarkable in their magnitude and persistence. Deepening socio-economic crises have pushed a large section of the population out of the formal sector into the realm of illegal activities, including crime and illicit drugs. Yet the country response to drug problems is skewed towards law enforcement, grossly neglecting treatment and prevention.

The history of drug use

Nigeria has one of the highest prevalence of cannabis use (14.3%) in Africa and ranks third for a one year prevalence of cocaine (0.7%) and opiates (0.7%) (Onifade et al. 2011). Cannabis has been available in the region since 1940 s, while cocaine and heroin arrived in the 1980 s (Asare and Obot 2013). Oviasu (1976) highlighted the high levels of amphetamine and stimulant use in Benin City between 1969 and 1972, and there is evidence that amphetamine type substances (ATS), especially methamphetamine, are being produced in Nigeria. The country has become a favourite with drug traffickers (UNODC 2012). There are also reports of dependence on narcotic painkillers such as pentazocine, used as an analgesic in common with other prescription medications (Makanjuola and Olatunji 2009).

By the 1950 s, problems associated with the use of cannabis were becoming evident in the increasing cases of schizophrenia, anxiety disorders and other mental health problems found among patients in psychiatric clinics in western Nigeria (Asuni 1964; Lambo 1965). Cannabis is the most common substance of use in Nigerian (Klein 1999). Although the consumption of cannabis cuts across gender and social status, young people are the predominant consumers. Initially, illicit drugs were mostly used by affluent residents of big Nigerian cities. Ebie et al. (1981) reported the organisation of 'cocaine parties' by some wealthy Nigerians in Benin city. But cocaine and heroin are now widely available and consumption has increased.

The trade in heroin began when Nigerian naval officers undergoing training in India began to smuggle Southwest Asian heroin (US DEA, in Obot 2004). South American drug traffickers introduced cocaine into Nigeria by using West Africa as a staging post for smuggling the drug to Europe (Akyeampong 2005; Ellis 2009). Akindipe et al (2014) have pointed out that Africa has evolved from a drug transit to a drug using continent, and this is particularly true in Nigeria. Injecting drug use is on the increase in some Sub-Saharan African countries including Nigeria (Trathen et al. 2012), and this brings with it the increased risk of the transmission of HIV especially in the absence of harm reduction measures.

Although Nigeria has a low HIV prevalence, especially for Africa, Nigeria had an HIV prevalence of 4.1%

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(Akindipe et al. 2014) mostly via heterosexual sex, but female drug users, regardless of whether they were injectors, were three to ten times more likely to be positive than male users and this is probably because they turn to commercial sex work to pay for their drug habits and because of stigma female drug injectors remain a hidden population. Iwuagwu et al. (2015) reported that prevalence of HIV among female injectors is 7 times higher than that of males because of stigma and the hidden nature of female injecting. Nigeria is a good example of a country where harm reduction measures could avoid an explosion of HIV among injectors

The evolution of drug legislation

Drug problems have a relatively long history in Nigeria, as well as efforts to control them. Attempt to control the production, distribution and consumption of dangerous drugs in Nigeria go back to the colonial period. British colonial government attempted to introduce the control measures contained in the 1912 Opium Control Treaty in all her territories. Thus, in 1935 the Dangerous Drugs Ordinance was promulgated in Nigeria to control the production and consumption of dangerous substances. At the time alcohol was the substance widely produced and consumed in Nigeria. The commodity came under control by the colonial administration. The original intention was to protect inebriated 'natives' from the negative effects of dangerous substances. But it transformed into a 'system of tariffs and quotas on gins, schnapps and brandy imports' followed by 'bans on distilled liquors, fermented beers, bottled beers and wine' (Klein 1999: 54). The control of these substances came to serve the economic interests of the colonisers and formed the foundation of the colonial political economy (Pan 1975).

Nigeria inherited its psychoactive substance control system from the British colonial administration at independence. The country has had some of the most severe laws ever applied to eradicate drug trafficking and use (Obot 2004). The Indian Hemp (Cannabis) Decree of 1966 stipulated death penalty or 21 years imprisonment for the cultivation of cannabis, 10 years imprisonment for trafficking in cannabis and 10 years for possession and/or smoking of cannabis. These stipulations were amended by the Indian Hemp Act of 1975. The Act abolished the death penalty provision, and reduced the sanction for cannabis smoking to 6 months and/or a fine.

Things changed again in 1984. While The Indian Hemp (Amendment) Decree reinstated other stiff penalties for drug-related offences, the Special Tribunal (Miscellaneous Offences) Decree of 1984 stipulated death penalty by firing squad for 'dealing in, buying, selling, exposing or offering for sale or inducing any person to buy, sell, smoke or inhale the drug known as cocaine or other similar drug' (Federal Military Government, 1984; in Obot 2004). Enacted in July 1984, the decree took a retroactive effect beginning from 31 December 1983 (the day the new government took over power). Three young men arrested for trafficking in cocaine and heroin before the decree was enacted were convicted and executed by firing squad in line with the provisions of the decree. The death penalty was again repealed and replaced with life imprisonment by the Special Tribunal (Miscellaneous Offences) (Amendment) Decree of 1986.

The NDLEA and drugs control

From 1966 when the first legislation on psychoactive substances in post-colonial Nigeria came into effect, the government has waged a relentless war against drugs with the aim of 'exterminating illicit drug trafficking and consumption in Nigerian society'. In 1989, the National Drug Law Enforcement Agency (NDLEA) was established to co-ordinate drug control activity in Nigeria, in response to the 1988 United Nations Convention against Illicit Trafficking in Narcotic Drugs and Psychotropic Substances. The agency adopts a military approach to the drug problem with a focus on the interdiction of drug consignments in airports and seaports, eradication of narcotic crop cultivation and arrest and prosecution of drug offenders, including drug users. But the apparent success of drug control, measured in terms of arrests figures and drug seizures, is achieved at the cost of public health and civil liberties.

The NDLEA is a paramilitary establishment and its mandate is to 'enforce laws against the cultivation, processing, sales, trafficking and use of hard drugs'. The agency has 18 functions including investigating drug offences, arrest and prosecution of drug offenders, confiscation and/or seizure of the property or proceeds of drug-related offences, eradication of illicit cultivation of narcotic plants and interdicting drugs at air and seaports among others. Only 2 of the 18 functions relate to drug demand reduction. This disparity underscores the fact that the NDLEA is primarily a law enforcement agency.

The NDLEA Decree stipulates prison terms ranging from 15 to 25 years and huge financial fines for drug offenders in order to cripple drug offenders financially and curtail further involvement in drug-related crimes. The Decree also provides that any organisation colluding with offenders to perpetrate a drug offence or to conceal proceeds from illicit drug trade is liable on conviction to a term of 25 years imprisonment or two million Naira fine. Other measures adopted in dealing with drug offences are contained in the National Drug Law Enforcement (Amendment) Decree No 33 of 1990, which prescribes a jail term of five years for persons caught abroad for trafficking in drugs through Nigeria.

The NDLEA has been successful judging by conventional standards of drug prohibition. For example, in 2008 Nigeria was certified by the United States for the eight successive times. The country has been lauded for its progress in counter narcotics and for effective co-operation with the US in tackling drug-related crimes and money laundering in West Africa. Measured in terms of output indicators such as rates of arrests and drug seizure, the NDLEA has been successful. But the impact of the agency's operations on the availability and consumption of illicit drugs has been marginal. The very psychoactive substances which the NDLEA fights relentlessly to counter are still widely available in the country and are used by the population with attendant health and socio-economic problems.

Drug law enforcement activities, which satisfies the requirements of Nigeria's foreign partners and international organisations such as the United Nations Office on Drugs and Crime (UNODC) and the International Narcotics Control Board (INCB), masks the gruesome reality of a growing problem of drug consumption and dependence in the population. Treatment and rehabilitation services for drug dependent persons are almost non-existent. Drug users make up a sizeable proportion of the prison population.

A balanced response to drug problems

Drug control in Nigeria has been driven by the need to maintain a good relationship with international partners and to sustain public order at home. It is informed by moral panic arising from the ways drugs are portrayed, especially in the media. Psychoactive substances are portrayed as a problem because they promote social instability and criminality, compromise security and damage the image of the country. The need to stem the problems associated with drugs by combating drug trafficking has justified overzealous law enforcement activities. Drug problems are generically defined as criminal offences subject to generalised and severe penalties.

However, fulfilling international obligations and maintaining the law do not have to be instituted at the expense of effective demand reduction and treatment. The United Nations General Assembly in its 2016 special session on global drug problems (UNGASS 2016) highlighted the need for treatment as well as the need to reduce the physical and social harm caused by drug use, recognising that the emphasis on the efforts to control illicit drugs through law enforcement has lead away from policies to tackle the medical and social consequences of drug use. This is a break from the previous emphases on drug control by UNODC and other UN agencies.

As stated earlier, law enforcement has had little effects on availability and use of illicit drugs. The availability of illicit drugs in the local market has increased even as figures of arrests and seizures of drugs increases. Law enforcement increases the risk of trading in drugs, which contributes to increase in the price of drugs and this makes the trade very lucrative. Furthermore, law enforcement activities only succeed in dislodging drug users from the streets into 'adopting more dangerous practices – stronger drugs replace moderate drugs, consumption moves to riskier settings where social controls are weak, and more dangerous methods of administration (smoking crack as opposed to snorting cocaine) are adopted' (Klein 2011: 65).

Furthermore, law enforcement progressively worsens the human rights status of drug users. Klein has argued that 'a drug user stands to suffer far greater harm from arrest, interrogation, imprisonment and a criminal record than he or she would have from using the drug' (Ibid, 65). The problems which drug users face are compounded by limited access to treatment services. But these issues hardly register in drug policy discussions, which continuously dwell on how to improve effectiveness of countering drug trafficking.

As Klantschnig has pointed out:

> *International concerns about drugs in West Africa have focused overwhelmingly on the growing transit trade in cocaine, while drug use, treatment and the evidence-base of policy in West Africa have largely been ignored. Recent African policy initiatives addressing these neglected areas should therefore be strongly supported… anti-drug campaigns, fought most fiercely in the mid-1980s and 1990s and, to some degree, continuing up to today, have left many Nigerians harassed, arrested and incarcerated. Further, drug users in need of treatment have few options for professional help* (Klantschnig 2013, pp 1871–72).

Drug control in West Africa has long been skewed towards supply reduction rather than treatment (Asare and Obot 2013). Demand reduction refers to all activities aimed at reducing the demand for drugs, from prevention, treatment and supply reduction. Governments have tended to focus on awareness campaigns which show little evidence of curbing demand (Babor et al. 2010). Demand reduction needs to include treatment so that there will be a smaller market for drugs. Public health policy should include disease reduction and prevention measures which were demonstrated to have reduced the transmission of HIV and other diseases elsewhere in the world, more than 20 years ago (e.g. Stimson 1996).

What is currently available in Nigeria?

Treatment services for drug users are very limited and vary according to the part of the country where the need is. Onifade et al. (2011) surveyed treatment services in Nigeria and found that there was no current data on substance treatment demand and treatment facilities. A rapid situation assessment was undertaken in 1998 by The United Nations International Drug Control Program (UNDCP) covering 22 states in Nigeria in all of the 6 geopolitical zones in the country. The study found that treatment facilities existed in all of the 22 states assessed but usually as part of psychiatric, general or university teaching hospitals. There were also traditional and religious facilities for substance abuse treatment and rehabilitation. Thirty-one units dedicated to the treatment of substance misuse in Nigeria were identified. Although this was nearly 20 years ago, little seems to have changed.

Asare and Obot (2013) emphasise that treatment covers a wide range of services (with varying records of effectiveness) and that residential services are not the only option. But many of these services are not available in West Africa where they are needed. Many services that are available are aimed at people with mental health problems, and in some areas traditional and faith based facilities provide treatment but often with little regulation and reputation for abusive and inhumane practices.

A report published in 2004 by UNODC identified 72 centres, many of which were psychiatric facilities but not necessarily substance abuse treatment facilities, only 14 of these 72 centres were identified as suitable for capacity building and the distribution of these centres was skewed towards the South West geopolitical zone, with a share of nearly 50%. There was report of poor access to treatment for people living in the Northern region. Adelekan and Lawal (2006) reported that traditional healing homes were an

available form of treatment in the country but only 3.3% - 24.8% (depending on the region) had access to any form of substance use treatment.

The statistics on treatment facilities are not current and the situation may have improved. But it is clear that not only are facilities inadequate for the scope of the problem, but also access is difficult and many are facilities are situated in psychiatric centres. What are needed are local community services across the country with trained staff, cost-effective and sufficiently local to be accessible.

What is needed?

Pates and Obot (2014) suggested a model of training a number of NGO agencies in brief interventions and establishing a network of treatment agencies throughout the country. This is a model that has been taken up by UNODC and has begun a series of training programmes aimed at providing local services across the country. This was not intended to replace other effective treatment services but an attempt to describe the possible establishment of grass root services where nothing exists both in major urban areas and rural areas. It is also clear that this is primary care intervention and cannot deal with the most serious problems or where there may be co-occurring mental health problems. In these cases it is hoped that trained staff can work with existing skilled staff.

Ideally a full system with three tiers of intervention, primary (at local level in local facilities), secondary (specialist ambulant treatment services) and tertiary (residential detoxification and rehabilitation) facilities would be developed across the country. Services should be available throughout the country, available at a community level with good access for potential clients. These should include opiate substitution programmes where opiate use is prevalent and also harm reduction measures such as needle exchange which have been shown to be important in reducing the risk of the spread of HIV spread (Stimson 1996, op. cit.). Effective prevention programmes should also be introduced carrying realistic messages and protective measures. It is also important to try to reduce the stigma of female drug users who are heavily stigmatised in Nigeria and because of this experience a much higher risk of contracting HIV and other blood borne diseases.

If drug use continues to increase with a concomitant increase in injecting, the potential for the parenteral transmission of other blood borne diseases such as malaria, Ebola, Zika fever and Lassa fever (Pates and Pates in preparation) may become a greater complicating factor in the disease burden for Nigeria. These services cannot be introduced immediately as they will involve substantial funding, establishment of facilities and training of staff. At a time when the Nigerian economy is suffering from the fall in global oil prices, corruption administrative structures in Nigeria and the insecurity in the northern of the country through the activities of Boko Haram, it is a difficult equation to balance. However, Nigeria is potentially one of the richest countries in Africa and the risk of ignoring the need for services will in the long term be much more expensive both in the financial burden of treatment but also in terms of human lives.

Conclusions

There needs to be a change from an emphasis on law enforcement to a policy that includes the need for treatment and harm reduction services. As earlier pointed out, the NDLEA cannot effectively combine the functions of drug supply control with those of drug demand reduction without prioritising the former above the latter. Perhaps a new agency should be established to co-ordinate DDR activities with an emphasis on treatment and harm reduction. This will bring about the needed balance between supply control and demand reduction. Such a balanced approach present potentials for containing drug problems in Nigeria. It also has economic consequences as the cost burden of disease such as HIV and hepatitis and other blood borne diseases is much greater than the cost of providing basic treatment and harm reduction measures. It would also give Nigeria the opportunity to become a model for effective treatment services in West Africa.

Disclosure statement

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