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DRUG USE IN NIGERIA

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Drug Use in Nigeria 2018



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PREFACE

The National Survey on Drug Use and Health was conducted by the National Bureau of Statistics (NBS) and the Centre for Research and Information on Substance Abuse (CRISA) with technical support from the United Nations Office on Drugs and Crime (UNODC). It was funded by the European Union (EU) under the 10th European Development Fund (EDF) as part of the UNODC implemented project, “Response to Drugs and Related Organised Crime in Nigeria”. The project aims to support Nigeria in fighting drug production, trafficking and use and improved access to quality drug prevention, treatment and care services in Nigeria.

This is the first comprehensive nationwide national drug use survey to be conducted in Nigeria. The survey has three components; the first is the National Household Survey on Drug Use and Health (NHSDUH) conducted by NBS; the second aspect is the National Survey on Problem Drug Use (NSPDU) and the third aspect is the Key Informant Survey (KIS). The NSPDU and KIS were conducted by CRISA. The three aspects of the survey cover all 36 states of the Federation, as well as the Federal Capital Territory. During the National Household Survey, 38,850 households that spread across rural and urban areas were canvassed at respondents’ residences. Additionally, the NSPDU involved interviews with a total of 9,344 problem drug users across all 36 states of the Federation, as well as the Federal Capital Territory. A total of 2,787 persons were interviewed for the KIS.

The survey provides statistically-sound and policy-relevant data on the extent and pattern of drug use in Nigeria, the socio-demographic characteristics of drug users, their living conditions and other information such as gender, age, marital status, education and employment status. It also provides information on age of onset of drug use, frequency and pattern of use, high risk drug use as well as extent of drugs use, drug dependency, and sexual behavior among drug users. This report provides evidence for policy makers, both in government and outside government working in drug and crime control to inform the strategies and policies for drug control, especially on drug treatment responses and eventually in care access to drug treatment and reduce such habits among Nigerians. Information

from this survey will also serve as baseline data for tracking the Sustainable Development Goals (SDGs) in Nigeria, specifically Goal 3 to “ensure healthy lives and promote well-being for all at all ages” and Target 3.5 to strengthen prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol.

It is our sincere hope and expectation that the results and the dataset from this survey will be used by the public most especially the policy-makers, planners, researchers, development partners and Non-Governmental Organisations (NGOs) to formulate and monitor policies, programmes and strategies that help to develop targeted services for drug users and their families, with a focus on affordable easily accessible community-based approaches that will increase access to services for this under-served population and go a long way in addressing the issue of drug use in communities across the country.

We would like to convey the gratitude of the Federal Ministry of Health and the National Bureau of Statistics to all respondents across the country that provided us with useful information on a rather sensitive topic. Be assured that your information was handled with strict confidentiality as required by the statistical law in Nigeria (Federal Republic of Nigeria Official Gazette, No. 60 Vol. 94: Act No. 9 Title: The Statistics Act, 2007) and as per the ethical clearance received from the National Health Research Committee of Nigeria (NHREC). We also like to appreciate all staff of NBS and CRISA involved in this exercise, particularly the field staff across the country, for their dedication and hard work towards the successful completion of the survey. This is certainly another feat in the ongoing improvements being recorded in the statistical system, and your efforts and hard work is duly acknowledged.

The survey was strictly monitored for quality control by internal NBS staff. In addition, there was external quality control and monitoring provided by the The Market Research Consultancy Ltd. (MRC) and members of the Technical Working Group representing various government ministries, departments, agencies and experts. Their hard work and commitment is duly acknowledged.

Finally, we acknowledge the support of the European Union to Nigeria, especially in the area of strengthening the drug control responses in the country. We extend our sincere appreciation to the United Nations Office on Drugs and Crime for its support in taking forward a balanced, human-rights and evidence-based approach to drug control in Nigeria and for their support in conceptualising and implementing the survey.

We would like to particularly acknowledge and appreciate the hard work and commitment of all Ministries, Departments and Agencies (MDAs) of government as well as NGOs who served as members of National Steering and Technical Committees for their valuable inputs and support throughout phases of the survey. Your contributions and commitment to a successful implementation of this survey is appreciated and has made the publication of this report possible.



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ABBREVIATIONS AND ACRONYMS

| | |
|-----------------|--|
| ADD | Attention Deficit Disorder |
| ADHD | Attention Deficit Hyperactivity Disorder |
| CI | Confidence Interval |
| CRISA | Centre for Research and Information on Substance Abuse |
| CSNetSDA | Civil Society Network on Substance and Drug Abuse |
| CSOs | Civil Society Organizations |
| EA | Enumeration Area |
| EFCC | Economic and Financial Crimes Commission |
| FCT | Federal Capital Territory |
| FMOH | Federal Ministry of Health |
| GDP | Gross Domestic Product |
| HIV | Human immunodeficiency virus |
| HRDU | High-risk drug user |
| ICD | International Classification of Disease, WHO |
| IMC | Inter-Ministerial Committee on Drug Control |
| MBM | Multiplier Benchmark Method |
| MDMA | 3,4-Methylenedioxymethamphetamine |
| LSD | Lysergic acid diethylamide |
| MS | Master sample |
| N | Number |
| NCS | Nigerian Customs Service |
| NDCMP | National Drug Control Master Plan |
| NDLEA | National Drug Law Enforcement Agency |
| NENDU | Nigerian Epidemiological Network on Drug Use |
| NGN | Nigerian Naira (currency) |
| NGO | Non-governmental organization |
| NHSDUH | National Household Survey on Drug Use and Health |
| NIS | Nigerian Immigration Service |
| NISH | National Integrated Survey of Households |
| NNDDR | NGO Network on Drug Demand Reduction |
| NPopC | National Population Commission |
| NPF | Nigerian Police Force |
| NSUM | Network Scale-up Method |
| OTC | Over-the-counter |
| PDM | Prescription Drug Misuse |
| PSU | Primary Sampling Unit |
| PWID | People Who Inject Drugs |
| SDS | Severity of dependence scale |
| SSU | Secondary Sampling Unit |
| TB | Tuberculosis |
| UN | United Nations |
| UNODC | United Nations Office on Drugs and Crime |
| USD | United States Dollar |
| WHO | World Health Organization |

EXECUTIVE SUMMARY

This report presents the results of the first large-scale, nation-wide survey to examine the extent and patterns of drug use in Nigeria. The results of this survey aim to provide the baseline information needed for the design and implementation of effective prevention, treatment and care services that are evidence-based and targeted to reduce the demand for drugs and prevent the morbidity and mortality attributable to drug use in Nigeria.



ONE OF FOUR
drug users, is a woman

The results of this survey highlight a considerable level of past-year use of psychoactive substances in Nigeria, in particular the use of cannabis, the non-medical use of prescription opioids (mainly tramadol, and to lesser extent codeine, or morphine) and cough syrups (containing codeine or dextromethorphan).

The past year prevalence of any drug use in Nigeria is estimated at 14.4 per cent or 14.3 million people aged between 15 and 64 years. The extent of drug use in Nigeria is comparatively high when compared with the 2016 global annual prevalence of any drug use of 5.6 per cent among the adult population.¹ The past year prevalence of

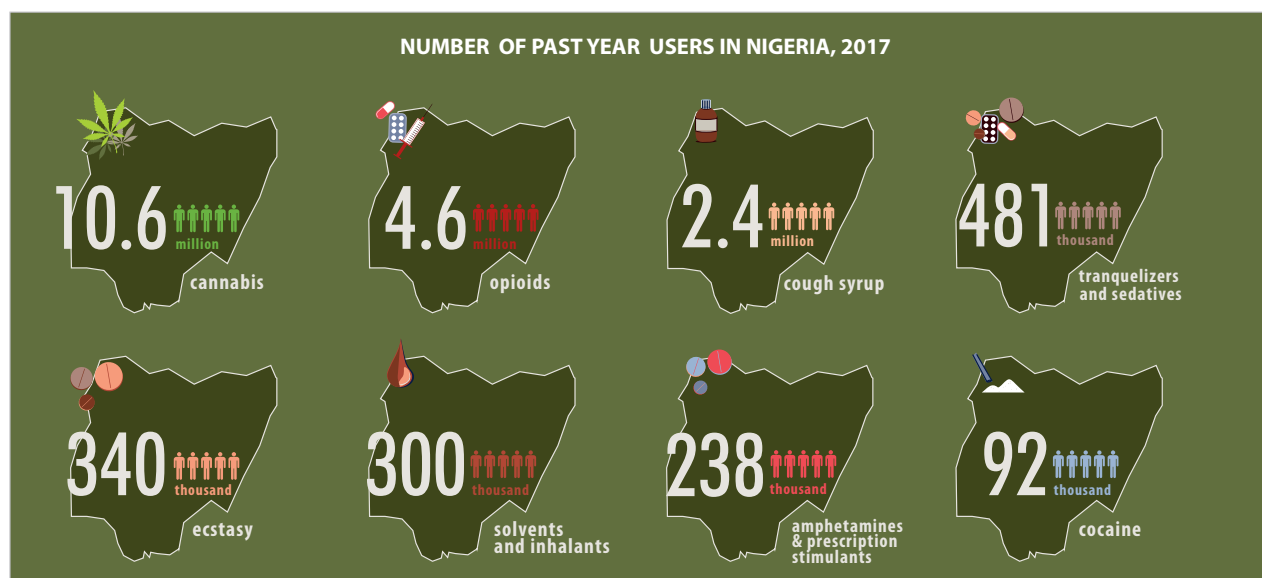
psychoactive substances excluding alcohol, overall was higher among men in Nigeria, however the gender difference in the non-medical use of prescription opioids, tranquilizers and cough syrups was less marked. Drug use was most common among those who were between the ages of 25 and 39 years, while the rates of past year use were lowest among those who were below 24 years of age. Cannabis was the most commonly used drug followed by opioids, mainly the non-medical use of prescription opioids and cough syrup.

A dichotomy in the past year prevalence of drug use was found between the North and South geopolitical zones. Highest past-year prevalence of drug use was found in the southern political zones: South-East, South-West, and South-South zones (past year prevalence ranging between 13.8–22.4 per cent of the population) compared to the North (ranging between 10–14.9 per cent of the population).

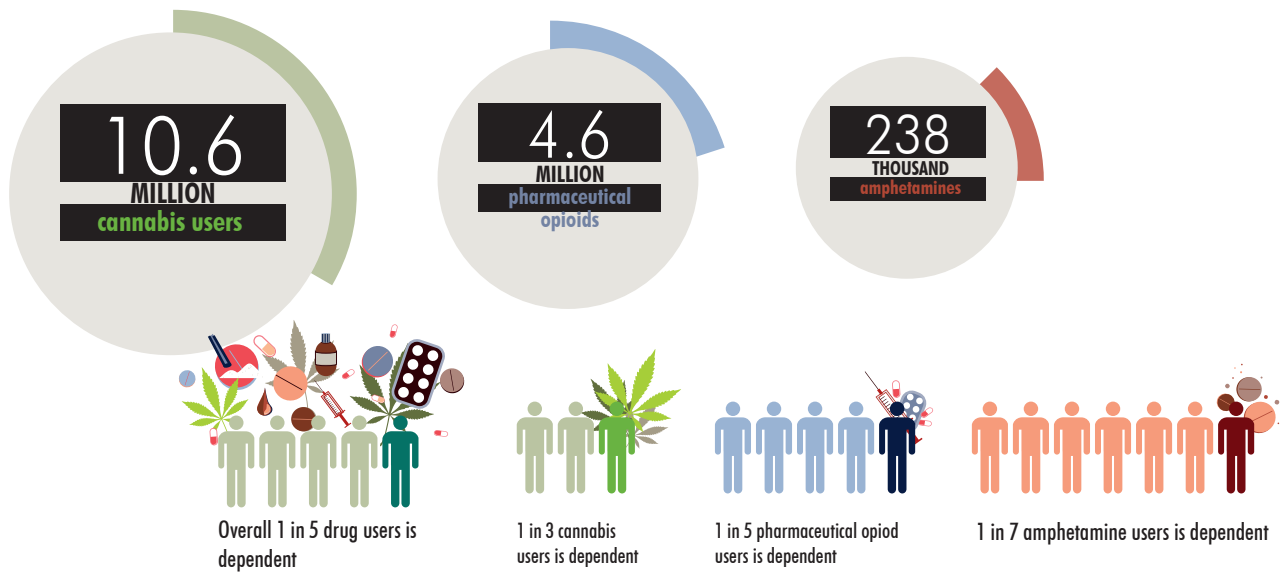
376 thousand high risk drug users



ONE OF FIVE high risk drug users, **injects** drugs (80,000 users inject drugs in Nigeria)



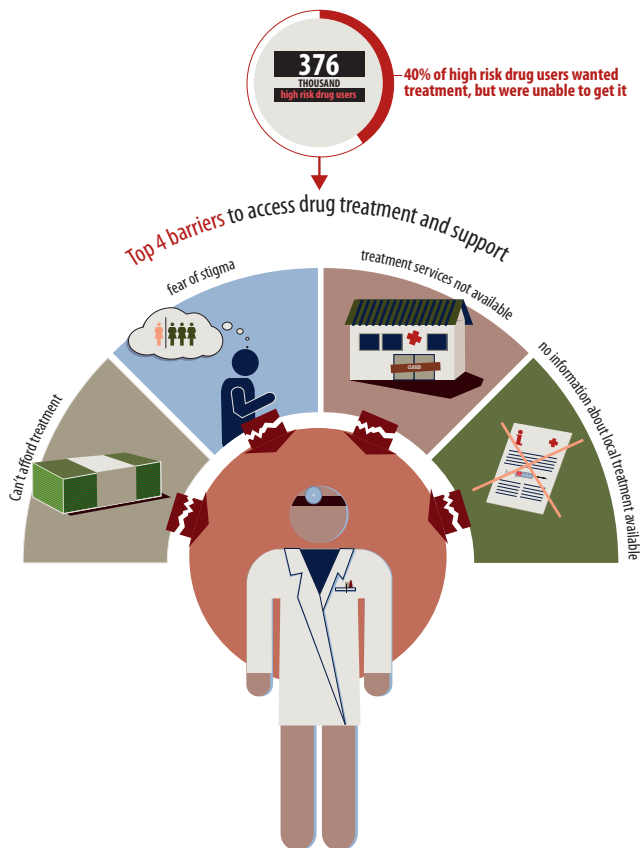
¹ UNODC, *World Drug Report 2018*.



People who inject drugs constitute a sizeable proportion of high risk drug users in Nigeria. 1 in 5 high risk drug users is injecting drugs. The most common drugs injected in the past year were pharmaceutical opioids, followed by cocaine and heroin. While overall, more men were injecting drugs, women were more likely than men to report injecting heroin. The extent of risky injecting practices and sexual behaviours among the high risk drug users and in particular those who inject drugs is also of concern as

is the extent of self-reported HIV among this group. Women who injected drugs were more likely than men to engage in high-risk sexual behaviours further compounding their risk for acquiring HIV among other infections.

There is a clear gap in meeting the needs for treatment and care for people with drug use disorders. Two-thirds of high-risk drug users reported a self-perceived need for drug treatment. Around 40 per cent among those reported that they had wanted to receive drug treatment but were unable to access such services. The cost of treatment, stigma associated with accessing such services as well as stigma associated with substance use in general, and availability of adequate drug treatment services were the major barriers in accessing drug treatment in Nigeria.



Past-year users of tranquilizers, heroin and methamphetamine were more likely to report chronic health conditions and poorer health status as compared with other drug users or the general population. Access to services to reduce the adverse consequences of drug use was also limited. Less than half of the high risk drug users had received HIV testing and counselling while in treatment. While this proportion was higher among women, it was lower among those injecting compared to all high-risk drug users. Only 12 per cent of the high risk drug users reported referral to anti-retroviral therapy.

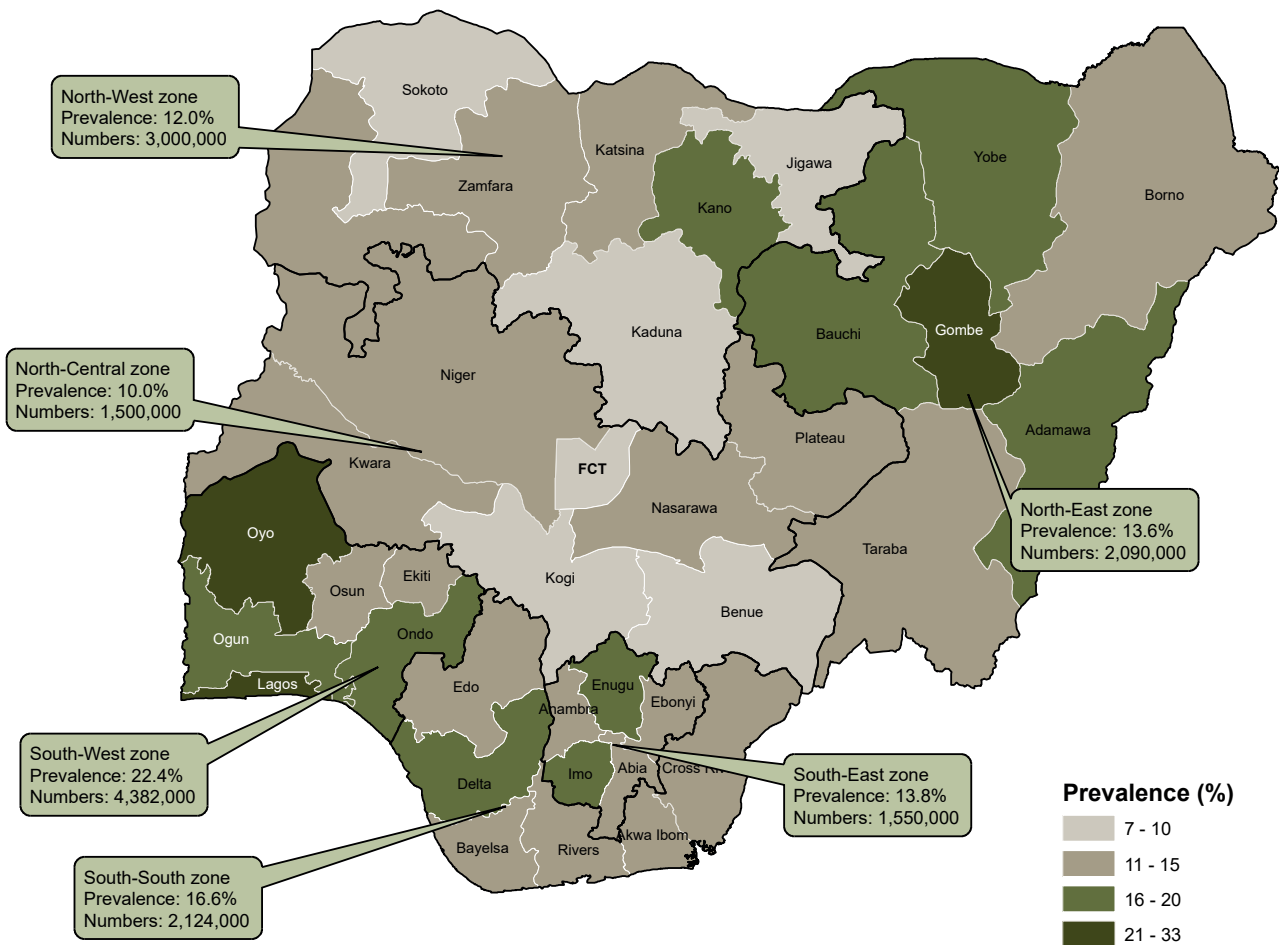
Nearly one quarter of high-risk drug users had been arrested for a drug-related offence during the course of their drug use, while the majority (73 per cent) had been arrested for possession of drugs, many high risk drug users had also been arrested for burglary, sex work, shoplifting and theft.

The social consequences of drug use are also evident in Nigeria. Key informants considered that there were major social problems such as disruption in family lives, loss in productivity and legal problems as a consequence of drug use in their communities. Also, nearly 1 in 8 persons in the general population had experienced consequences due to other peoples' drug use in their families, workplace and communities.



1 out of 7 have used drugs in the past year (aged 15-64)

Prevalence of drug use in Nigeria by geopolitical zones and states, 2017



Note: The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations.

KEY FINDINGS

- In Nigeria, one in seven persons aged 15-64 years had used a drug (other than tobacco and alcohol) in the past year. The past year prevalence of any drug use is estimated at 14.4 per cent (range 14.0 per cent - 14.8 per cent), corresponding to 14.3 million people aged 15-64 years who had used a psychoactive substance in the past year for non-medical purposes.
- Among every 4 drug users in Nigeria 1 is a woman. More men (annual prevalence of 21.8 per cent or 10.8 million men) than women (annual prevalence of 7.0 per cent or 3.4 million women) reported past-year drug use in Nigeria.
- The highest levels of any past-year drug use was among those aged 25-39 years.
- 1 in 5 person who had used drugs in the past year is suffering from drug user disorders².
- Cannabis is the most commonly used drug. An estimated 10.8 per cent per cent of the population or 10.6 million people, had used cannabis in the past year. The average age of initiation of cannabis use among the general population was 19 years.
- Cannabis use was 7 times higher among men (18.8 per cent among men vs. 2.6 per cent of women), while the gender gap in the non-medical use of pharmaceutical opioids (such as tramadol) was less marked (6 per cent among men vs. 3.3 per cent among women).
- An estimated 4.7 per cent of the population, i.e. 4.6 million people had used opioids (such as tramadol, codeine, or morphine) for non-medical purposes in the past year.
- The non-medical use of cough syrups containing codeine and dextromethorphan is estimated at 2.4 per cent of the adult population (nearly 2.4 million people). The misuse of cough syrups is almost comparable among men (2.3 per cent) and women (2.5 per cent).
- The non-medical use of tranquilizers (0.5 per cent), and the use of ecstasy (0.3 per cent), inhalants (0.3 per cent) amphetamines (0.2 per cent) and cocaine (0.1 per cent) though not insignificant remains lower than the drugs mentioned earlier.

2 Substance or drug use disorders — the Diagnostic and Statistical Manual of Mental Disorders (fifth edition) of the American Psychiatric Association also refers to “drug or substance use disorder” as patterns of symptoms resulting from the use of a substance despite experiencing problems as a result of using substances. Depending on the number of symptoms identified, substance use disorder may vary from moderate to severe. People with drug use disorders need treatment, health and social care and rehabilitation. Harmful use of substances and dependence are features of drug use disorders.

- Overall, an estimated 376,000 were estimated to be high risk drug users.³ The majority of high risk drug users were regular users of opioids.
- 1 in 5 high-risk drug users injects drugs, i.e., nearly 80,000 people (nearly 0.1 per cent of the adult population) are estimated to be PWID. The majority (78 per cent) of those injecting drugs were men. The most common drugs injected in the past year were pharmaceutical opioids (such as tramadol, codeine, or morphine), followed by cocaine, heroin and tranquilizers.
- Poly-drug use was very common - among high-risk drug users nearly all (95 per cent) as compared to nearly half of the drug users in the general population reported using either simultaneously or concurrently more than one drug in the past year.
- An estimated 87,000 (nearly 0.1 per cent of the population) had used heroin in the past year. The mean age of initiation of heroin use was 22 years, and almost half of regular heroin users reported smoking it. Proportionally more women than men, were likely to report injecting heroin.
- Geographically, the highest past-year prevalence of drug use was found in the southern geopolitical zones (past year prevalence ranging between 13.8 per cent and 22.4 per cent) compared to the northern geopolitical zones (past year prevalence ranging between 10 per cent and 13.6 per cent).
- Nearly 40 per cent of high-risk drug users indicated a need for treatment of drug use disorders. Most of the high-risk drug users considered it was difficult to access drug treatment. The cost of treatment and stigma attached to drug use and seeking treatment were cited as the primary barriers in accessing or availing drug treatment services.
- Yobe, Imo, Bayelsa, Rivers and Lagos States were ranked as “the states where it was more difficult to access treatment for drug use disorders”.
- Nearly one quarter of high-risk drug users had been arrested for a drug-related offence during the course of their drug use, while the majority (73 per cent) had been arrested for possession of drugs, many high-risk drug users had also been arrested for theft (12 per cent), sex work (5 per cent), burglary (4 per cent) and shoplifting (2 per cent).
- Two-thirds of people who used drugs reported having serious problems, as result of their drug use, such as missing school or work, doing a poor job at work/school or neglecting their family or children.

3 For the purpose of this survey, high-risk drug users were defined as those who had used opioids, crack/cocaine or amphetamines in the past 12 months as well as used for at least 5 times in the past thirty days.

- Nearly 1 in 8 persons (12 per cent of the adult population) in Nigeria has suffered some kind of consequence due to another person's drug use. Among those who had experienced any consequences, most had felt threatened or afraid of someone's use of drugs (8 per cent of the adult population). Other important conse-

quences that people had experienced were that someone using drugs had harmed them physically (5 per cent of the adult population) or that they had stopped seeing a relative or friend due to their drug use (5 per cent of the adult population).

Annual prevalence of drug use by gender in Nigeria, 2017

| | Men | | Women | | National | |
|---|----------------------|-------------------|----------------------|-------------------|----------------------|-------------------|
| | Estimated prevalence | Estimated number* | Estimated prevalence | Estimated number* | Estimated prevalence | Estimated number* |
| Any drug use | 21.8 | 10,850,000 | 7.0 | 3,430,000 | 14.4 | 14,300,000 |
| High-risk drug use | 0.6 | 319,000 | 0.12 | 57,000 | 0.4 | 376,000 |
| People who inject drugs | 0.12 | 61,000 | 0.04 | 18,000 | 0.08 | 80,000 |
| By drug type | | | | | | |
| Cannabis | 18.8 | 9,360,000 | 2.6 | 1,280,000 | 10.8 | 10,640,000 |
| Opioids | 6.0 | 3,010,000 | 3.3 | 1,606,000 | 4.7 | 4,610,000 |
| <i>Heroin</i> | 0.1 | 71,000 | 0.03 | 16,000 | 0.1 | 87,000 |
| <i>Pharmaceutical opioids (tramadol, codeine, morphine)</i> | 6.0 | 3,008,000 | 3.3 | 1,600,000 | 4.7 | 4,608,000 |
| Cocaine | 0.1 | 71,000 | 0.04 | 21,000 | 0.1 | 92,000 |
| Tranquilizers/sedatives | 0.5 | 270,000 | 0.4 | 212,000 | 0.5 | 481,000 |
| Amphetamines | 0.3 | 161,000 | 0.2 | 77,000 | 0.2 | 238,000 |
| <i>Pharmaceutical amphetamine and illicit amphetamine</i> | 0.2 | 96,400 | 0.1 | 58,100 | 0.2 | 155,000 |
| <i>Methamphetamine</i> | 0.1 | 69,500 | 0.04 | 19,000 | 0.1 | 89,000 |
| Ecstasy | 0.4 | 211,000 | 0.3 | 129,000 | 0.3 | 340,000 |
| Hallucinogens | 0.03 | 16,500 | 0.02 | 10,000 | 0.03 | 27,000 |
| Solvents/inhalants | 0.5 | 248,000 | 0.1 | 51,000 | 0.3 | 300,000 |
| Cough syrups | 2.3 | 1,157,000 | 2.5 | 1,200,000 | 2.4 | 2,360,000 |

* Aggregated categories were adjusted for the proportion of users known to be poly-drug users weighted by poly-drug use in each survey (nationally 75 per cent of users were poly-drug users). Gender-specific poly-drug user adjustments were also applied to drug use categories of opioids and amphetamines. As a result, numbers for each drug type will not sum to national totals. Due to rounding of the estimates (percentage or numbers) the estimates may not add up.

THE WAY FORWARD

The 2030 Agenda for Sustainable Development and its goals affirm that “there can be no sustainable development without peace and no peace without sustainable development”. This draws together the strands of peace, rule of law, human rights, development and equality to form a comprehensive and forward-looking framework. Addressing the drug problems in Nigeria and the efforts to achieve the Sustainable Development Goals are thus complementary and mutually reinforcing.

The findings from the drug use survey provide the evidence to inform the national debate among policy makers and other stakeholders for reviewing and updating the current National Drug Control Master Plan as well as for formulating the next Plan covering 2020-2024.

Considering the extent of non-medical use of pharmaceutical opioids, tranquilizers and cough syrups among the adult population, while ensuring that the controlled substances are adequately made available for medical and scientific purposes, it is imperative to address their diversion from licit channels as well as their illicit production or availability in the illicit markets in the form of spurious or fraudulent medicines. The recommendation provided in the outcome document of the UN General Assembly Special Session on Drugs (UNGASS) 2016⁴, as well as other national, UNODC and WHO documents, provide adequate guidance in this regard.^{5, 6, 7, 8}

Programmes for the prevention of drug use, treatment and care of drug use disorders, and prevention and care of HIV, hepatitis C and other infections among high-risk drug users need to be upscaled with a wider geographical coverage of those interventions.

There is a major gap in availability and accessibility of drug treatment services in the country. The cost of treatment itself, limited number of interventions provided and the stigma attached to drug use are major impediments in provision of quality drug treatment services that can cater for a large segment of the drug using population in the

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4 UNODC, *Outcome Document of the 2016 United Nations General Assembly Special Session On The World Drug Problem*, 2016.

5 WHO, *Ensuring balance in national policies on controlled substances: guidance for availability and accessibility of controlled medicine*, ISBN 978 92 4 156417 5.

6 UNODC, *Technical Guidance: Increasing access and availability of controlled medicines*, advanced draft, March 2018.

7 INCB, *Availability of Internationally Controlled Drugs: Ensuring Adequate Access for Medical and Scientific Purposes*, ISBN: 978-92-1-148285-0, 2016.

8 Nigeria, Federal Ministry of Health, *National Policy for Controlled Medicines*, 2017.

country. Therefore, availability, accessibility, and coverage of quality and evidence-based effective treatment and care services for people with drug use disorders are priority to address in Nigeria. The International Standards for the Treatment of Drug Use Disorders were prepared to support Member States in the development and expansion of treatment services that offer effective and ethical drug treatment. The goal of such treatment is to reverse the negative impact that persisting drug use disorders have on the individual and to help them achieve as full recovery as possible from the disorder and to become a productive member of their society. The National Minimum Standards for Drug Dependence Treatment in Nigeria and the National Guidelines for the Treatment of Substance Use Disorders in Nigeria, developed in recent years, based on the International Standards provide adequate guidelines to improve the availability and accessibility of drug treatment services in Nigeria. Another area of consideration is to develop gender-specific treatment programmes that would take into account in their design and delivery of services among other issues, sexual and reproductive health, social welfare, and childcare needs unique to women.

Prevention of drug use aims to help people, not only those of younger age, to avoid or delay the initiation of use of psychoactive substances, or, if they have already started, to avert the development of harmful use and substance use disorders. Effective prevention involves the positive engagement of children, youth and adults with their families, schools, workplace and community. To maximize the utilization of resources for effective and science-based prevention interventions the UNODC International Standards on Drug Use Prevention provide the necessary guidelines. The evidence suggests that among the different prevention programmes, those with a focus on parenting, families, and life skills education at different levels of children's development (i.e. infancy, early and middle childhood, adolescence and adulthood), and their needs are more effective than other interventions. Efforts to support the prevention and treatment of drug use also include providing people who use drugs with the necessary knowledge and skills to prevent overdoses, including through the administration of naloxone.

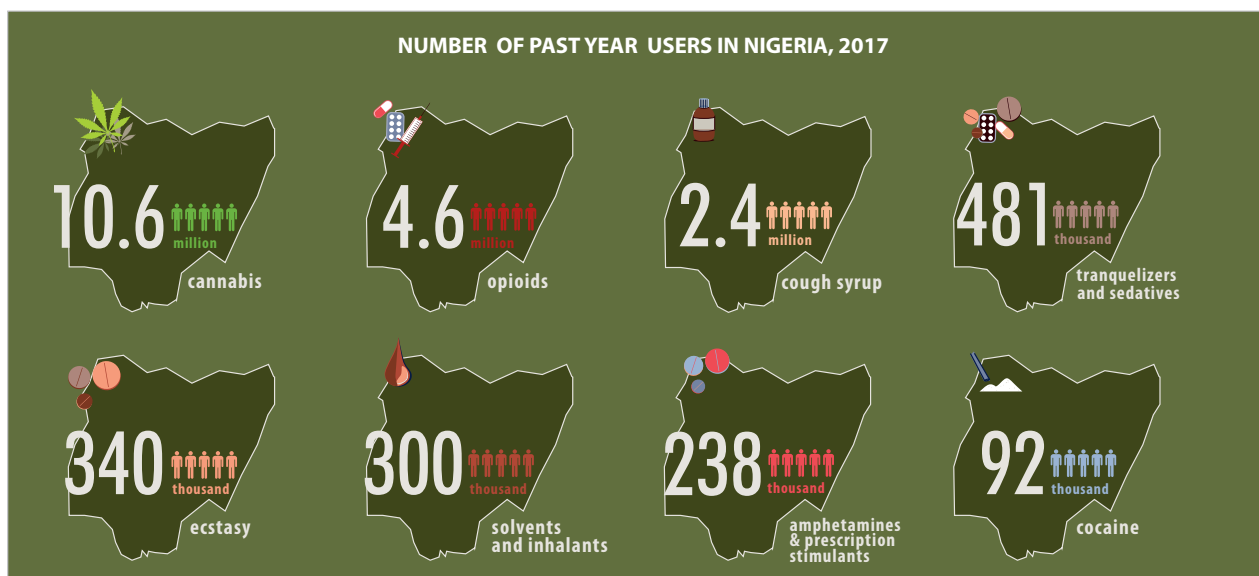
Furthermore, scaling up the coverage and provision of a comprehensive package of services⁹, for prevention, treatment and care of HIV for people who use drugs in the community and in prison settings is another priority area to reduce the burden of disease for people using drugs.

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9 WHO, UNODC, UNAIDS *Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users*, 2012 revisions.

Finally, the drug use survey has provided a comprehensive picture of the extent of drug use and related harms among the adult population in Nigeria. However, there is a need for a mechanism such as the establishment of a drug observatory that can regularly collate data and analyse the drug situation in the country to further inform policy and programme development. The drug observatory could regularly monitor, through established indicators of drug use and supply, the emerging new drug threats, the implementation of regular drug use surveys in the general population and among youth, analysis of patterns of drug use among vulnerable population groups, and the monitoring of the extent and quality of responses to address the drug situation in the country.

1. EXTENT OF DRUG USE IN NIGERIA



An estimated 14.4 per cent (range 14 per cent - 14.8 per cent) of the population in Nigeria¹⁰, or 14.3 million people between 15 and 64 years of age had used drugs, excluding alcohol and tobacco, in 2017. This estimate includes people who had used a drug at least once in the past 12 months as well high-risk drug users.¹¹ The estimates have been adjusted to account for individuals who had used more than one drug, in other words “any drug use” counts individuals only once even if they had used multiple substances in the past year. As a result, the sum of individual drug estimates will add to a number greater than the estimated total. Poly-drug use adjustment was also done for opioids (heroin and pharmaceutical opioids - tramadol, codeine, morphine) and amphetamines (amphetamine and methamphetamine) users, to account for the number of people who used both substances in a class of drugs.

Cannabis was the most widely used substance in the past year in Nigeria, followed by pharmaceutical opioids (mainly tramadol, and to a lesser extent codeine or morphine) and cough syrups containing codeine or dextromethorphan. The information presented in the table on the extent of use of prescription drugs such as

pharmaceutical opioids, tranquilizers/sedatives and amphetamine refers to their use without the advice of a doctor and for reasons other than medical. High-risk drug users¹² were estimated to account for 0.4 per cent of the population (approximately 376,000 people) - nearly 90 per cent of these are opioid users.

Among the high-risk drug users, approximately 80,000 (0.08 per cent of the population aged 15-64) were estimated to be those who injected drugs. This estimate is based on the proportion of high-risk drug users who reported injecting any drug in the past 12 months, and adjusted to the national estimate of high-risk drug users. The majority (75 per cent) of people injecting drugs were injecting opioids.

Poly-drug use

Poly-drug use is a fairly common phenomenon among drug users in Nigeria both in the general population and among high-risk drug users. Nearly all (95 per cent) of the high-risk drug users reported using more than one substance either concurrently or sequentially in the past 12 months¹³. Among drug users in the general population this was lower with 42 per cent of respondents reporting use of more than one substance in the past year¹⁴.

10 Based on the national population estimate of 98,882,000 people aged 15-64 (United Nations, Department of Economic and Social Affairs, Population Division).

11 For the purpose of this survey, high-risk drug users were defined as those who had used opioids, crack/cocaine or amphetamines in the past 12 months as well as used for at least 5 times in the past thirty days.

12 For the purpose of this survey, high-risk drug users were defined as those who had used opioids, crack/cocaine or amphetamines in the past 12 months as well as used for at least 5 times in the past thirty days.

13 Based on a survey of 9,344 respondents.

14 Based on a survey of 38,782 respondents.

TABLE 1 | Annual prevalence of drug use in Nigeria among the population 15-64 years of age, 2017

| | Estimated prevalence (%) [*] | Low estimate (%) | High estimate (%) | Estimate numbers |
|---|---------------------------------------|------------------|-------------------|-------------------|
| Any drug use[*] | 14.4 | 14 | 14.8 | 14,300,000 |
| Cannabis | 10.8 | 10.3 | 11.3 | 10,640,000 |
| Opioids | 4.7 | 4.3 | 5.1 | 4,610,000 |
| <i>Heroin</i> | 0.1 | 0.0001 | 0.2 | 87,000 |
| <i>Pharmaceutical opioids (tramadol, codeine, morphine)</i> | 4.7 | 4.2 | 5.1 | 4,608,000 |
| Cocaine | 0.1 | 0.0001 | 0.2 | 92,000 |
| Tranquilizers/sedatives | 0.5 | 0.0001 | 0.9 | 481,000 |
| Amphetamines | 0.24 | 0.0001 | 0.6 | 238,000 |
| <i>Pharmaceutical amphetamines</i> | 0.16 | 0.0001 | 0.5 | 155,000 |
| <i>Methamphetamine</i> | 0.1 | 0.0001 | 1 | 89,000 |
| Ecstasy | 0.3 | 0.0001 | 1.2 | 340,000 |
| Hallucinogens | 0.03 | 0.0001 | 0.8 | 27,000 |
| Solvents/inhalants | 0.3 | 0.0001 | 1.2 | 300,000 |
| Cough syrups (containing codeine or dextromethorphan) | 2.4 | 1.5 | 3.3 | 2,360,000 |

Source: Based on the national population estimate of 98,882,000 people aged 15-64 (United Nations, Department of Economic and Social Affairs, Population Division).

^{*}Aggregated categories were adjusted for the proportion of users in the total population known to be poly-drug users (75 per cent). Aggregated estimates for categories of opioids and amphetamines were adjusted for the proportion of users known to be poly-drug users. Poly-drug use rates for specific drug categories were determined from the source population of the prevalence estimate (the general population or high-risk drug users).

TABLE 2 | Annual prevalence of high-risk drug use in Nigeria by drug type, 2017

| | Estimated prevalence (%) [*] | Low estimate (%) | High estimate (%) | Estimated numbers |
|---------------------------------------|---------------------------------------|------------------|-------------------|-------------------|
| High-risk drug users | 0.4 | 0.3 | 0.5 | 376,000 |
| People who inject drugs (PWID) | 0.1 | 0.02 | 0.14 | 80,000 |
| Opioids | 0.3 | 0.2 | 0.5 | 336,000 |
| <i>Pharmaceutical opioids</i> | 0.3 | 0.15 | 0.4 | 280,000 |
| <i>Heroin</i> | 0.05 | 0.0001 | 0.14 | 51,000 |
| Cocaine | 0.02 | 0.0001 | 0.05 | 23,000 |
| Amphetamines | 0.02 | 0.0001 | 0.05 | 23,000 |

^{*}High-risk drug use estimates were adjusted for poly-drug use (95 per cent of high-risk drug users). Injecting drug use is a mode of drug administration. The estimated number of people who inject drugs is a subset of the overall estimate of high-risk drug users.

TABLE 3 : Proportion of high-risk drug users who reported using one or more types of drugs

| Number of drugs used in past 12 months | Proportion (%) |
|--|----------------|
| 1 drug type | 5 |
| 2 drug types | 12 |
| 3 drug types | 24 |
| 4 drug types | 28 |
| 5 drug types | 17 |
| 6 drug types | 9 |
| >=7 drug types | 5 |

Nearly half of the high-risk drug users reported using between 3 and 4 different substances in the 12 months prior to this survey. The most commonly reported substances used in combination were cannabis, pharmaceutical opioids (tramadol, codeine, morphine), cough syrups and alcohol. High-risk opioid users who used more than one drug reported using most frequently cannabis, tranquilizers/sedatives, cocaine, alcohol and cough syrups (containing codeine or dextromethorphan) in the past year.

Past year drug users within the general population also reported the same pattern of poly-drug use, a majority of poly-drug users reported using concurrently or sequentially cannabis, pharmaceutical opioids (tramadol, codeine, morphine), cough syrups and tranquilizers.

Extent of drug use by geopolitical zones

Nigeria comprises 37 administrative states within six geopolitical zones: North-East, North-West, North-Central, South-East, South-West and South-South. Roughly three quarters of respondents surveyed within each zone resided in rural areas, with the exception of the South-West zone in which three-quarters of respondents were found to be from urban areas. This is likely a result of Lagos State, which includes the mega-city Lagos, subsumed as part of South-West zone. The survey found higher past-year prevalence of drug use among the southern geopolitical zones (range 13.8 per cent to 22.4 per cent, see subsections below) compared to the northern geopolitical zones (range 10 per cent-13.6 per cent). The high prevalence of drug use in the southern zones is driven primarily by Lagos and Oyo States. Different scientific papers, including a sys-

tematic review, published in peer-reviewed journals have shown an association between reduced risk of substance use and religiosity and/or spirituality¹⁵ - higher religious involvement, private religious practices and religious affiliations have been broadly associated¹⁶ with less use of alcohol, tobacco and other drugs in different cultural settings.¹⁷ Similarly, scientific literature has also documented that urbanization and different characteristics of the urban environment, including collective efficacy such as deprived neighbourhoods, population density and the built environment, may be associated with drug use and misuse.¹⁸ However for Nigeria, it is unclear how the different social, cultural, religious influences and urbanization impact substance use among the general population within these different geo-political zones.

North-Central Zone

The North-Central zone contains Benue, Kogi, Kwara, Nasarawa, Plateau and Niger States and the Federal Capital Territory (FCT) Abuja. The estimated annual prevalence of drug use is 10 per cent in this zone, equivalent to 1.5 million past year drug users. The extent of drug use in the North-Central zone is 30 per cent lower than the overall national past year prevalence of drug use. Cannabis, cough syrups (containing codeine or dextromethorphan) and pharmaceutical opioids (tramadol, codeine, morphine) are the three groups of substance with high prevalence in the North-Central zone.

- 15 Dale D. Chitwoor and others, "A systematic review of recent literature on religiosity and substance use", *Journal of Drug Issues*, vol 38, No. 3 (July 2008), pp 653-688.
- 16 The scientific literature however does not establish any causal relationship or association.
- 17 Giancarlo Lucchetti and others, "Spirituality, religiosity and substance use: Evidence and proposed mechanisms", *Journal of Substance Abuse and Alcoholism*, 2(2): 1016 (2014).
- 18 Sandro Galea, and others, "Drug use, misuse, and the urban environment", *Drug and Alcohol Review*, 23, 127-136 (March 2005).

TABLE 4 : Annual prevalence of drug use by drug type in North-Central zone

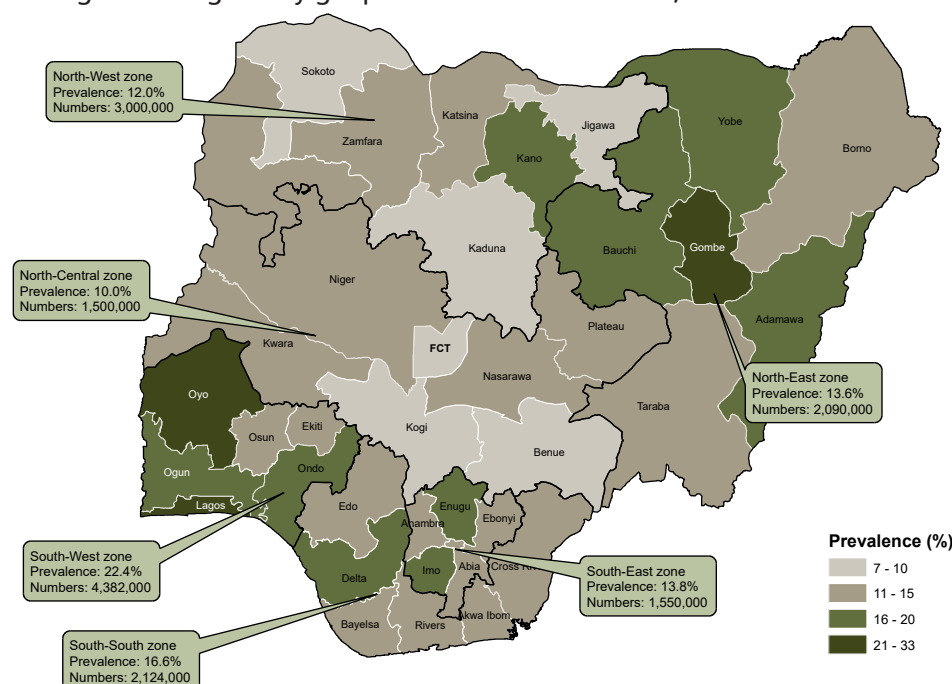
| Drug type/class | Estimated prevalence (%) | Low estimate (%) | High estimate (%) | Estimated numbers* |
|---|--------------------------|------------------|-------------------|--------------------|
| Any drug use | 10.0 | 9.7 | 10.4 | 1,500,000 |
| Cannabis | 8.4 | 7.9 | 8.8 | 1,250,000 |
| Opioids | 1.1 | 0.9 | 1.3 | 164,000 |
| Heroin | 0.02 | <0.0001 | 0.09 | 3,600 |
| Pharmaceutical opioids (tramadol, codeine, morphine) | 1.1 | 0.9 | 1.3 | 160,000 |
| Cocaine | 0.01 | 0.0001 | 0.1 | 1,800 |
| Tranquilizers/sedatives | 0.1 | 0.0001 | 0.3 | 17,000 |
| Amphetamines | 0.1 | 0.0001 | 0.4 | 21,600 |
| Pharmaceutical amphetamines | 0.1 | 0.0001 | 0.3 | 14,500 |
| Methamphetamine | 0.05 | 0.0001 | 0.01 | 7,200 |
| Ecstasy | 0.03 | 0.0001 | 0.3 | 4,600 |
| Hallucinogens | 0.02 | 0.0001 | 0.01 | 2,700 |
| Solvents/inhalants | 0.2 | 0.0001 | 0.9 | 30,400 |
| Cough syrups (containing codeine or dextromethorphan) | 1.4 | 0.7 | 2.1 | 216,000 |

* Based on state population estimates aggregated into geopolitical zones. North-Central population was 14,956,817 people aged 15-64 (United Nations, Department of Economic and Social Affairs, Population Division national estimates of 2016). State-level estimates were adjusted for poly-drug use, and aggregated at the zone level. The estimates have been rounded.

TABLE 5 : Annual prevalence of any drug use by state in North-Central zone

| State | Estimated prevalence (%) | Low estimate (%) | High estimate (%) | Estimated numbers |
|-----------|--------------------------|------------------|-------------------|-------------------|
| Benue | 8.0 | 7.7 | 8.0 | 236,000 |
| Kogi | 9.2 | 8.9 | 9.2 | 212,000 |
| Kwara | 13.0 | 12.7 | 13.0 | 213,000 |
| Nasarawa | 11.8 | 11.4 | 11.8 | 152,000 |
| Niger | 11.6 | 11.2 | 11.6 | 330,000 |
| Plateau | 11.0 | 10.8 | 11.1 | 240,000 |
| FCT Abuja | 10.0 | 9.7 | 1.0 | 180,000 |

Prevalence of drug use in Nigeria by geopolitical zones and states, 2017



Note: The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations.

North-East Zone

The North-East zone includes Adamawa, Bauchi, Borno, Gombe, Taraba and Yobe States. The estimated annual prevalence of drug users in the North-East zone is 13.6 per cent or over 2 million past year users. The overall extent of drug use in the North-East zone is comparable with the national prevalence. However, the prevalence of cannabis

use in the zone is lower than national estimates, whereas the use of opioids (tramadol, codeine, morphine), ecstasy, and non-medical use of cough syrups is higher than the national estimates. Within the North-East zone, the highest prevalence of past year drug use is estimated for the Gombe State (21 per cent of the adult population).

TABLE 6 : Annual prevalence of drug use in North-East zone

| Drug type/class | Estimated prevalence (%) | Low estimate (%) | High estimate (%) | Estimated numbers* |
|---|--------------------------|------------------|-------------------|--------------------|
| Any drug use | 13.6 | 13.2 | 13.9 | 2,090,000 |
| Cannabis | 8.1 | 7.6 | 8.5 | 1,250,000 |
| Opioids | 6.6 | 6.1 | 7.0 | 1,013,000 |
| <i>Heroin</i> | 0.08 | 0.0001 | 0.19 | 12,000 |
| <i>Pharmaceutical opioids (tramadol, codeine, morphine)</i> | 6.5 | 6.0 | 7.0 | 1,000,000 |
| Cocaine | 0.03 | 0.0001 | 0.1 | 1,800 |
| Tranquilizers/sedatives | 0.1 | 0.0001 | 0.3 | 125,500 |
| Amphetamines | 0.4 | 0.0001 | 0.9 | 60,000 |
| <i>Pharmaceutical amphetamines</i> | 0.2 | 0.0001 | 0.6 | 37,000 |
| <i>Methamphetamine</i> | 0.15 | 0.0001 | 0.01 | 23,000 |
| Ecstasy | 0.6 | 0.0001 | 1.8 | 92,000 |
| Hallucinogens | 0.04 | 0.0001 | 0.01 | 6,500 |
| Solvents/inhalants | 0.7 | 0.0001 | 2.1 | 114,000 |
| Cough syrups (containing codeine or dextromethorphan) | 3.0 | 2.0 | 4.0 | 460,000 |

* Based on state population estimates aggregated into geopolitical zones. North-East population was 15,405,601 people aged 15-64 (United Nations, Department of Economic and Social Affairs, Population Division national estimates of 2016). State-level estimates were adjusted for poly-drug use, and aggregated at the zone level. The estimates have been rounded.

TABLE 7 : Annual prevalence of drug use by state in North-East zone

| State | Estimated prevalence (%) | Low estimate (%) | High estimate (%) | Estimated numbers |
|---------|--------------------------|------------------|-------------------|-------------------|
| Adamawa | 17.0 | 17.0 | 17.0 | 370,000 |
| Bauchi | 16.0 | 16.0 | 16.0 | 530,000 |
| Borno | 12.0 | 11.0 | 12.0 | 350,000 |
| Gombe | 21.2 | 20.7 | 21.2 | 350,000 |
| Taraba | 14.0 | 13.0 | 14.0 | 213,000 |
| Yobe | 18.0 | 18.0 | 18.0 | 300,000 |

North-West Zone

The North-West zone includes Jigawa, Kaduna, Kano, Katsina, Kebbi, Sokoto and Zamfara States. At approximately 25 million people in 2016,¹⁹ the zone has the largest population of all the geo-political zones in Nigeria. The prevalence of drug use in the North-West zone is estimated

at 12 per cent of the population or approximately 3 million past year users aged 15-64 years. The use of cannabis and non-medical use of opioids (tramadol, codeine, morphine) and cough syrups (containing codeine or dextromethorphan) are also the most common in this zone.

TABLE 8 | Annual prevalence of drug use in North-West zone

| Drug type/class | Estimated prevalence (%) | Low estimate (%) | High estimate (%) | Estimated numbers |
|---|--------------------------|------------------|-------------------|-------------------|
| Any drug use | 12.0 | 12.0 | 12.3 | 3,000,000 |
| Cannabis | 8.4 | 8.0 | 8.9 | 2,100,000 |
| Opioids | 2.7 | 2.4 | 3.0 | 690,000 |
| <i>Heroin</i> | 0.06 | 0.0001 | 0.16 | 16,000 |
| <i>Pharmaceutical opioids (tramadol, codeine, morphine)</i> | 2.7 | 2.4 | 3.0 | 670,000 |
| Cocaine | 0.02 | 0.0001 | 0.1 | 4,200 |
| Tranquilizers/sedatives | 0.2 | 0.0001 | 0.4 | 42,700 |
| Amphetamines | 0.04 | 0.0001 | 0.2 | 9,300 |
| <i>Pharmaceutical amphetamines</i> | 0.03 | 0.0001 | 0.2 | 7,200 |
| <i>Methamphetamine</i> | 0.01 | 0.0001 | 0.3 | 2,100 |
| Ecstasy | 0.9 | 0.0001 | 2.3 | 215,000 |
| Hallucinogens | 0.04 | 0.0001 | 0.01 | 9,500 |
| Solvents/inhalants | 0.4 | 0.0001 | 1.5 | 110,000 |
| Cough syrups (containing codeine or dextromethorphan) | 1.5 | 0.8 | 2.2 | 373,000 |

TABLE 9 | Annual prevalence of drug use by state in North-West zone

| State | Estimated prevalence (%) | Low estimate (%) | High estimate (%) | Estimated numbers |
|---------|--------------------------|------------------|-------------------|-------------------|
| Jigawa | 7.0 | 6.8 | 7.0 | 211,000 |
| Kaduna | 10.0 | 10.6 | 10.0 | 462,000 |
| Kano | 16.0 | 15.6 | 16.0 | 1,070,000 |
| Katsina | 12.0 | 11.6 | 12.0 | 481,000 |
| Kebbi | 12.6 | 12.2 | 12.6 | 286,000 |
| Sokoto | 9.0 | 8.7 | 9.0 | 230,000 |
| Zamfara | 13.5 | 13.1 | 13.5 | 312,000 |

¹⁹ Based on state population estimates aggregated into geopolitical zones. North-West population was 25,024,304 people aged 15-64 (United Nations, Department of Economic and Social Affairs, Population Division national estimates of 2016). State-level estimates were adjusted for poly-drug use, and aggregated at the zone level.

South-East Zone

The South-East zone comprises Abia, Anambra, Ebonyi, Enugu and Imo States. The past year prevalence of any drug use in the zone is estimated at 13.8 per cent of the population or 1.5 million people aged 15-64. The past year prevalence of cannabis, heroin, cocaine use and non-

medical use of cough syrups (containing codeine or dextromethorphan) in the South-East zone is comparable with the national estimates. Overall, Imo State in the zone has a past year prevalence of any drug use exceeding the national estimates.

TABLE 10 : Annual prevalence of drug use in South-East zone

| Drug type/class | Estimated prevalence (%) | Low estimate (%) | High estimate (%) | Estimated numbers* |
|---|--------------------------|------------------|-------------------|--------------------|
| Any drug use | 13.8 | 13.5 | 14.2 | 1,550,000 |
| Cannabis | 10.9 | 10.4 | 11.4 | 1,226,000 |
| Opioids | 3.2 | 2.9 | 3.5 | 360,000 |
| <i>Heroin</i> | 0.07 | 0.0001 | 0.2 | 7,600 |
| <i>Pharmaceutical opioids (tramadol, codeine, morphine)</i> | 3.1 | 2.8 | 3.5 | 352,000 |
| Cocaine | 0.1 | 0.0001 | 0.2 | 9,000 |
| Tranquilizers/sedatives | 0.5 | 0.1 | 0.8 | 51,000 |
| Amphetamines | 0.2 | 0.0001 | 0.5 | 18,000 |
| <i>Pharmaceutical amphetamines</i> | 0.1 | 0.0001 | 0.4 | 11,000 |
| <i>Methamphetamine</i> | 0.06 | 0.0001 | 0.8 | 6,700 |
| Ecstasy | 0.06 | 0.0001 | 0.4 | 6,700 |
| Hallucinogens | 0.02 | 0.0001 | 0.01 | 2,300 |
| Solvents/inhalants | 0.04 | 0.0001 | 0.4 | 4,600 |
| Cough syrups (containing codeine or dextromethorphan) | 2.7 | 1.7 | 3.6 | 301,000 |

* Based on state population estimates aggregated into geopolitical zones. South-East population was 11,225,849 people aged 15-64 (United Nations, Department of Economic and Social Affairs, Population Division national estimates of 2016). State-level estimates were adjusted for poly-drug use, and aggregated at the zone level.

TABLE 11 : Annual prevalence of drug use by state in South-East zone

| State | Estimated prevalence (%) | Low estimate (%) | High estimate (%) | Estimated numbers |
|---------|--------------------------|------------------|-------------------|-------------------|
| Abia | 11.3 | 11.0 | 11.3 | 216,000 |
| Anambra | 11.2 | 10.9 | 11.2 | 317,000 |
| Ebonyi | 12.8 | 12.4 | 12.8 | 188,000 |
| Enugu | 16.3 | 15.9 | 16.3 | 370,000 |
| Imo | 18.1 | 17.7 | 18.1 | 500,000 |

South-West Zone

The South-West zone comprises Ekiti, Lagos, Ogun, Ondo, Osun and Oyo States. With approximately 6.4 million people aged 15-64 residing in Lagos State, it is the second most populous state in Nigeria. Lagos city itself is an urban mega centre with one of the most populous urban agglomerations. The estimated past year prevalence of any drug use in South-West zone is nearly twice the national prevalence - an estimated 22.4 per cent or 4.38 million people aged 15-64 had used drugs in the past year. The high rates of past year drug use in the zone are driven by the high prevalence in Lagos and Oyo States. The past year prevalence of cannabis use was particularly high in

the zone with an estimated 2.7 million past year users (14 per cent of the adult population), as was opioid use, especially non-medical use of pharmaceutical opioids such as tramadol, codeine, or morphine, as well as the non-medical use of tranquilizers and cough syrups containing codeine or dextromethorphan. Drug use in Lagos and Oyo States is characterized by a high past year prevalence of cannabis use (20.0 and 15.3 per cent respectively), and use of opioids (11.3 and 8.3 per cent respectively). The non-medical use of cough syrups is equally spread over the states in the South-West zone.

TABLE 12 | Annual prevalence of drug use in South-West Zone

| Drug type/class | Estimated prevalence (%) | Low estimate (%) | High estimate (%) | Estimated numbers* |
|---|--------------------------|------------------|-------------------|--------------------|
| Any drug use | 22.4 | 21.9 | 22.9 | 4,382,000 |
| Cannabis | 14.1 | 13.6 | 14.7 | 2,760,000 |
| Opioids | 7.9 | 7.4 | 8.4 | 1,540,000 |
| <i>Heroin</i> | 0.04 | 0.0001 | 0.12 | 8,300 |
| <i>Pharmaceutical opioids (tramadol, codeine, morphine)</i> | 7.8 | 7.3 | 8.4 | 1,530,000 |
| Cocaine | 0.04 | 0.0001 | 0.1 | 7,900 |
| Tranquilizers/sedatives | 1.1 | 0.5 | 1.7 | 207,000 |
| Amphetamines | 0.3 | 0.0001 | 0.7 | 58,500 |
| <i>Pharmaceutical amphetamines</i> | 0.2 | 0.0001 | 0.6 | 40,700 |
| <i>Methamphetamine</i> | 0.1 | 0.0001 | 1.0 | 17,800 |
| Ecstasy | 0.06 | 0.0001 | 0.5 | 12,600 |
| Hallucinogens | 0.01 | 0.0001 | 0.01 | 2,600 |
| Solvents/inhalants | 0.2 | 0.0001 | 0.9 | 36,000 |
| Cough syrups (containing codeine or dextromethorphan) | 3.6 | 2.5 | 4.7 | 700,000 |

* Based on state population estimates aggregated into geopolitical zones. South-West population was 19,561,018 people aged 15-64 (United Nations, Department of Economic and Social Affairs, Population Division national estimates of 2016). State-level estimates were adjusted for poly-drug use, and aggregated at the zone level.

TABLE 13 | Annual prevalence of drug use by state in South-West Zone

| State | Estimated prevalence (%) | Low estimate (%) | High estimate (%) | Estimated numbers |
|-------|--------------------------|------------------|-------------------|-------------------|
| Ekiti | 11.9 | 11.6 | 11.9 | 200,000 |
| Lagos | 33.0 | 32.0 | 33.0 | 2,117,000 |
| Ogun | 17.0 | 16.0 | 17.0 | 440,000 |
| Ondo | 17.0 | 17.0 | 17.0 | 401,000 |
| Osun | 14.0 | 14.0 | 14.0 | 336,000 |
| Oyo | 23.0 | 23.0 | 23.0 | 930,000 |

South-South Zone

Finally, the South-South zone includes the States of Akwa Ibom, Bayelsa, Delta, Edo, Rivers and Cross River. The estimated past year prevalence of any drug use in the South-South zone is almost comparable to the national past year prevalence of any drug use, with 16.6 per cent or 2.1 million people aged 15-64 in the zone estimated to have used any drug in the past year.

Cannabis, pharmaceutical opioids (tramadol, codeine, morphine) and cough syrups containing codeine or dextromethorphan are the main group of substances reportedly used among the population in the South-South zone. Past year cannabis use was slightly higher in the South-South zone, compared to the national annual prevalence of this drug, whereas the non-medical use of pharmaceutical opioids and cough syrups was lower than the national rates.

TABLE 14 | Annual prevalence of drug use in South-South Zone

| Drug type/class | Estimated prevalence (%) | Low estimate (%) | High estimate (%) | Estimated numbers* |
|---|--------------------------|------------------|-------------------|--------------------|
| Any drug use | 16.6 | 16.2 | 17.1 | 2,124,000 |
| Cannabis | 14.8 | 14.2 | 15.3 | 1,883,000 |
| Opioids | 3.3 | 3.0 | 3.7 | 428,000 |
| <i>Heroin</i> | 0.13 | 0.0001 | 0.27 | 16,600 |
| <i>Pharmaceutical opioids (tramadol, codeine, morphine)</i> | 3.2 | 2.8 | 3.6 | 411,000 |
| Cocaine | 0.03 | 0.0001 | 0.1 | 3,300 |
| Tranquilizers/sedatives | 0.3 | 0.0001 | 0.6 | 38,000 |
| Amphetamines | 0.5 | 0.0001 | 1 | 58,900 |
| <i>Pharmaceutical amphetamines</i> | 0.3 | 0.0001 | 0.7 | 34,700 |
| <i>Methamphetamine</i> | 0.18 | 0.0001 | 1.5 | 23,300 |
| Ecstasy | 0.07 | 0.0001 | 0.5 | 9,400 |
| Hallucinogens | 0.02 | 0.0001 | 0.01 | 3,000 |
| Solvents/inhalants | 0.03 | 0.0001 | 0.3 | 3,900 |
| Cough syrups (containing codeine or dextromethorphan) | 2.4 | 1.5 | 3.3 | 307,000 |

* Based on state population estimates aggregated into geopolitical zones. South-South population was 12,763,644 people aged 15-64 (United Nations, Department of Economic and Social Affairs, Population Division national estimates of 2016). State-level estimates were adjusted for poly-drug use, and aggregated at the zone level.

TABLE 15 | Annual prevalence of drug use by state in South-South Zone

| | Estimated prevalence (%) | Low estimate (%) | High estimate (%) | Estimated numbers |
|-------------|--------------------------|------------------|-------------------|-------------------|
| Akwa Ibom | 12.5 | 12.2 | 12.5 | 352,000 |
| Bayelsa | 14.0 | 14.0 | 14.0 | 163,000 |
| Cross River | 11.8 | 10.4 | 11.8 | 233,000 |
| Delta | 18.0 | 17.0 | 18.0 | 513,000 |
| Edo | 15.0 | 15.0 | 15.0 | 330,000 |
| Rivers | 15.0 | 15.0 | 15.0 | 580,000 |

2. PATTERNS OF DRUG USE

Gender and drug use

Proportionally more men than women have used drugs in Nigeria in the past year - one in four drug users in Nigeria is a woman. While men are 7 times more likely than women to use cannabis, the gender difference in the non-medical use of pharmaceutical opioids - such as tramadol, codeine, and morphine, tranquilizers and cough syrups containing codeine or dextromethorphan is less pronounced. Men are also more likely than women to be high-risk drug users, including those who inject drugs.



FIG. 1 Gender and drug use

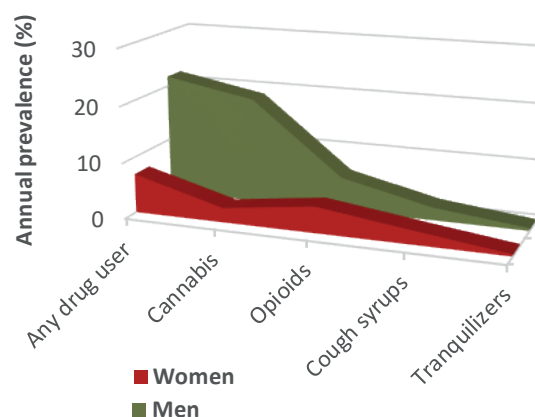
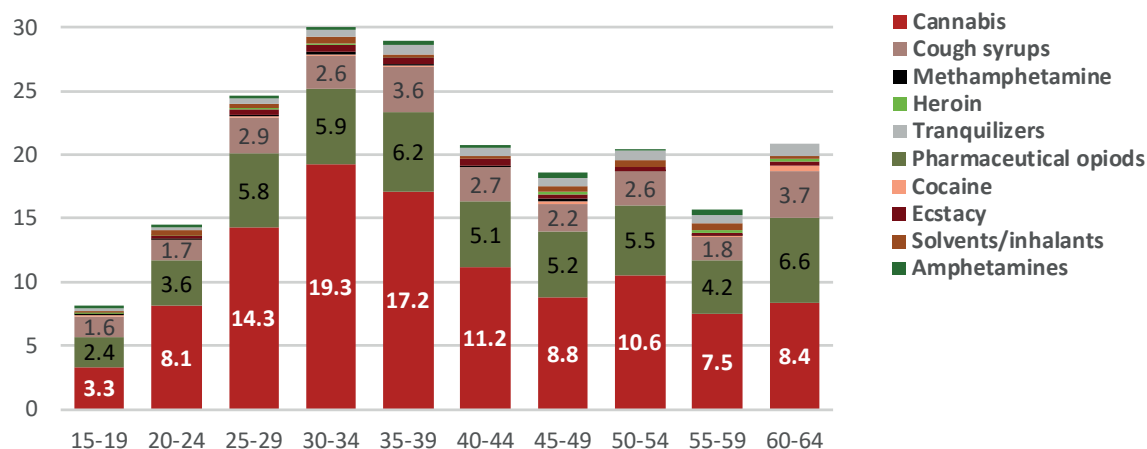


TABLE 16 Annual prevalence of drug use by sex, 2017

| | Men | | Women | | National | |
|---|-------------------------------|-------------------|-------------------------------|-------------------|----------------------|-------------------|
| | Estimated prevalence (95% CI) | Estimated number* | Estimated prevalence (95% CI) | Estimated number* | Estimated prevalence | Estimated number* |
| Any Drug Use | 21.8 (21.2-22.3) | 10,850,000 | 7.0 (6.6-7.4) | 3,430,000 | 14.4 | 14,300,000 |
| High-risk drug use | 0.6 (0.63-0.64) | 319,000 | 0.12 (0.11-0.12) | 57,000 | 0.4 | 376,000 |
| People who inject drugs | 0.12 (0.05-0.19) | 61,000 | 0.04 (0.002-0.07) | 18,000 | 0.08 | 80,000 |
| By drug type | | | | | | |
| Cannabis | 18.8 (17.8-19.7) | 9,360,000 | 2.6 (2.2-3.0) | 1,280,000 | 10.8 | 10,640,000 |
| Opioids | 6.0 (5.6-6.5) | 3,010,000 | 3.3 (2.9-3.6) | 1,606,000 | 4.7 | 4,610,000 |
| <i>Heroin</i> | 0.1 (0.0001-0.3) | 71,000 | 0.03 (0.0001-0.1) | 16,000 | 0.1 | 87,000 |
| <i>Pharmaceutical opioids (tramadol, codeine, morphine)</i> | 6.0 (5.5-6.6) | 3,008,000 | 3.3 (2.9-3.7) | 1,600,000 | 4.7 | 4,608,000 |
| Cocaine | 0.1 (0.0001-0.3) | 71,000 | 0.04 (0.0001-0.1) | 21,000 | 0.1 | 92,000 |
| Tranquilizers/sedatives | 0.5 (0.0001-1.2) | 270,000 | 0.4 (0.0001-1.0) | 212,000 | 0.5 | 481,000 |
| Amphetamines | 0.3 (0.0001-0.8) | 161,000 | 0.2 (0.0001-0.5) | 77,000 | 0.2 | 238,000 |
| <i>Pharmaceutical amphetamine and illicit amphetamine</i> | 0.2 (0.0001-0.6) | 96,400 | 0.1 (0.0001-0.4) | 58,100 | 0.2 | 155,000 |
| <i>Methamphetamine</i> | 0.1 (0.0001-1.3) | 69,500 | 0.04 (0.0001-0.7) | 19,000 | 0.1 | 89,000 |
| Ecstasy | 0.4 (0.0001-1.6) | 211,000 | 0.3 (0.0001-1.2) | 129,000 | 0.3 | 340,000 |
| Hallucinogens | 0.03 (0.0001-1.2) | 16,500 | 0.02 (0.0001-0.9) | 10,000 | 0.03 | 27,000 |
| Solvents/inhalants | 0.5 (0.0001-1.8) | 248,000 | 0.1 (0.0001-0.7) | 51,000 | 0.3 | 300,000 |
| Cough syrups (containing codeine or dextromethorphan) | 2.3 (1.2-3.4) | 1,157,000 | 2.5 (1.3-3.6) | 1,200,000 | 2.4 | 2,360,000 |

* Aggregated categories were adjusted for the proportion of users known to be poly-drug users weighted by poly-drug use in each survey (nationally 75 per cent of users were poly-drug users). Gender-specific poly-drug user adjustments were also applied to drug use categories of opioids and amphetamines. As a result, numbers for each drug type will not sum to national totals. Due to rounding of the estimates (percentage or numbers) the estimates may not add up.

FIG. 2 Annual prevalence of drug use by age group and drug type



Age and drug use

While the use of drugs is observed among all age groups in Nigeria, overall past-year use of most drug types is high among young people within the age brackets of 25 and 39 years. This is true for cannabis as well as for non-medical use of prescription opioids (tramadol, codeine, morphine) and cough syrups containing codeine or dextromethorphan. While the use of amphetamines and ecstasy is seen more among young people, there is negligible use of these drugs among the older population. However, there is considerable non-medical use of pharmaceutical opioids and cough syrup among older people within the age brackets of 45 and 64 years.

Cannabis

Cannabis is the most commonly used drug in Nigeria with 10.8 per cent (or 10.6 million people) of the adult population reporting use in the past year. Nigeria is among the main countries globally that reported high quantities of cannabis herb seized in 2016.²⁰ The extent of cannabis use in Nigeria is comparable to the 2016 UNODC prevalence estimates of cannabis use in West and Central Africa (13.2 per cent).²¹

Cannabis use is reported 7 times higher among men than women with past year prevalence estimated at 18.8 per cent among men as compared to 2.6 per cent among women. The current mean age of men using cannabis was 34 years while women cannabis users were slightly younger – with a mean age of 31 years. The average age of initiation of cannabis use was 19 years regardless of gender. Thus at present, on average a cannabis user had been using

cannabis for nearly 15 years. A typical cannabis user was characterized by having completed senior secondary school and to be in full-time regular employment. Most of the cannabis users were either married (monogamous - 51 per cent) or single (never married - 38 per cent). Nearly one third of people in the general population and two thirds among the high-risk drug users who reported cannabis use in the past year were daily or nearly daily users of cannabis.

The average daily expenditure on cannabis in the past 30 days among cannabis users within the general population was ₦ 363 (Nigerian Naira) - equivalent to USD 1.15²² Considering that the minimum wage of a full time worker in Nigeria is ₦ 18,000 per month (or USD 57 per month), the average daily expenditure on cannabis use amounts to almost 2 per cent of the minimum monthly wage of a full time worker in Nigeria. However, high-risk drug users spent considerably more of their earnings on cannabis per day in the past month, i.e., ₦ 1,340 or USD 4.25.

Opioids: heroin and pharmaceutical opioids

Opioids is a generic term applied to opiates and their synthetic analogues with actions similar to those of morphine. Therefore, opioids are commonly used as painkillers, for the treatment of acute and chronic pain, and as an anaesthetic during surgery. Synthetic opioids are structurally diverse, can be extremely potent, and include a variety of substances including a number of fentanyl derivatives, methadone, buprenorphine and

20 UNODC, *World Drug Report 2018*.

21 Ibid.

22 Based on UN currency conversion rate of 315 Naira to USD between April to May 2017.

AH-7921.²³ Nationwide, 4.7 per cent of the adult population are estimated to be past year users of opioids – this places Nigeria among the countries with high estimates of non-medical opioid use globally. The estimate of past year opioid use is driven predominantly by past-year non-medical use of pharmaceutical opioids such as tramadol, codeine or morphine. The majority (85 per cent) of people who had misused pharmaceutical opioids in the past year used these orally while over 12 per cent had injected pharmaceutical opioids – proportionately more women (20 per cent) than men (11.5 per cent) had injected pharmaceutical opioids.

The mean age of initiation of non-medical use of pharmaceutical opioids was 21 years. On average, the past-year opioid users had regularly used opioids for 12 years. Nearly 80 per cent of all opioid users were daily or nearly daily users. The past year prevalence of non-medical use of pharmaceutical opioids (tramadol, codeine, morphine) among those aged 60-64 was also high. Also, the gender gap in the non-medical use of pharmaceutical opioids was less pronounced as compared to that of cannabis use. These patterns of non-medical use of pharmaceutical opioids among the elderly and among women correspond with findings in other countries.^{24, 25}

The non-medical users of pharmaceutical opioids were most likely to be married (monogamous) or single (never married) and to report living rent-free either with friends or family. Past-year users were also more likely to have received vocational education/training, and to be working in part-time employment or doing irregular jobs. On average, among the general population, urban users spent ₦ 310 NGN (nearly 1 USD) per day in the past 30 days on pharmaceutical opioids compared to ₦ 190 NGN (USD 0.60) spent per day in the rural settings. There was no significant difference between genders in the average amount of money spent per day for non-medical use of pharmaceutical opioids. High-risk drug users, however spent on average ₦ 1,145 (USD 3.6) per day in the past 30 days for non-medical use of pharmaceutical opioids.

Heroin use in Nigeria is less common - an estimated 87,000 people or nearly 0.1 per cent of the Nigerian population had used heroin in the past 12 months. The mean age of heroin initiation was 22 years, as was the age of first injecting the drug. Almost half (49 per cent) of regular

heroin users reported smoking as their usual method of use. While men were four times more likely than women to report past year heroin use, proportionately more women (37 per cent) than men (20 per cent) who had used heroin reported injecting it in the past year. Heroin users were more likely to be working on a casual basis, and more likely to be sleeping on the streets. Women heroin users reportedly spent slightly more money than men per day in the past 30 days on their heroin use (₦ 3,500 NGN or USD 11 per day for women, vs. ₦ 3,070 or nearly USD 10 per day for men). The scientific literature describes that women have less control than men over how and from whom they acquire their drugs (mostly illicit drugs) and are more likely to have those supplied by a male partner.²⁶ This can partly explain the disparity among men and women in the monthly expenditure on heroin use in Nigeria.

Stimulants: amphetamines, cocaine and ecstasy

Stimulants are psychoactive drugs also referred to as psychostimulants, that have a stimulatory effect on the central nervous system. Stimulants are characterized by their ability to increase alertness, heighten arousal and cause behavioural excitement.²⁷ Pharmaceutical stimulants include, among others Adderall, Dexedrine or Ritalin, that are often prescribed to treat attention deficit disorder (ADD), attention deficit hyperactivity disorder (ADHD) and narcolepsy. However, these are also commonly misused along with illicitly sourced amphetamine. Overall, 670,000 people (an estimated 0.6 per cent of the population aged 15-64) had used different stimulants such as amphetamines (including non-medical use of prescription amphetamine, illicit amphetamines), cocaine and ecstasy in the past 12 months. Ecstasy (0.3 per cent or 340,000 past

TABLE 17 : Annual prevalence of stimulants by drug type

| | Estimated prevalence | Estimated Number |
|---|----------------------|------------------|
| Cocaine | 0.09 | 92,000 |
| Amphetamines | 0.24 | 238,000 |
| Amphetamines (prescription and illicit amphetamine) | 0.16 | 155,000 |
| Methamphetamine | 0.09 | 89,000 |
| Ecstasy | 0.3 | 340,000 |

23 UNODC, Terminology and information on drugs, Third edition, 2016.

24 Cynthia I. Campbell and others, "Age and Gender Trends in Long-Term Opioid Analgesic Use for Noncancer Pain", American Journal of Public Health, vol. 100, No. 12 (December 2010), pp. 2541-2547.

25 UNODC, World Drug Report 2018.

26 UNODC, World Drug Report 2018.

27 Jerrold S. Meyer and Linda F. Quenzer, eds., Psychopharmacology: drugs, the brain, and behaviour, 3rd ed., (Oxford University Press 2018).

year users) and amphetamines (0.2 per cent or 238,000 past year users) users account for the majority of stimulant use in Nigeria. Among the estimated 155,000 past year amphetamine users nearly 15 per cent were those who had used illicit amphetamine, whereas the remaining had used pharmaceutical amphetamine for non-medical purposes.

The mean age of initiation of ecstasy use was 19 years among women and nearly 23 years among men whereas the duration of use did not vary among men and women - mean duration of ecstasy use was 13 years. On average men spent ₦ 775 or USD 2.5 per day compared to women who spent ₦ 926 or USD 2.9 per day on their ecstasy use in the past 30 days. Nearly one third of the past year ecstasy users were daily or nearly daily users of ecstasy. Compared with other age groups, the use of ecstasy was more common among those who were within 25-39 years age groups.

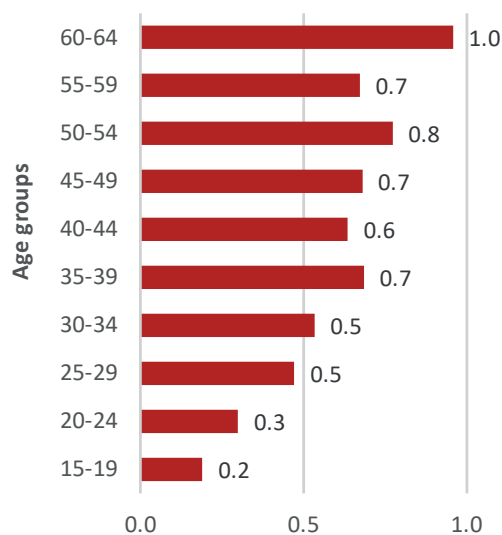
The mean age of initiation of pharmaceutical amphetamine was 23 years with no difference in the age of initiation among men and women. Compared to men, women reported a longer duration of regular use of pharmaceutical amphetamine - over 9 years among women and 6 years among men. Compared to other age groups, the non-medical use of prescription amphetamines was higher among those who were aged between 30 and 39 years. The non-medical use of prescription amphetamine was also commonly reported among students. Women spent nearly 20 per cent more per day than men on the use of amphetamine - on average women had spent ₦ 2,100 (USD 6.6) per day compared to men who spent ₦ 1,700 (USD 5.4) per day on amphetamine use in the past 30 days.

The use of cocaine and methamphetamine (both crystal and tablet form) is less common in Nigeria with an estimated 92,000 past year users of cocaine and 89,000 past year methamphetamine users in the country. While cocaine use was more common among those who were between 25 and 39 years old, more methamphetamine users were between the ages of 30 and 39. On average, cocaine users reported spending ₦ 6,300 NGN (or 20 USD) per day on cocaine (₦ 7,000 by women or 22 USD spent per day). This amount is nearly half of the national minimum wage per month. Similarly methamphetamine users spent an average of ₦ 4,000 (or USD 13) per day in the past 30 days – though it was slightly higher among women. Only one quarter of men and women cocaine users were daily or nearly daily users, whereas the majority of both men and women users reported using methamphetamine 2-3 times per week.

Non-medical use of other pharmaceutical or over-the-counter drugs

The non-medical use of other pharmaceutical drugs, such as sedatives and tranquilizers, is a major concern in many countries. Globally some 60 countries rank the non-medical use of tranquilizers such as benzodiazepines as among one of the main drugs of abuse.²⁸ In Nigeria, less than one per cent of the population aged 15-64 years reported past-year non-medical use of tranquilizers or sedatives (0.5 per cent or 481,000 persons). The non-medical use of tranquilizers is reported at comparable levels among men and women (0.5 per cent among men vs. 0.4 per cent among women). Within the general population, people had initiated non-medical use of tranquilizers at age of 26 and therefore higher levels of non-medical use of tranquilizers is observed with increasing age. The typical user of tranquilizers for non-medical purposes, was around 38 years old, mainly married, and had a senior secondary school level of education. There was no difference in the non-medical use of tranquilizers among those who had regular full time work or those who were currently not working.

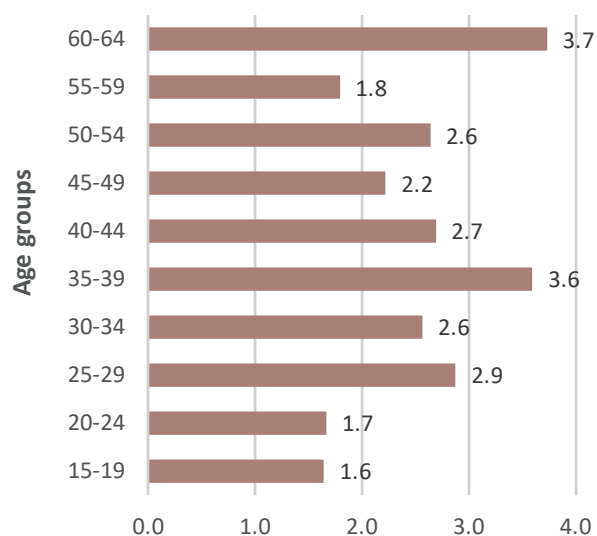
FIG. 3 Annual prevalence of non-medical use of tranquilizers by age group



Over-the-counter (OTC) medicines are those that are available for purchase without a prescription and could be purchased from a pharmacist or from any other sale point that stocks such medicines. In Nigeria the non-medical use of cough syrups containing codeine or dextromethorphan (such as *Coldex* or *Benylin*) is the third most common form of substance misuse.

28 UNODC, *World Drug Report 2018*.

FIG. 4 Annual prevalence of non-medical use of cough syrups by age group



As with the non-medical use of other pharmaceutical preparations, the past year non-medical use of cough syrups was comparable among men and women (2.3 per cent among men vs. 2.5 per cent among women) or roughly 2.4 million people had used cough syrups in the past year for non-medical purposes. The non-medical use of codeine containing cough syrups is also quite widespread among the different age groups with higher levels of their misuse seen among those aged 35-39 years and those aged 60-64 years. The mean age of initiation of non-medical use of cough syrups was 20 years while the mean duration of its regular use was 8 years. Nearly half of the people who used cough syrups for non-medical purposes used those daily or near daily. The average expenditure for the non-medical use of cough syrups was ₦ 3050 or nearly USD 10 per day in the past 30 days. A typical person misusing cough syrup is either married (monogamous) or single (never married), and has completed senior secondary school. There is no significant difference in the occupational status (either regular full time work or not working at all) of those misusing cough syrups. One third among those who had misused cough syrups in the past year, and were not currently working, were students.

Solvents or inhalants

Nationwide, the past year prevalence of solvents or inhalants use was relatively low at 0.3 per cent or 300,000 people aged 15-64. The use of inhalants was higher among men than women (0.5 per cent men vs. 0.1 per cent women). Past year users of inhalants reported initiating use at 18 years of age, and most users had been using inhalants on average for 16 years. Past year use was higher

in rural areas than urban areas (23 per cent of users resided in urban areas vs. 76 per cent in rural areas). No differences were found for educational attainment, employment status or job type regarding those solvent users.

Tobacco and alcohol use

Among the general population, nearly 15 per cent of the adult population had smoked or used a tobacco product, whereas nearly 7 per cent of men and 1 per cent of women were currently (past 30 days) smoking or using tobacco products. These estimates of current tobacco use among the general population are comparable with the results of 2012 Global Adult Tobacco Survey conducted in Nigeria.²⁹ With a mean number of 78 cigarettes smoked per month, manufactured cigarettes were the most common tobacco product used in Nigeria.

Overall, nearly one quarter of the adult population in Nigeria reported using an alcoholic drink in their lifetime. In the past year, 25 per cent of men and 13 per cent of women reported having an alcoholic drink. Among those who reported alcohol use in the past year, over 40 per cent reported using alcohol occasionally. However, among those one third of men and 15 per cent of women reported daily or near daily use of alcohol over the past 12 months. On average, men reported binge drinking³⁰ on three occasions in the past 30 days, while women reported binge drinking on 2 occasions. Both the use of alcohol and tobacco was much higher among drug users than amongst the general population.

Knowledge and awareness about drug use and HIV and AIDS among the general population

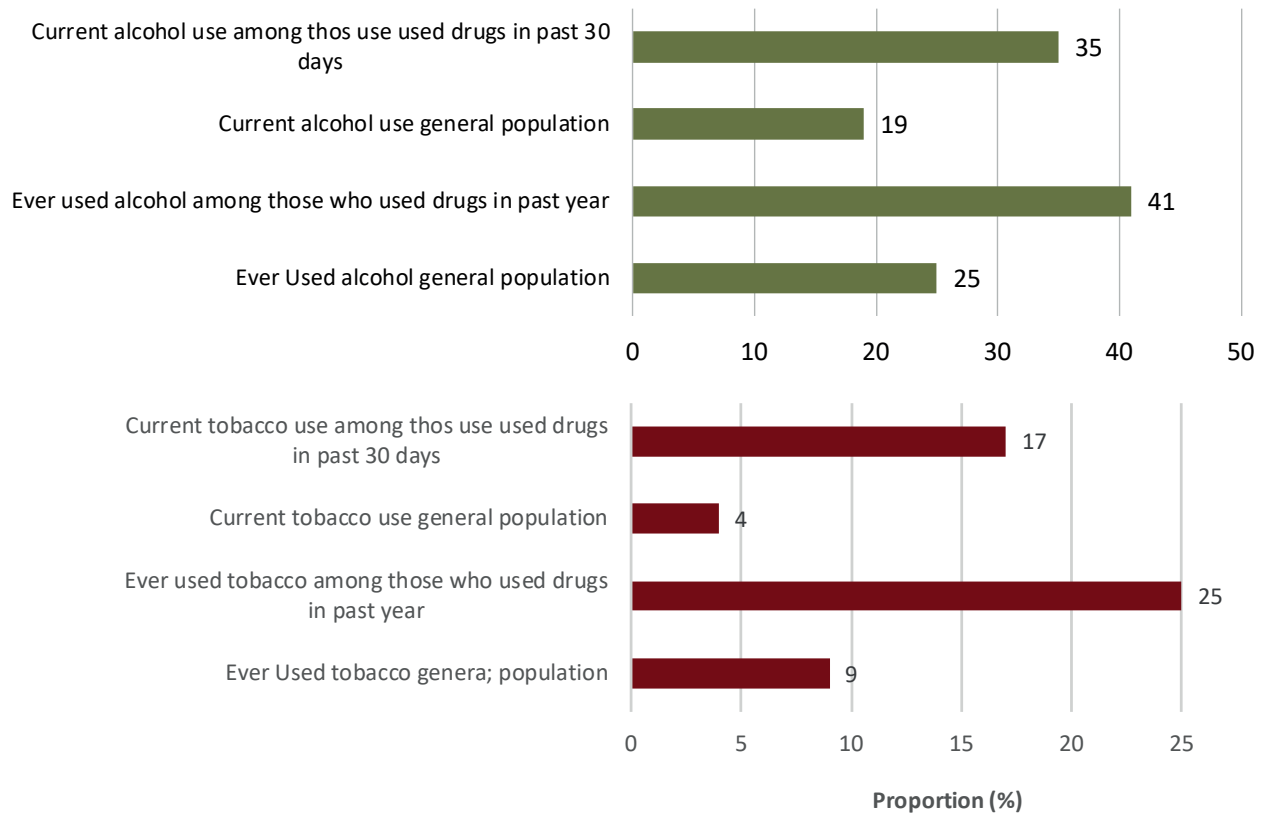
Among those who were interviewed in the general population, two-thirds had heard of cannabis, and less than half (41 per cent) had heard of pharmaceutical opioids such as tramadol, codeine, or morphine as substances of abuse. More respondents reporting knowing of cocaine (44 per cent) than cough syrups containing codeine or dextromethorphan (32 per cent), despite the latter's widespread non-medical use in the country. Hallucinogens, methamphetamine, and amphetamines were least likely to be known among the general population (6 per cent).

For the majority of the population, neighbourhood or community talk was the main source of information or awareness about cannabis use as well as about the non-

²⁹ WHO, Global adult tobacco survey Nigeria 2012, Fact Sheet.

³⁰ Binge drinking is defined as having more than five standard drinks for men and 4 standard drinks for women in a row.

FIG. 5 Alcohol and tobacco use within the general population and those who used drugs



medical use of pharmaceutical opioids (such as tramadol, codeine, or morphine) and cough syrups (that may contain codeine or dextromethorphan). With regard to cocaine, more people were likely to learn about cocaine use through radio or television than through other sources. Within the community, friends were the most common source on information about drug use.

Knowledge and awareness of HIV

Knowledge and awareness of HIV and AIDS among the general population was high. The majority (81 per cent) of the adults interviewed knew about HIV and AIDS and the mode of transmission of HIV. The knowledge about HIV was higher among individuals who had reported using at least one drug in their lifetime (91 per cent), as well as past-year poly-drug users (92 per cent). Slightly more men (88 per cent) than women (82 per cent) knew about HIV and AIDS, and how HIV is spread. People who reported being married in a polygamous union (77 per cent), those living in rural areas (78 per cent), and people who were unable to read and write (28 per cent) were less likely than others to know about HIV and AIDS.

3. HIGH-RISK DRUG USE

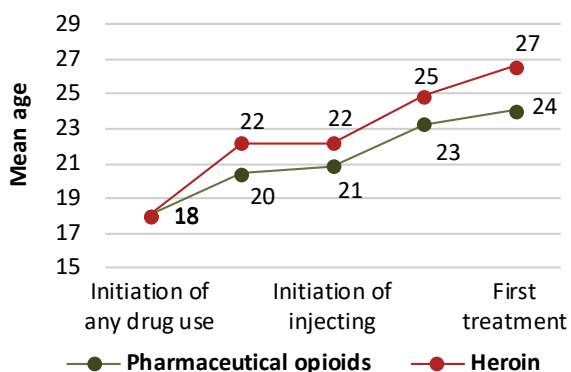
High-risk drug users represent a sub-population of the more hidden, regular and problematic drug users that are not usually sampled in household surveys. For the purpose of this survey high-risk drug users were defined as those who had used opioids, crack/cocaine or amphetamines in the past 12 months, and had used those drugs on at least 5 occasions in the past thirty days.

In Nigeria, an estimated 376,000 (0.4 per cent of the population aged 15-64) were estimated as high-risk drug users. Nearly 90 per cent of the high-risk drug users had been regularly using opioids – mainly pharmaceutical opioids such as tramadol, codeine, or morphine - while the remaining had either used cocaine or amphetamines. Over 20 per cent of the high-risk drug users were injecting drugs.

A typical high-risk drug user is a male, aged 29 years and single (who has never married). He had lived in a house, either with family or friends, in the past six months. He had either done casual work or was unemployed in the past six months (prior to the interview). In the same period a typical high-risk drug user had financially supported himself through wages or casual work, and was partly supported by his family and friends as well as through begging, selling drugs or through petty crimes.

For the majority of high-risk drug users, cannabis was the first drug they had used in their lifetime at the age of 18 before moving on to opioid use and injecting. The high-risk drug user had used opioids for an average of 4 years before he was arrested for a drug-related offence and had entered treatment for his drug use disorders for the first time around a year later. The progression from initiation of any drug use to entering treatment for the first time took 6 years.

FIG. 6 Progression from initiation of substance use to treatment of drug use disorders among high risk opioid users

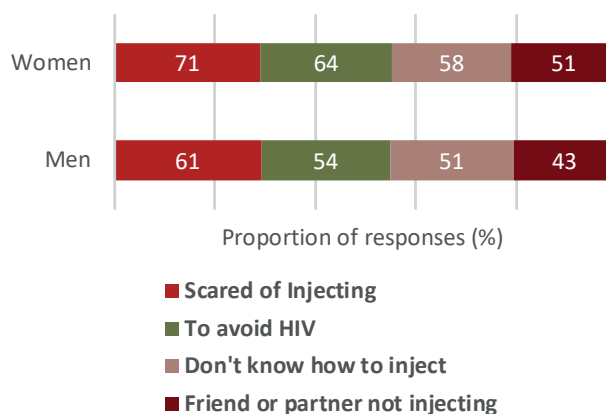


People who inject drugs (PWID)

Injecting drug use is associated with many serious drug-related harms, such as the transmission of HIV and viral hepatitis, fatal and non-fatal overdoses, bacterial infections at injection sites etc. Among the high-risk drug users 21 per cent, or an estimated 80,000 users, had injected drugs (both in the past 12 months and currently). Nearly 17 per cent of the PWID were women.

Among the high-risk drug users who had never injected drugs the main reason for not injecting was that they were afraid of injecting. In addition to this, the other important reasons cited were “to avoid HIV”, that they did not know how to inject or as a peer influence were not injecting as their friends or partners were not injecting.

FIG. 7 Self-reported reasons for not injecting among high-risk drug users



Note: High-risk drug users had cited more than one reason for not injecting

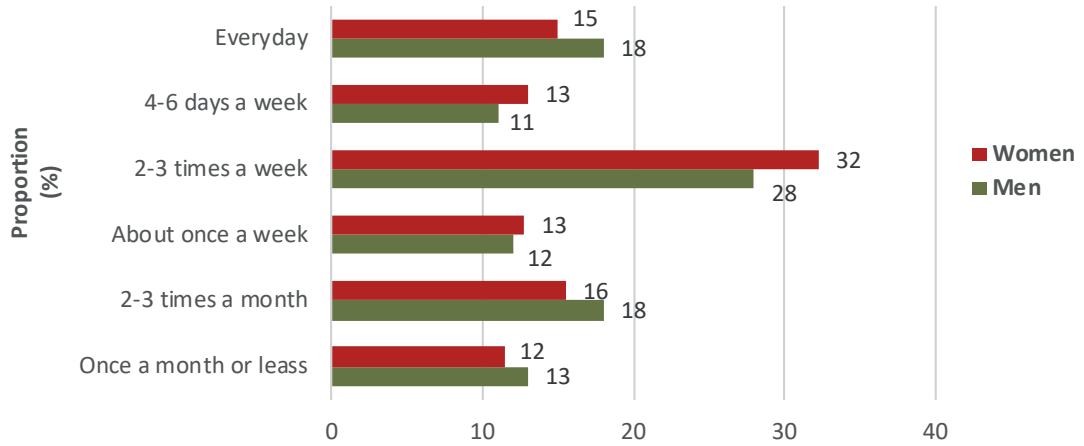
The most common drugs injected in the past 6 months were pharmaceutical opioids (tramadol, codeine, morphine), followed by cocaine, heroin and tranquilizers. While overall more men than women had injected drugs in the past 6 months, proportionally more women than men had injected opioids (heroin and pharmaceutical opioids) and tranquilizers in the past six months.

The mean age at which the high-risk drug users first injected was 21 years, while female injectors were slightly younger (mean age 20 years) than male injectors when they had initiated injecting drugs (21 years of age).

Injecting practices

Within the past six months, more than half of the PWID reported injecting drugs daily or nearly daily. Women were

FIG. 8 Frequency of injecting in a month among men and women who injected drugs



slightly more likely than men to inject daily or nearly daily - 54 per cent of men vs. 58 per cent of women were daily or near daily injecting. On a typical day when they injected drugs more women than men reported injecting two to three times a day (40 per cent of women vs. 35 per cent of men). In the past six months, PWID were most likely to inject drugs where they lived, at a drug dealer's place or at the place of their sexual partner. Women were more likely than men to report injecting drugs at the home of their sexual partner. Similarly, in the past six months PWID had mostly injected with their friends and acquaintances, spouse or sexual partners, or people the PWID knew in general.

Injecting risk behaviours

The association between injecting drug use and HIV is well established. Unsafe injection practices, such as sharing contaminated needles, are a major risk factor for transmission of blood-borne infections such as hepatitis B, C,

and HIV. Access to interventions such as needle and syringe programmes, and opioid substitution therapies, are known to be effective in reducing harms and improving morbidity and mortality among this vulnerable group. Understanding injecting practices and behaviours of PWID is an important first step to effectively target such interventions.

Overall, it was "quite easy" for the interviewed PWID to obtain a new needle or syringe. Pharmacists, friends, as well as another person injecting or a drug dealer were the most common sources to obtain new needles and syringes. It is important to note that except for pharmacies, drop in centres, or outreach workers, the others (friends, drug dealers, spouse, etc.) are considered as secondary sources of obtaining needles and syringes.

In the past six months, nearly half of the PWID reported that they had used a needle or syringe after someone else had used it or another person had injected with their used

FIG. 9 Most common sources of obtaining needles and syringes

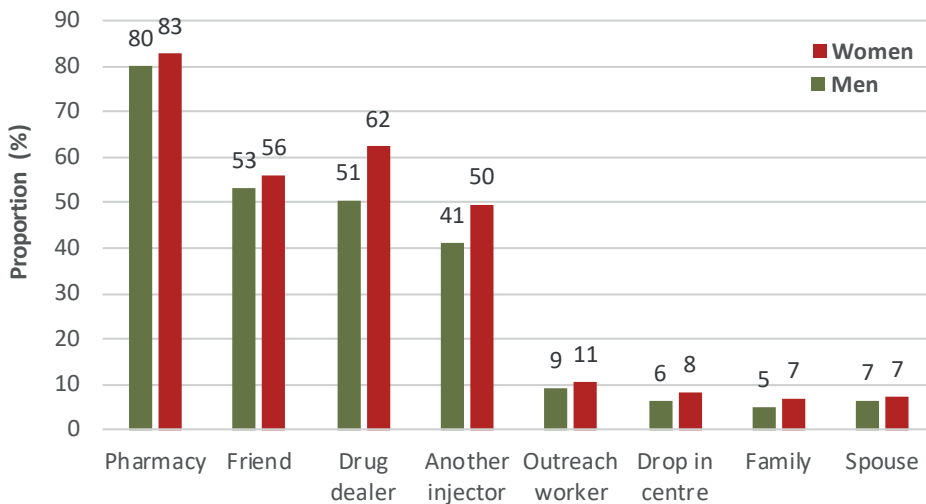
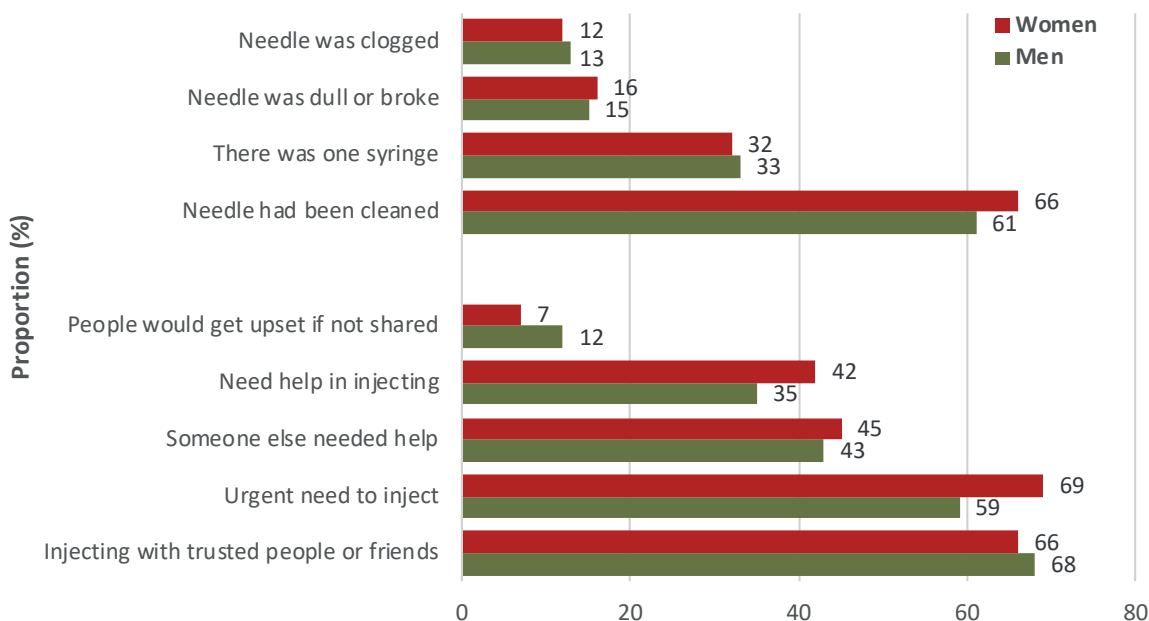


FIG. 10 Reasons for sharing needle and syringes among men and women who injected drugs



needle or syringe. Women were more likely to report using their partner's needle or syringe, or sharing needles and syringes in general.

The reasons that PWID cited for sharing needles and syringes relate either to group dynamics or the lack of availability of clean needles and syringes at the time of injecting. The most common reasons for sharing needles and syringes were: they were injecting with people they trusted, such as their sexual partner, lover or friend; the needle had been cleaned; someone needed help in injecting; and that there was an urgent need to inject. Women were more likely to report that they shared needles and syringes because of an urgent need to inject at that moment.

More men than women reported using a clean needle and syringe each time they had injected drugs (44 per cent vs. 31 per cent of women) in the past month. Women on the other hand were more likely than men to report obtaining a new needle or syringe to inject between 2-3 times a week in the past month. On average a PWID used a syringe 3 times (range: 1-18 times) before obtaining a new needle or syringe to inject drugs.

In the past thirty days that the PWID had been injecting, nearly half of them reported never sharing drugs from the same pool (cooker), using the same cotton swab, or using already used rinse water to clean injection needles. The remaining half, however had shared the different drug injecting paraphernalia with varying frequency while they were injecting in the past 30 days – practices that increase

the transmission risk of HIV and hepatitis C among PWID.

Except for cleaning the needles and syringes with cold water, the majority of PWID had never used any method to clean their used needle or syringe before injecting. Those that had reported using any of the methods did so with varying frequency in the past 30 days. Cleaning with a tissue or cloth and cleaning with cold water were practices reported more often. However except for using bleach, none of these methods render a needle or syringe safe, i.e., not contaminated with HIV and HCV. Overall, men were more likely than women to report never cleaning used needles or syringes before injecting.

FIG. 11 Frequency of obtaining a new needle or syringe while injecting in the past month

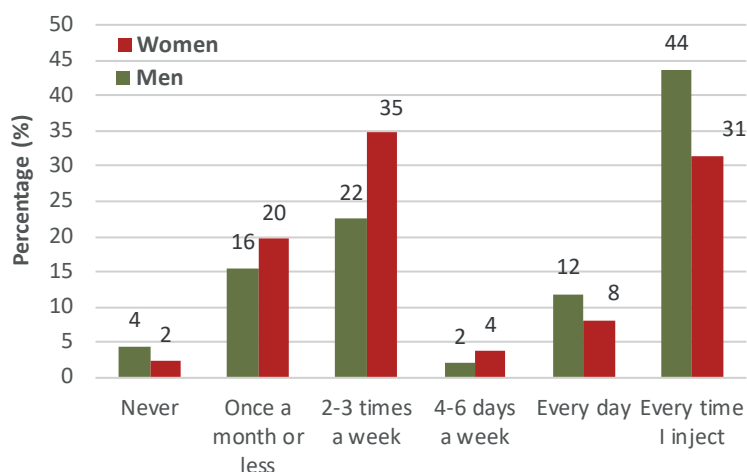


FIG. 12 Frequency of sharing injecting paraphernalia in the past 30 days among PWID

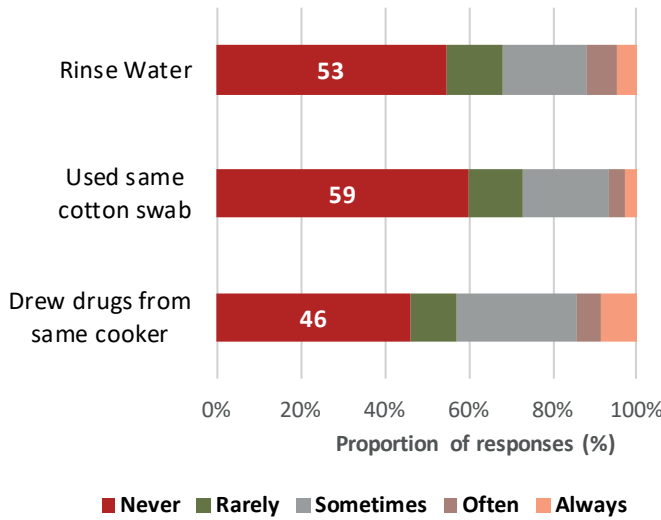
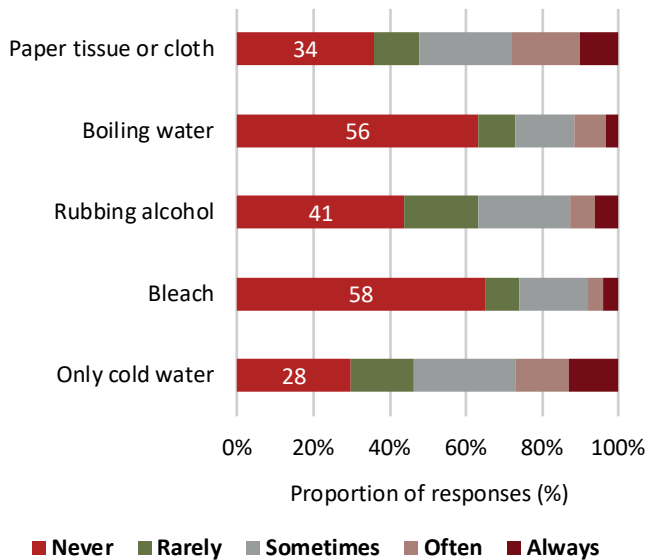


FIG. 13 Frequency of cleaning used needles and syringes by different methods in the past 30 days among PWID



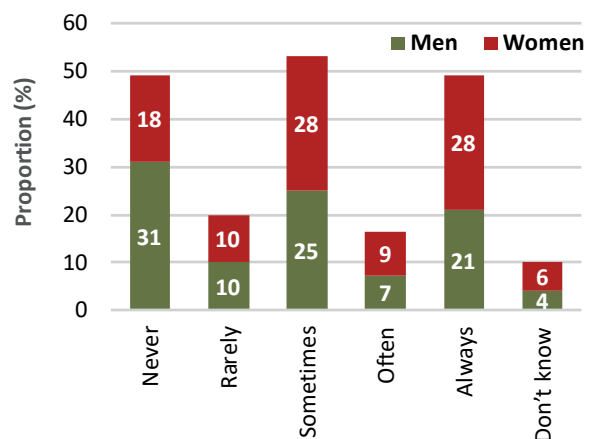
Sexual behaviours

The mean age of first sexual experience among high-risk drug users was 17 years. Almost half of the high-risk drug users (46 per cent) reported an increase in sexual partners after their initiation of drug use. This proportion was higher in general among women high-risk drug users (51 per cent) and those high-risk drug users, including women, who reported injecting drugs. Women high-risk drug users were also significantly more likely than men to

report having sex with other people who used drugs (67 per cent women vs. 46 per cent men), and having sex more frequently in the past 6 months – nearly half of the women high-risk drug users reported having sex daily or nearly daily as compared to one third of the men high-risk drug users.

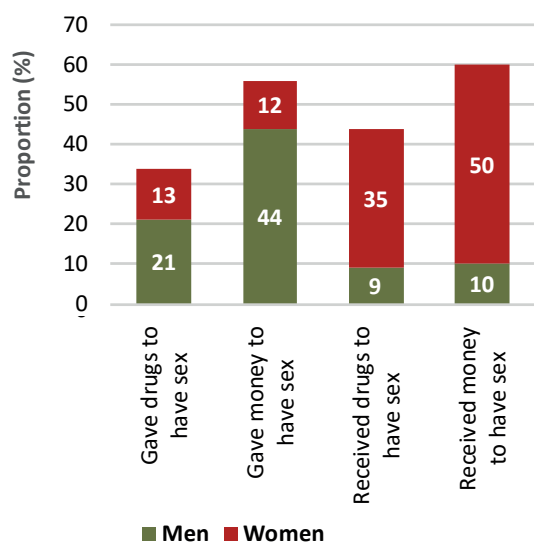
Both men and women high-risk drug users reported an average of 2 steady sexual partners over the past six months. Nearly half of women high-risk drug users and one third of men reported that their steady sexual partner also used drugs. Among these, more women than men were likely to report their steady sexual partner to be injecting (28 per cent women vs. 11 per cent men). Similarly more women high-risk drug users (39 per cent) as compared to men (25 per cent) reported that their steady sexual partners had sex with other men and women. Finally, 5 per cent of women and 4 per cent of men reported that their steady sexual partners were living with HIV. Furthermore, male high-risk drug users on average reported having sex with 4 women and 10 men (as casual sex partners) while women high-risk drug users reported having sex with around 5 men and 7 women in the past six months. Males were more likely than women to report never using a condom (31 per cent vs. women 18 per cent), whereas women were more likely to report always using a condom (29 per cent vs. men 21 per cent) while having sex with their partners in the past six months.

FIG. 14 Frequency of condom use during sexual intercourse among high-risk drug users in the past six months



An important aspect of sexual risk behaviours among high-risk drug users is the exchange of money and drugs for sex. Overall, men high-risk drug users were 3 times more likely to give money to have sex whereas women were 4-5 times more likely to receive money or drugs to have sex.

FIG. 15 Proportion (%) of high-risk drug users who gave or received money or drugs to have sex



Self-reported blood-borne infections and tuberculosis among high-risk drug users

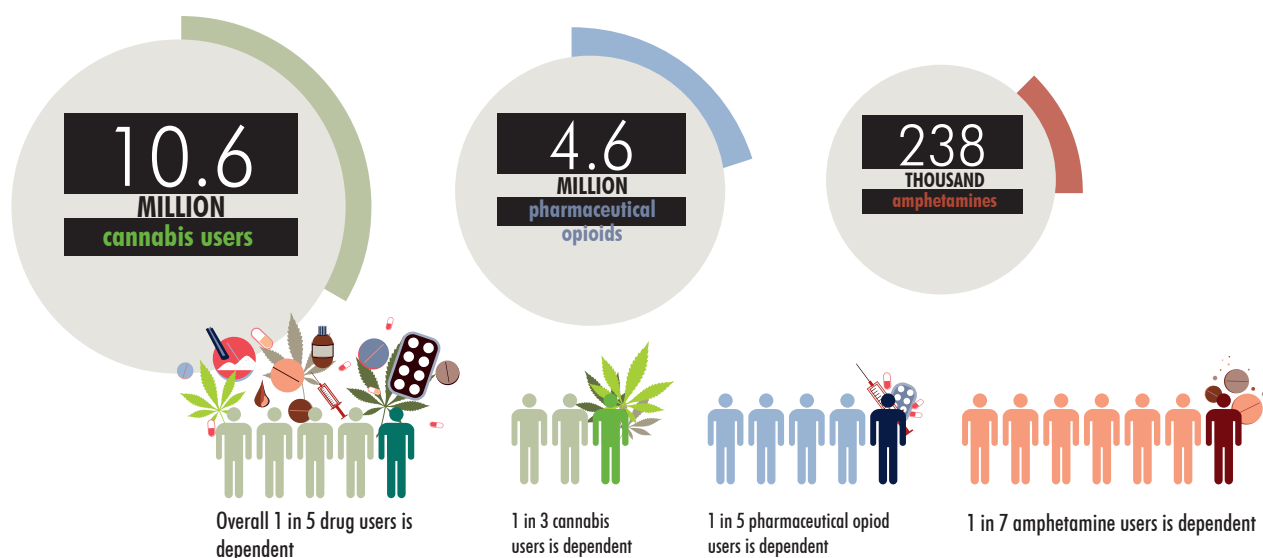
Overall, around 6 per cent of the high-risk drug users reported that they were living with HIV. More women high-risk drug users than men reported living with HIV. Similarly around 9 per cent of the PWID (9.1 per cent men and 9.8 per cent women) reported they were living with HIV. Although the self-reported HIV prevalence among PWID may be subject to reporting bias, it is important to note that the 2014 national data on HIV among PWID, based on bio-behavioural surveillance covering 6 states, reported that 3.4 per cent of PWID were living with HIV.³¹ Also subject to reporting biases, and the extent of testing for other blood-borne infections routinely done among the general public or among drug users, around 6.6 per cent of the high-risk drug users reported they were diagnosed with hepatitis B, while 2.3 per cent reported they were diagnosed with hepatitis C and 3.4 per cent with tuberculosis.

TABLE 18 Self-reported prevalence of infections among high-risk drug users including PWID

| | Among all high-risk drug users | | | Among PWID | | |
|--------------|--------------------------------|-----|-------|------------|-----|-------|
| | Overall | Men | Women | Overall | Men | Women |
| Hepatitis C | 2.3 | 2.2 | 2.9 | 3.3 | 3.1 | 3.9 |
| Hepatitis B | 6.6 | 6.4 | 7.7 | 7.8 | 8 | 7.4 |
| HIV | 6.2 | 5.9 | 8.0 | 9.2 | 9.1 | 9.8 |
| Tuberculosis | 3.4 | 3.2 | 4 | 5.1 | 4.8 | 5.9 |

³¹ National HIV/AIDS & STIs Control Programme. Federal Ministry of Health, Nigeria. Integrated Biological and Behavioural Surveillance Survey (IBBSS) 2014. November, 2015.

4. HEALTH CONSEQUENCES OF DRUG USE



Drug dependence and severity of dependence among drug users

Based on a set of questions using the different domains of dependence, as given in the WHO ICD 10 criteria,³² 33 20 per cent of people who self-reported past year use of any drug (other than tobacco and alcohol) were considered drug dependent. More than one third of cannabis users, one quarter of heroin users, and 20 per cent of those who had misused pharmaceutical opioids (such as tramadol, codeine, morphine) in the past twelve months met the criteria of dependence or of those suffering from drug use disorders. It is important to note that the extent of drug use disorders among those who had used drugs in the past year is only indicative and does not reflect a clinical diagnosis of dependence or drug use disorders among the adult population using drugs in Nigeria.

The Severity of Dependence Scale (SDS)³⁴ is a measurement tool used to ascertain the extent of dependence

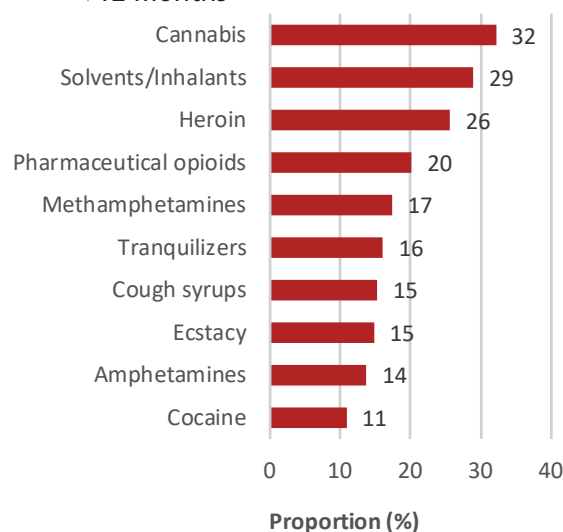
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32 World Health Organization. ICD-10 Dependence Syndrome, available at: http://www.who.int/substance_abuse/terminology/definition1/en/

33 Substance or drug use disorders — the Diagnostic and Statistical Manual of Mental Disorders (fifth edition) of the American Psychiatric Association also refers to “drug or substance use disorder” as patterns of symptoms resulting from the use of a substance despite experiencing problems as a result of using substances. Depending on the number of symptoms identified, substance use disorder may vary from moderate to severe. People with drug use disorders need treatment, health and social care and rehabilitation. Harmful use of substances and dependence are features of drug use disorders.

34 Michael Gossop, Paul Griffiths, Beverley Powis, and John Strang, “Severity of dependence and route of administration of heroin, cocaine, and amphetamines”. *British Journal of Addiction* (1992) 87:1527-1536.

FIG. 16 | Extent of drug use disorders by drug type among the adult population who self-reported use of drugs in the past 12 months



among regular users of different drug types. The SDS contains five questions ranked on a Likert-scale that are concerned with psychological components of drug dependence.³⁵ The scores are correlated to quantity, frequency and length of drug use. High scores of SDS have been associated with high-risk injecting and sexual behaviours, psychological morbidity, and higher risk of overdose.³⁶ From a public health perspective high scores

••

35 Ibid.

36 Michael Gossop, and others, “The severity of dependence scale (SDS): psychometric properties of the SDS in English and Australian samples of heroin, cocaine, and amphetamine users”, *Addiction* (1995) 90:607-614.

TABLE 19 | Severity of dependence among high-risk drug users by drug type

| | Heroin | Pharmaceutical opioids | Cocaine | Amphetamines |
|---|--------|------------------------|---------|--------------|
| Proportion of high-risk drug users with severity of dependence (%) | 86 | 82 | 82 | 74 |
| Mean score of SDS | | | | |
| Overall | 8.2 | 7 | 7.1 | 6.6 |
| Men | 8.5 | 7 | 7.2 | 6.5 |
| Women | 7 | 6.8 | 6.7 | 7.3 |

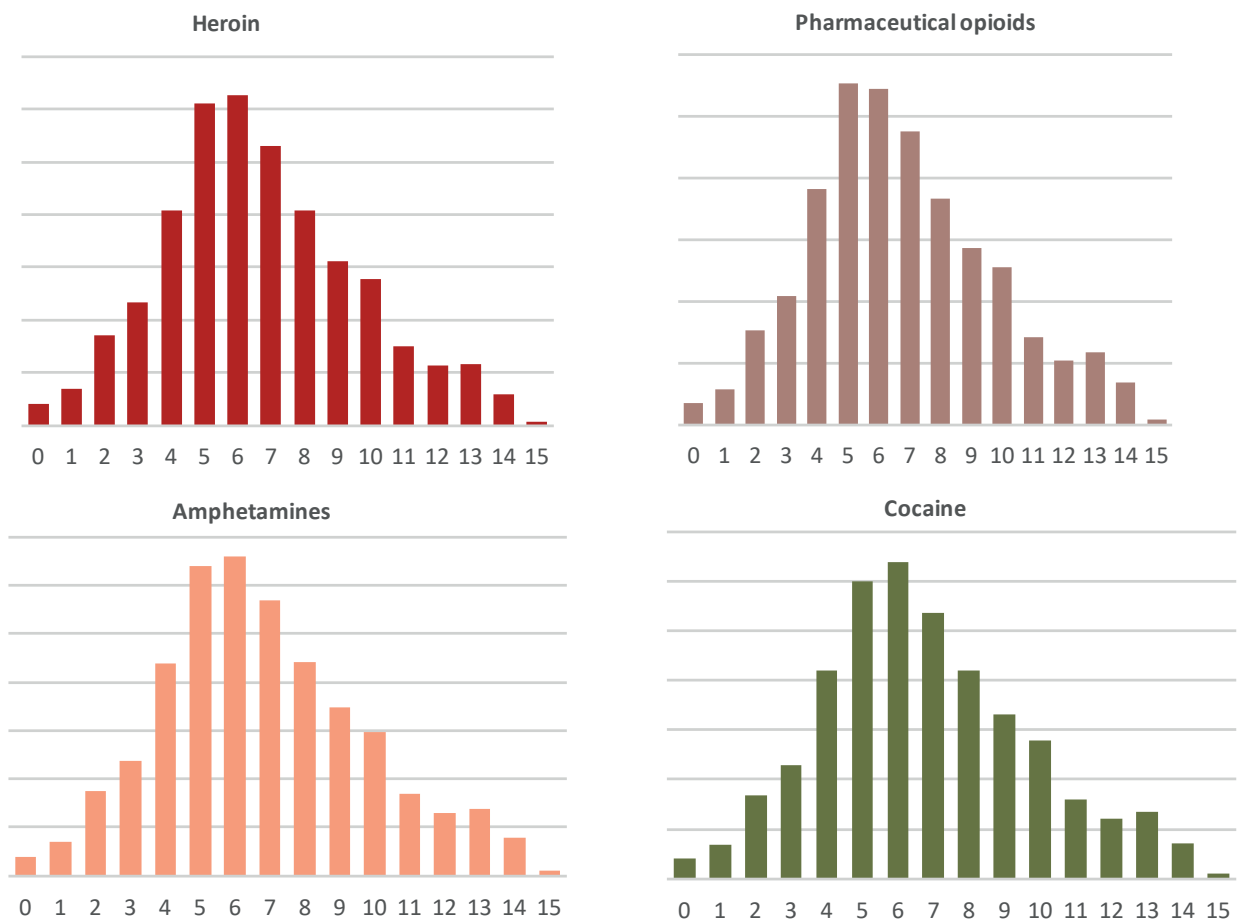
indicate the extent to which high-risk drug users may require structured interventions to address their drug use disorder. Cut-off values for SDS scores vary according to drug type, for example, a cut-off value of five among heroin users, or a value of 4 among cocaine or amphetamine users, is indicative of the need for structured interventions to address their drug use disorder.³⁷

In Nigeria, more than 80 per cent of the high-risk drug users had severity of dependence that would require some

intervention to address their problematic drug use. Except for amphetamines, male high-risk drug users had higher mean values than women of severity of dependence.

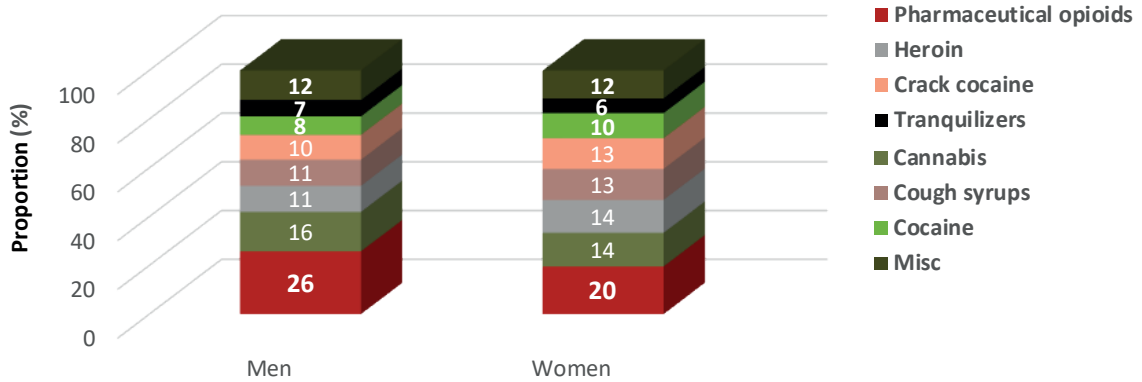
The high-risk drug users ranked pharmaceutical opioids (tramadol, codeine, morphine), cannabis and heroin among the drugs that had caused most harm to them. Proportionally more men perceived pharmaceutical opioids and cannabis to be the most harmful drugs, while more women high-risk drug users considered heroin,

FIG. 17 | The extent of severity of dependence among high-risk drug users



³⁷ Ibid.

FIG. 18 Perception of drugs that caused more harm to high-risk drug users



Note: Miscellaneous drugs include alcohol, inhalants, ecstasy, LSD and PCP.

codeine-based cough syrup, and cocaine as the most harmful drugs.

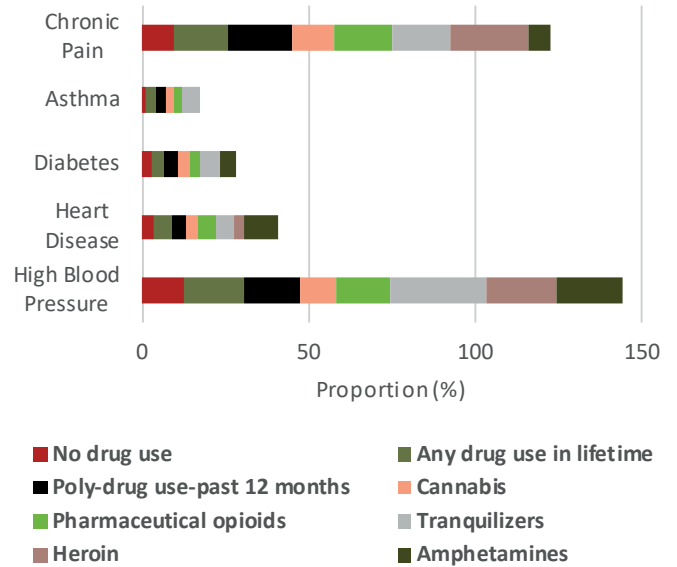
Personal health and drug use among the adult population

Respondents in the national household survey were asked to rate their perceived health status on a scale from 1 to 5, with 1 being very good and 5 being very poor. Overall, less than half of respondents self-reported very good health (46 per cent). On the other hand, those who reported that they had recently used alcohol, tobacco and other drugs were more likely to report poor health status compared to non-users. Also those who reported simultaneous or concurrent use of more than one substance had lower (perceived) health status than other drug users.

When respondents were asked about having ever been diagnosed with specific health conditions, chronic pain and high blood pressure stood out as the two main conditions drug users were (reportedly) diagnosed with. Furthermore, past-year users of methamphetamine reported higher rates of heart disease, high blood pressure, diabetes and chronic pain. Past year heroin users reported higher rates of high blood pressure and chronic pain, while past-year users of pharmaceutical tranquilizers self-reported higher rates of high blood pressure, diabetes and chronic pain. This data is limited in so far as being self-reported, lacking confirmed medical diagnosis and without indication of time period of onset relative to drug use, however they do support the self-rated health status described above and indicate poorer health among people who use drugs.

Moreover, those in the general population who reported using at least one drug in their lifetime were more likely to be hospitalized in the past 12 months (13 per cent) compared to those who had never used any drug (8 per cent), this was even higher among those who reported

FIG. 19 Self-reported ailments among those who reported use of substances in their lifetime and in past 12 months by drug type



poly-drug use (16 per cent) in the past year and past-30 days (18 per cent). While all respondents reported visiting government or private hospitals most often when ill, past-year drug users were more likely to also report seeking medical assistance from community health workers, pharmacies, patent medical vendors, or traditional practitioners/spiritual healers than those who did not report any drug use.

Provision of structured treatment and other services for drug users

In Nigeria, treatment for problem drug use is based mainly in tertiary hospitals, while some non-governmental organizations (NGOs) and faith-based centres offer limited ser-

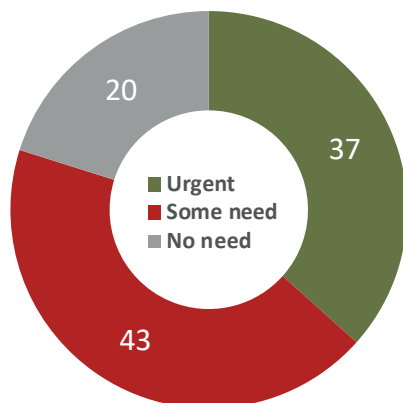
TABLE 20 Mean score of perceived ease or difficulty in accessing drug treatment services by drug users, by geopolitical zone and states

| (a) Mean score | | (b) Mean score | | (c) Mean score | |
|----------------|-----|----------------|-----|----------------|-----|
| North Central | 3.6 | North East | 3.4 | North West | 3.4 |
| BENUE | 4 | ADAMAWA | 3.6 | JIGAWA | 4.1 |
| KOGI | 3.9 | BAUCHI | 3.4 | KADUNA | 3.4 |
| KWARA | 3.6 | BORNO | 1.9 | KANO | 3.9 |
| NASARAWA | 3.4 | GOMBE | 2.8 | KATSINA | 2.9 |
| PLATEAU | 3.7 | TARABA | 3.1 | KEBBI | 4 |
| FCT | 3.3 | YOBE | 4.3 | SOKOTO | 1.9 |
| NIGER | 3.6 | | | ZAMFARA | 3.6 |

| (d) Mean score | | (e) Mean score | | (f) Mean score | |
|----------------|-----|----------------|-----|----------------|-----|
| South East | 3.8 | South South | 3.9 | South West | 3.9 |
| ABIA | 3 | AKWA IBOM | 3.4 | EKITI | 3.7 |
| ANAMBRA | 4.1 | BAYELSA | 4.4 | LAGOS | 4.3 |
| EBONYI | 4.1 | CROSS RIVER | 3.8 | OGUN | 4 |
| ENUGU | 4.2 | DELTA | 4.1 | ONDO | 3.8 |
| IMO | 3.8 | EDO | 3.2 | OSUN | 3.8 |
| | | RIVERS | 4.4 | OYO | 3.8 |

Note: The question was asked on a Likert scale with 1 being very easy and 5 very difficult – thus the mean scores reflect the relative ease or difficulty in accessing drug treatment services in the different geo-political zones and states within those in Nigeria.

FIG. 20 Perceived need for treatment among high-risk drug users



vices. Inpatient and limited outpatient services are offered in drug units within some hospitals. Drug treatment services are not available free of cost, which limits their access. There are also informal treatment programmes that are faith-based or provided by traditional healers.

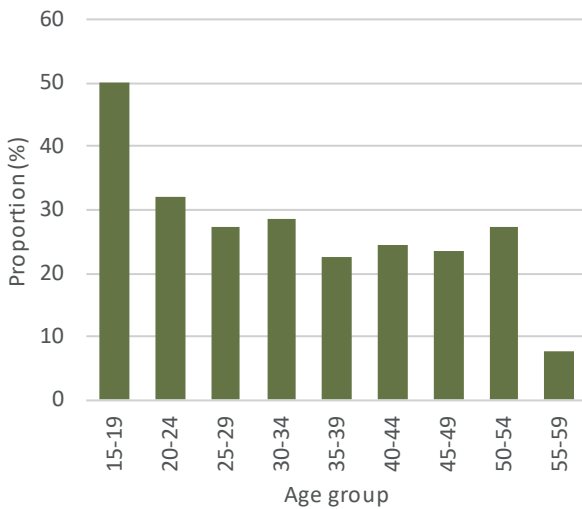
While the majority of high-risk drug users indicated a need of treatment for their drug use disorders, they considered it was substantially difficult to access such treatment in their areas. The question was asked on a Likert scales with 1 being very easy and 5 very difficult. The mean score of ease or difficulty in accessing drug treatment nationally was 3.6.



Provision of drug treatment services and interventions

Nearly 40 per cent of high-risk drug users reported that they had wanted help or treatment for their drug problems but were unable to get it. Only 12 per cent of the high-risk drug users had received treatment for a drug problem over the course of their using drugs - a rate only slightly higher for women (13 per cent women vs. 12 per cent men). In the past 12 months, only 4 per cent of the high-risk drug users had received treatment. Older drug users were more likely to have ever received treatment, likely reflecting a longer duration of drug use, yet the majority of high-risk drug users who reported being in treatment within the past 12 months were under 35 years of age. The mean age at which high-risk drug users had received drug treatment for the first time was 25 years for men and 23 years for women. The average time between initiating drug use and entering treatment was around 3 years for men, and around 2 years since initiation of drug use for women.

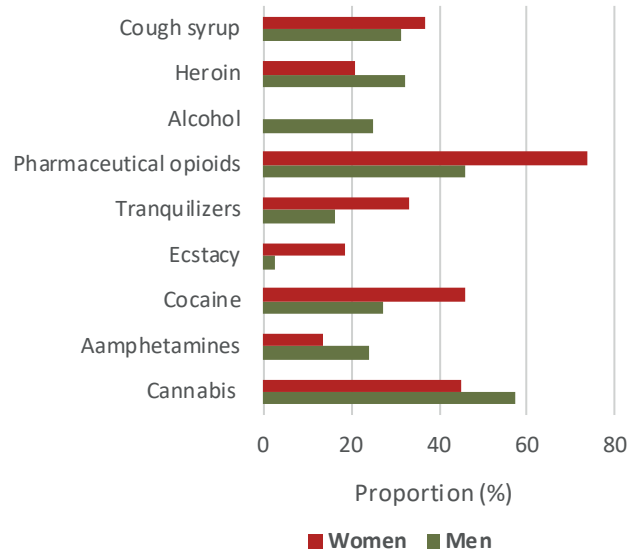
FIG. 21 Proportion of high-risk drug user who received treatment in the past 12 months, by age groups



Of the 4 per cent of high-risk drug users who had received treatment in the past 12 months, men were more likely to have received treatment for cannabis use and pharmaceutical opioids such as tramadol, codeine, or morphine. Women on the other hand were more likely to report receiving treatment for pharmaceutical opioids and cocaine use disorders.

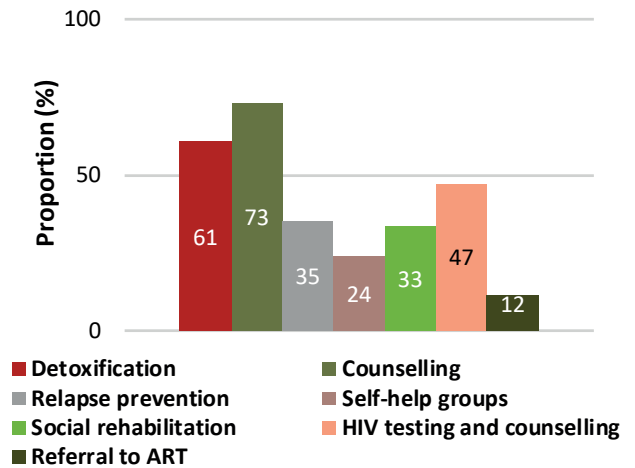
While in treatment, counselling followed by detoxification were the main interventions high-risk drug users had received. Other interventions, such as relapse prevention or social rehabilitation, were reported by a smaller proportion of drug users while in treatment. Also, nearly half of

FIG. 22 Proportion of high-risk drug users by primary drug for which they had received treatment in the past 12 months



Note: the high drug users may have received treatment multiple times and/or for different drugs in the past 12 months.

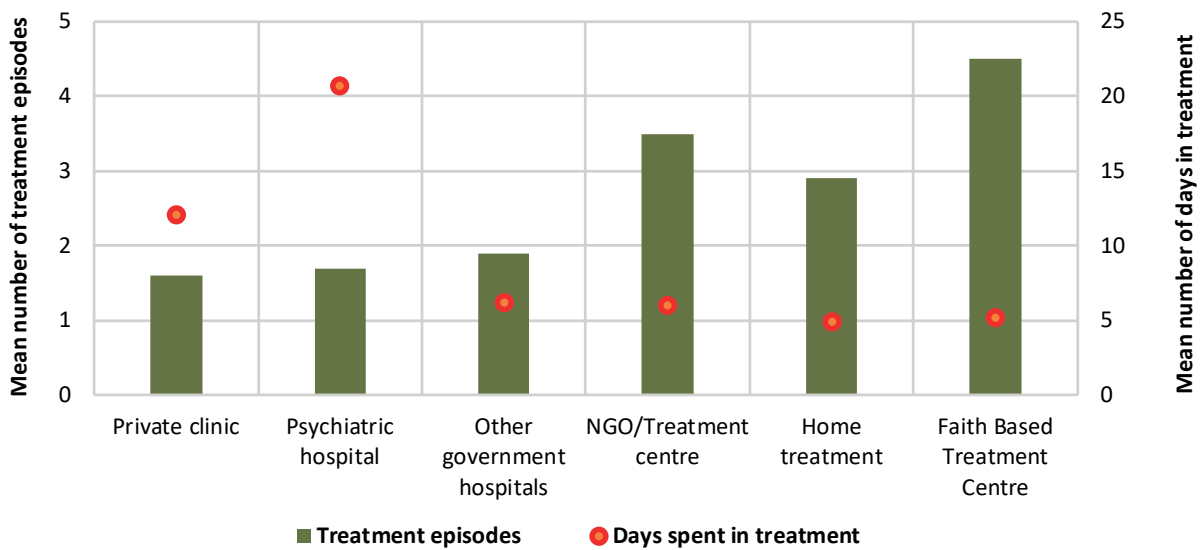
FIG. 23 Interventions drug users reported receiving at most recent treatment episode



high-risk drug users reported receiving HIV testing and counselling while in treatment.

On average, the high-risk drug users had been in drug treatment on 3 occasions over the course of their drug using careers. In the past twelve months, NGOs and faith-based treatment facilities were the ones more often accessed by high-risk drug users – 4 and 5 times respectively. On the other hand, drug users had spent on average more days in treatment at a psychiatric hospital or private clinic – 21 and 12 days respectively.

FIG. 24 Self-reported treatment episodes and average time spent in treatment in the past 12 months by type of treatment facility



Barriers to access support and services

Nearly 40 per cent of high-risk drug users reported that they had wanted help or treatment for their drug problems but were unable to get it. The most common reasons for not accessing drug treatment cited were the cost of the treatment, the stigma attached to drug use, that drug treatment services were not available, or that there was no information available about the local drug treatment ser-

vices. These are important points to consider as, along with making more treatment services available, policy makers also need to address the issue of the stigma associated with drug use or with a drug user accessing drug treatment, as well as to ensure that these services are affordable and readily accessible to those who need them.

FIG. 25 Reasons for not accessing drug treatment services

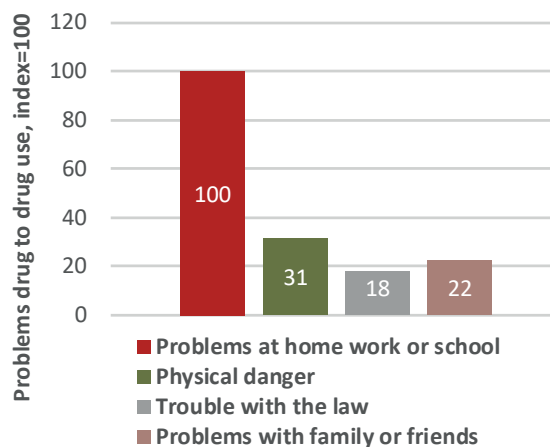


5. SOCIAL CONSEQUENCES OF DRUG USE: HARMS TO OTHERS

Harms to others is a concept that attempts to document the adverse effects of drug use on persons other than the drug user. These adverse effects cover issues such as effect on the health and wellbeing of a person, domestic violence, and relationship issues among others. In recent years, harms to others has been used in alcohol epidemiology in many countries to document precisely the extent of harms to others due to alcohol use. For the drug use survey in Nigeria, an attempt was made to document harms to themselves (drug users) and others due to drug use as perceived by the drug users themselves, key informants in the community, and those who had not used any substance in the general population.

As part of the drug use survey key informants were interviewed in the community and were asked, among other questions, their perceptions of the social problems they had observed as a result of drug use in their communities. These key informants considered that the use of cannabis, followed by non-medical use of pharmaceutical opioids and codeine based cough syrups, had caused the most problems in their communities. These social problems ranged from family issues (conflict or breakup), loss of work or employment, or legal issues (criminality or arrests) as a result of someone's drug use.

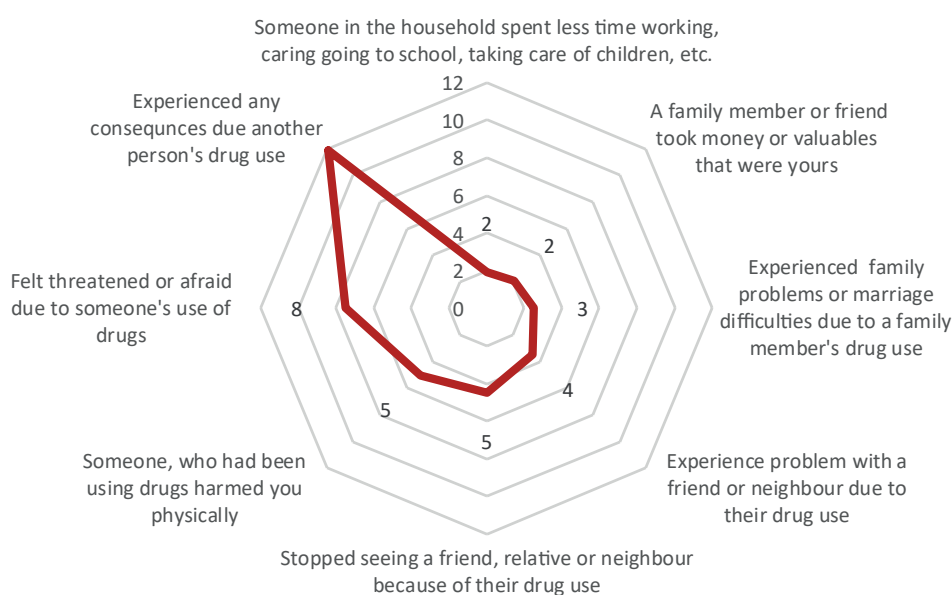
FIG. 26 Self-reported problems experienced as a result of drug use



Note: The self-reported problems experienced by drug users are presented relative to "problems at home, work or school" (100 per cent).

Drug users among the general population reported missing school or work, poor performance at school or work, or neglecting their family or children, as some of the major problems they had experienced as a result of their drug use. While nearly half of the drug users reported problems at home, school, or workplace as the main problems, fewer

FIG. 27 Proportion of the population aged 15-64 who had experienced consequences due to another person's drug use



Note: These questions on the domains of harms to others were adapted from harms to others' studies on alcohol use and applied for the first time for a drug use survey

drug users also reported being in physical danger, relationship issues within the family or with friends, or having trouble with law enforcement entities due to their drug use.

Respondents in the household survey were also asked if they had experienced any psychological or social consequences due to another person's drug use in the past 12 months. Among the general population those who had never used drugs, nearly 1 in 8 persons aged 15-64 years reported experiencing some consequences as a result of a person in their family, neighbourhood or community using drugs. Among those who had experienced any consequences, most of them had felt threatened or afraid of someone's use of drugs (8 per cent of the adult population). Other important consequences that people had experienced were that someone using drugs had harmed them physically (5 per cent of the adult population) or that they had stopped seeing a relative or friend due to their drug use (5 per cent of the adult population). Also of concern is that 2 per cent of the adult population reported that a family member or a friend had taken their money or valuables - without their consent or willingness.

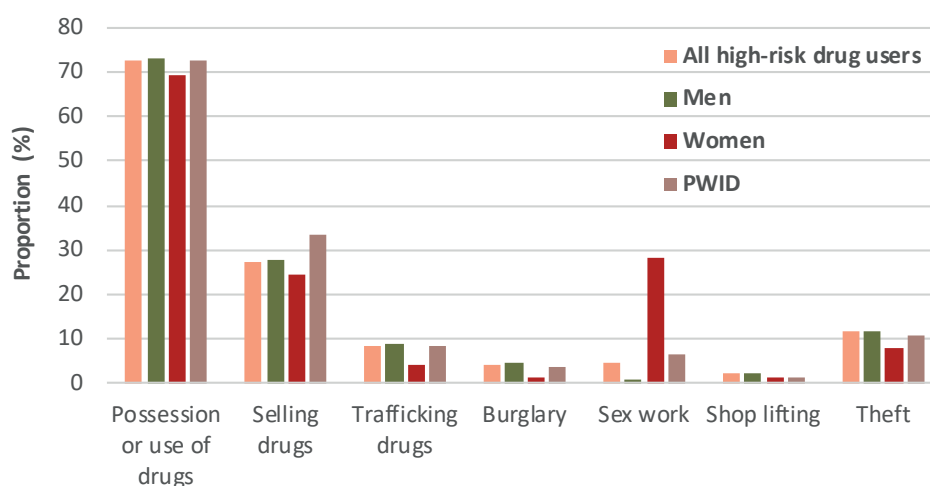
Drug use and the criminal justice system

Nearly one quarter of high-risk drug users had been arrested for a drug-related offence during the course of their drug use, while nearly 9 per cent were arrested in the past 12 months. Male high-risk drug users, and PWID among them, were more likely than others to have been arrested in their lifetime, as well as during the past 12 months, for a drug-related offence (29 per cent and 11 per cent respectively). Moreover, the likelihood of ever being arrested increased with increasing age.

The majority of drug users reported being arrested for possession and use of illicit drugs. Possession or use of cannabis, followed by cough syrups containing codeine, were the drug offences for which the majority of drug users had been arrested. Those arrested for cannabis use or possession were more likely to be drug users in older age groups and those who had steady or full-time jobs. Those arrested for possession of or using codeine-based cough syrups, as well as pharmaceutical opioids, were more likely to be in the younger age groups (15-24 years of age), and be students or unemployed. More women than men reported being arrested for cocaine and crack cocaine-related offences, although men were more likely to report being arrested for heroin use or possession. Overall, those arrested for cocaine or crack cocaine were more likely to be older than 40 years of age and unemployed. Arrests for sex work were almost exclusively reported among women, and were highest among women who reported injecting drugs. It is also important to note that among high-risk drug users who had been arrested, nearly 14 per cent of the had been arrested for thefts and shoplifting.

The mean age of a first arrest for a criminal offence was 24 years of age. On average, drug users reported being first arrested 7 years after initiation of drug use. For women, the first arrest on a criminal offence occurred slightly earlier at nearly 6 years after initiation of drug use, as was also the case for PWID. High-risk drug users reported being arrested an average of 3 times in their lifetime, with no difference between men and women, or age of drug users. The majority of drug users (61 per cent) who were arrested in the past 12 months reported spending between 1-5 months in prison. Male drug users and PWID were likely to spend around 7 months incarcerated on a criminal offence.

FIG. 28 | Percentage of high-risk drug users who reported having been arrested for criminal offences



6. POLICY IMPLICATIONS AND THE WAY FORWARD

The current report reveals that 14.4 per cent of the population aged 15-64 years in Nigeria (14.3 million people) have used drugs in the past 12 months. Cannabis was the most widely used substance in Nigeria, followed by prescription opioids (such as tramadol, codeine, or morphine) and cough syrups containing codeine or dextromethorphan.

High-risk drug users³⁸ were estimated to account for 0.4 per cent of the population (approximately 376,000 people) and almost all were regularly using opioids, predominantly pharmaceutical opioids such as tramadol, codeine or morphine. Among the high-risk drug users, nearly 80,000 were those who injected drugs.

One out of five persons who used drugs in the past year is suffering from drug use disorders, and there is an unmet need for drug treatment. Nearly 40 per cent of high-risk drug users wanted treatment but were unable to get it. Cost of treatment, the stigma associated with drug use, and the limited availability of drug treatment services were major barriers to accessing drug treatment in Nigeria.

In July 2018, prior to finalisation of this report, the key findings of the drug use survey were presented to the Technical Working Group and the National Steering Committee³⁹. In light of the findings of the drug use survey, the stakeholders suggested as the way forward some important issues for consideration by policy makers to address the drug problem in Nigeria. These are presented in the following paragraphs.

Drug use survey findings to inform the new National Drug Control Master Plan 2020–2024

Nigeria's National Drug Control Master Plan (NDCMP) for the period 2015 to 2019 aimed at strengthening responses to illicit drug use in order to contribute to the enhanced health, security and well-being of all Nigerians. The mid-term review of the NDCMP in 2017 recognised that progress had been made in the implementation of the Master Plan, but that almost all such activities were

38 In this survey, high-risk drug users were defined as those who had used opioids, crack/cocaine or amphetamines in the past 12 months as well as used for at least 5 times in the past thirty days.

39 Members of the National Steering Committee and Technical Working Group included representatives from Federal Ministry of Health; National Drug Law Enforcement Agency, National Agency for Food and Drug Administration and Control, Federal Ministry of Budget and National Planning, National Agency for the Control of AIDS, National Bureau of Statistics, Centre for Research and Information on Substance Abuse, Population Council, Market Research Consultancy, World Health Organization, UNODC.

supported by the European Union funded and UNODC implemented project “Response to drugs and related organized crime in Nigeria”. The review noted that there was inadequate funding on the part of the Nigerian Government to adequately implement this strategy. As this plan draws to a close, and the government is in the process of developing a new 5 year NDCMP for the period 2020 to 2024, as a way forward, it would be essential that the findings of the survey are used by policymakers and planners to inform the design of this new Master Plan with adequate allocation of national funding for its implementation.

Affordable and accessible scientific evidence-based drug treatment to be made available for people with drug use disorders

There is a major gap in the availability and accessibility of drug treatment services in the country. The cost of treatment itself, the limited number of interventions provided within treatment, and the stigma attached to drug use are all major impediments in the provision of quality drug treatment services that can cater for a large segment of the drug using population in Nigeria. Similarly, as other reports indicate, the national capacity to provide scientific evidence-based treatment is very limited.⁴⁰

In order to meet the diverse needs of the population suffering from drug use disorders, accessible and affordable drug treatment services in community settings need to be significantly expanded. It would be most cost effective if provision of drug treatment could be mainstreamed within the broader health care delivery system, including its provision in prison settings, and not restricted to highly specialized residential drug treatment services. Introducing and upscaling long-term opioid agonist treatment for people with opioid use disorders could also enhance the coverage of drug treatment services both in the community and in prison settings. Efforts to support the prevention and treatment of drug use would also include providing people who use drugs with the necessary knowledge and skills to prevent overdoses, including through the administration of naloxone.

40 Nigerian Epidemiological Network on Drug Use (NENDU) 2017 reports 1085 treatment episodes; NENDU 2016 reports 990 treatment episodes and NENDU 2015 reports 1044 treatment episodes. While the NENDU does not cover all treatment centres in the county, it covers 11 major hospitals and 7 commands of the NDLEA. It does indicate that treatment capacity will need to be rapidly expanded to provide quality coverage to drug users in need of services.

Another area of consideration is to develop gender-specific treatment services that would take into account in their design and delivery the sexual and reproductive health, social welfare, and childcare needs unique to women. Expansion of drug treatment services would also require ongoing efforts to build the capacity of service providers in line with both national treatment guidelines and the international standards on drug treatment.

Scaling up a comprehensive package of services for prevention, treatment and care of HIV among people who use drugs in the community and in prison settings

Prevention of the negative health and social consequences of drug use is critical for both drug users and society at large. UNAIDS reports that Nigeria's HIV epidemic is the second largest epidemic globally and affects all population groups and geographic areas of the country.⁴¹ The current report documents the widespread use of risky injecting practices and risky sexual behaviours among high-risk drug users, and in particular among those who inject drugs. The extent of self-reported HIV among this group is also an area of concern. The introduction and scaling up of core interventions, such as needle and syringe programmes and opioid substitution therapy among others, as outlined in the WHO, UNODC, UNAIDS "Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users", are important measures for prevention, treatment, and care of HIV among people who use drugs in the community and in prison settings.

Addressing stigma related to drug use

Efforts to enhance the coverage, accessibility, and affordability of drug treatment services can only be effective if those services are based on scientific evidence and respect for human rights, and if the stigma associated with drug use can be mitigated. Such stigma can be overcome by increasing understanding, among the policy makers, civil society leaders, service providers, and the public at large, of drug use disorders as complex, multifaceted and relapsing chronic conditions that require continuing care and interventions from many disciplines.⁴²

41 <http://www.unaids.org/en/regionscountries/countries/nigeria> (accessed 3 August 2018)

42 UNODC, *World Drug Report 2018*.

Evidence-based drug use prevention programmes

Prevention of drug use aims to help people, not only those of younger age, to avoid or delay the initiation of use of psychoactive substances, or if they have already started to avert the development of harmful use and substance use disorders. Effective prevention contributes significantly to the positive engagement of children, youth and adults with their families, schools, workplace and community. The International Standards present the evidence which suggests that among the different prevention programmes, those with a focus on parenting, families, and life skills education at different levels of children's development (i.e., infancy, early and middle childhood, adolescence and adulthood), and focus needs of children at those stages of development are more effective than other interventions. In order to maximize the utilization of resources for effective and science-based prevention interventions the UNODC "International Standards on Drug Use Prevention" provide the necessary guidelines. These guidelines need to be considered in the expansion of evidence-based drug prevention programmes for children, both in school and out of school settings.

Ensure availability of pain medication for medical and scientific purposes while preventing their diversion and misuse, as well as their illicit production or availability in the illicit market

Considering the extent of non-medical use of pharmaceutical opioids, tranquilizers and cough syrups among the adult population there is a need to ensure that while controlled substances are adequately made available for medical and scientific purposes, it is imperative to address their diversion from licit channels, as well as their illicit production or availability in the illicit markets in the form of spurious or fraudulent medicines. The recommendation provided in the outcome document of the UN General Assembly Special Session on Drugs (UNGASS) 2016, as well as other national, UNODC and WHO documents, provide adequate guidance in this regard.^{43, 44, 45, 46}

43 WHO, *Ensuring balance in national policies on controlled substances: guidance for availability and accessibility of controlled medicine*, ISBN 978 92 4 156417 5.

44 UNODC, *Technical Guidance: Increasing access and availability of controlled medicines*, advanced draft, March 2018.

45 INCB, *Availability of Internationally Controlled Drugs: Ensuring Adequate Access for Medical and Scientific Purposes*, ISBN: 978-92-1-148285-0, 2016.

46 Federal Ministry of Health, Nigeria, *National Policy for Controlled Medicines*, 2017.

Cooperation within the ECOWAS region on standardizing regulatory controls and the development and implementation of national supply management systems for controlled substances are additional strategies that policymakers may consider in this regard.

Monitoring and evaluation of drug use patterns, emerging trends, and responses to the drug problem

The drug use survey has provided a comprehensive picture on the extent of drug use and related harms among the adult population in Nigeria. On the other hand the Nigerian Epidemiological Network on Drug Use (NENDU) that was established in recent years, focuses only on treatment demand. There is a need for a mechanism, such as the establishment of a national drug observatory, that can regularly collate data from different sources and analyse the drug situation in the country to further inform policy and programme development. The drug observatory could regularly monitor, through established indicators of drug use and supply, emerging and new drugs, and trends in drug use; conduct drug use surveys with the general population and among young people; explore the patterns of drug use among vulnerable population groups, and monitor the extent and quality of government and non-governmental responses to address the drug situation in the country.

NDLEA to implement an intelligence-led policing model targeting mid- to high level traffickers

While it is critical to expand access to affordable drug treatment services, law enforcement responses also need to be enhanced to bolster effective drug supply suppression. Sustained efforts are required to ensure law enforcement approaches that are intelligence-led and target mid- to high level traffickers are implemented and by extension not focused on drug users. These strategies need to better incorporate the use of financial intelligence to detect drug traffickers and their criminal wealth.

7. NIGERIA – IN CONTEXT

Nigeria gained independence in 1960 and is a federation of 36 states and the Federal Capital Territory (FCT). Nigeria is located in West Africa and shares borders with Republic of Benin in the west, Chad and Cameroon in the east and Niger Republic in the north. Its coast in the south lies on the Gulf of Guinea in the Atlantic Ocean. The country is divided into six geopolitical zones. The country is inhabited by over 250 ethnic groups, of which the three largest are the Hausa, Igbo and Yoruba.

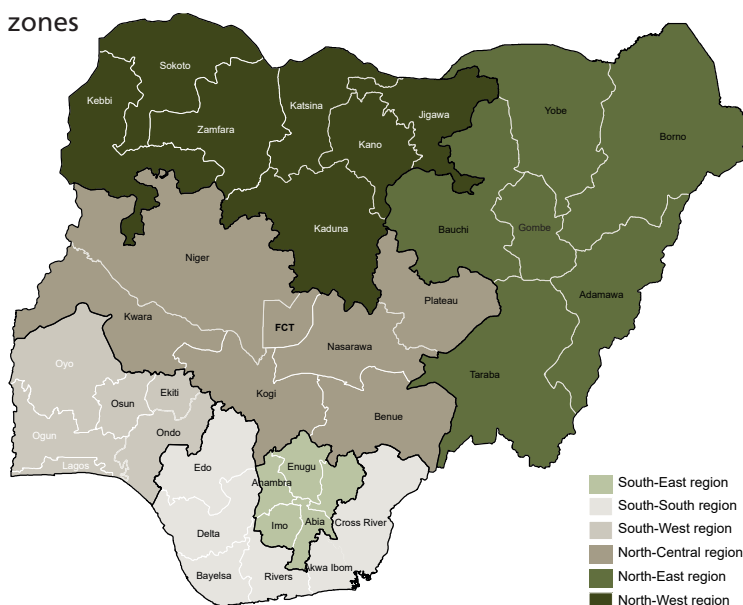
With approximately 186 million inhabitants^{47, 48}, Nigeria is the most populous country in Africa and the seventh most populous country in the world. The country is ranked 152 out of 188 countries in the United Nations Human Development Index⁴⁹, with close to half the population (46 per cent) living below the poverty line. Nigeria has a young population (median age is 17.9 years)⁵⁰ and nearly half (47.8 per cent) of the population live in urban areas. The literacy rate of the total population is 59.6 per cent⁵¹. In terms of health indicators, the *Human Development*

Report, 2016, indicates that the life expectancy at birth is 53.1 years⁵². In spite of this, the country has a low investment in public health with expenditure of less than 1 per cent of Gross Domestic Product (GDP). According to the same report, the gender inequality index shows disparity in the labour force participation rate between females and males, and in the gross national income per capita.

Drug supply

The 2017 report by the International Narcotics Control Board (INCB)⁵³ notes that West Africa remains a key transit point for drug trafficking. Other than cannabis and cocaine, seizure data indicate trafficking in precursors like ephedrine in Nigeria and in the synthetic opioid tramadol, which is not under international control but is increasingly being misused in Nigeria and in the broader West African region. The illicit manufacturing of amphetamines⁵⁴ and cultivation and production⁵⁵ of cannabis are also areas of concern in Nigeria.

Nigeria by geopolitical zones



Note: The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations.

47 Based on the population estimates of 2016.

48 United Nations, Department of Economic and Social Affairs, Population Division (2017). *World Population Prospects: The 2017 Revision*, 2017.

49 UNDP, *Human Development Report: Human Development for Everyone*, 2016.

50 United Nations, Department of Economic and Social Affairs, Population Division (2017). *World Population Prospects: The 2017 Revision*, 2017.

51 UNDP, *Human Development Report: Human Development for Everyone*, 2016.

52 UNDP, *Human Development Report: Human Development for Everyone*, 2016.

53 INCB, *Report of the International Narcotics Control Board (INCB) for 2017*, UN, Vienna, 2018.

54 UNODC, *Transnational organized crime in West Africa: a threat assessment*, February 2013.

55 Federal Republic of Nigeria, *NDLEA 2016 Annual Report*, Lagos, Nigeria, 2016.

The 2016 Annual Report of the National Drug Law Enforcement Agency (NDLEA)⁵⁶ indicates that while drug trafficking remains an issue in Nigeria, data from 2016 shows a decline in both the arrests related to and seizures of drugs. The total drug seizures during the period stood at 267,591.49 kg. These included cannabis (187,394 kg) followed by psychotropic substances (77,755 kg), methamphetamine (1,352 kg), and ephedrine (718 kg). Other drug seizures included 305 kg of cocaine and 66 kg of heroin. Data from seizures at Lagos International Airport⁵⁷, shows the inflow of drugs into Nigeria is approximately 49 per cent of the total drugs seized, whereas remaining proportion is the outward movement of drugs or couriers. The most favoured outward destination for drug couriers leaving Nigeria in 2016 was China, followed by South Africa. While several countries in Africa were reported as destination countries by the couriers, the Report acknowledges that these might not necessarily be the final destinations for the drugs they were carrying which could also be meant for markets in Europe and Asia.

Cocaine

While West Africa and Nigeria in particular, have been a hub for cocaine trafficking, according to the 2017 World Drug Report⁵⁸, in recent years there has been a decline in the quantities of cocaine intercepted in Africa which has gone in parallel with a decrease in the number of reports in Europe of African countries being used as transit areas. However, the same reports warn that this trend may be due to poor capacity of detection and reporting rather than a decrease in the actual flow of cocaine, as there have been some significant seizures of cocaine shipments destined for Africa. In the period 2010-2015 African countries most frequently reported Nigeria as the transit country within the region.⁵⁹ Data on cocaine seizures in Nigeria confirms that Nigeria continues to be a hub for cocaine trafficking, with the highest quantities in 2016 being seized in Lagos (seaport and airport) followed by Abuja.

TABLE 21 | Cocaine seizures in Nigeria

| Year | Cocaine seized (kg) |
|------|---------------------|
| 2013 | 290 |
| 2014 | 226 |
| 2015 | 260 |
| 2016 | 305 |

56 Federal Republic of Nigeria, NDLEA 2016 Annual Report, Lagos, Nigeria, 2016.
 57 Federal Republic of Nigeria, NDLEA 2016 Annual Report, Lagos, Nigeria, 2016.
 58 UNODC, World Drug Report 2017.
 59 UNODC, World Drug Report 2017.

Cannabis

As in previous years, cannabis topped the list of drugs seized by the NDLEA in 2016 and it continues to present a challenge in terms of trafficking and illicit cultivation⁶⁰. The cultivation of cannabis is well established in various parts of Nigeria and due to a range of climatic and geographical factors which create an ideal growing environment, is especially concentrated in the South West⁶¹. In 2016, 718 hectares of cannabis plantations nationwide were discovered and destroyed. Cannabis plantations are usually located in remote areas with difficult terrain that limits access, which poses challenges for drug interdiction, eradication and crop substitution.

TABLE 22 | Cannabis seizures and hectares of cannabis destroyed (NDLEA Annual reports)

| Year | Cannabis (kg) seized | Hectares of Cannabis eradicated |
|------|----------------------|---------------------------------|
| 2013 | 205,373 | 847 |
| 2014 | 158,852 | 4,529 |
| 2015 | 871,480 | 377 |
| 2016 | 187,394 | 718 |

Source: NDLEA Annual Reports.

Opioids

In 2016, NDLEA reported the seizure of 50,536 kg of tramadol, with the amount seized by NDLEA rising to 72,602 kg in 2017. This synthetic opioid analgesic is increasingly being used for non-medical purposes in the West African region, including in Nigeria⁶². According to the latest UNODC World Drug Report⁶³, yearly seizures of tramadol in the region have risen since 2013 from 300 kg to over 3 tonnes. Heroin also continues to be trafficked in Nigeria as is shown in the table below.

TABLE 23 | Heroin seizures in Nigeria

| Year | Heroin seized (kg) |
|------|--------------------|
| 2013 | 24.53 |
| 2014 | 56.45 |
| 2015 | 30.09 |
| 2016 | 65.22 |

Source: NDLEA Annual report for the years.

60 Federal Republic of Nigeria, NDLEA 2016 Annual Report, Lagos, Nigeria, 2016.
 61 NDLEA and UNODC, Report on Nigeria Cannabis survey Activities, 2013.
 62 Federal Republic of Nigeria, NDLEA 2016 Annual Report, Lagos, Nigeria, 2016.
 63 UNODC, World Drug Report 2017.

Amphetamine Type Substances

According to the INCB there is a growing concern about methamphetamine production in West Africa. Since 2011 the NDLEA has dismantled 12 methamphetamine laboratories and seized 84 kg of methamphetamine at these laboratory sites⁶⁴. In 2016, the NDLEA dismantled a so-called 'super lab' that was capable of producing 3,000 kg of methamphetamine in each cycle. In 2016, the NDLEA reported seizures of 1,352 kg of methamphetamine⁶⁵.

Precursors

In spite of limited data on precursors, the main seizures of precursors reported from Nigeria were of ephedrine being shipped to other countries in Africa. As in the past, the shipments of ephedrine seized in Nigeria were initially diverted from domestic channels of distribution. The NDLEA reports that it seized 718 kg of ephedrine in 2016 and 168 kg in 2017. Eleven of the methamphetamine laboratories seized in Nigeria were found to be utilizing a production method based on ephedrine as the precursor, whereas the large 'super lab' seized in 2016 relied on benzaldehyde. This is an organic compound used as a food additive and not under international control, from benzaldehyde the precursor chemical phenylacetone, commonly known as P2P can be extracted, which is then used to manufacture methamphetamine.

The National Agency for Food, Drug Administration and Control (NAFDAC) is responsible for the control, licensing and enforcement of controlled substances such as ephedrine. For at least the past five years, the government has approved the importation of over 10 tonnes of ephedrine annually. However, a national survey to estimate the needs for precursors such as ephedrine for medical and scientific purposes undertaken in 2017 by the Federal Ministry of Health and NAFDAC, indicated that the amount of ephedrine actually required could be substantially less than the amount currently imported. It is planned to repeat this survey in 2019 in order to establish the robustness of the estimated quantity of ephedrine required for medical and scientific purposes in Nigeria.

Drug use

Nigeria has had no monitoring system for drug use in place and no comprehensive and reliable data has existed nationally on the prevalence of drug use, the range of substances used, and the number of people with drug use

disorders. Information on drug use in the country has comprised drug treatment data from a few hospitals, and state or regional surveys and studies on drug use. However, due to different aims and methodologies of these studies, it has been difficult to extrapolate information on the extent and patterns of and trends in drug use nationally.

Nevertheless, most of these studies⁶⁶ have identified cannabis as the most commonly used substance, while the use of heroin and cocaine has been reported since the mid-1980s. In recent years the non-medical use of pharmaceutical opioids such as tramadol and codeine-based cough syrups has also been increasingly reported in Nigeria.

More recently the Federal Ministry of Education, NDLEA, FMOH, NAFDAC and UNODC have collaborated, as part of the European Union funded project "Response to Drugs and Related Organized Crime in Nigeria", on a Randomized Control Trial (RCT) on a drug prevention programme in school settings called *Unplugged*. Analysis of the data from the RCT has shown the extent of tobacco, alcohol and illicit drug use among school children (mainly aged 14 and 15 years) in Nigeria. The proportion of pupils who smoked cigarettes at least once in their life was, overall, quite low (5.1 per cent) except in the North-West zone where it was 13.4 per cent. In all the geo-political zones of Nigeria, alcohol was the most commonly used substance (33.6 per cent of pupils reported lifetime use). Overall life time use of cannabis was reported among 7.5 per cent of the students. The highest lifetime prevalence of cannabis use was reported in the North-West zone of Nigeria (21.2 per cent) followed by the North-East (14.2 per cent). For all substances, an increase in prevalence of substance use among students was observed with the increase in age. Substance use among girls was reported much lower as compared to boys.⁶⁷

Another source of data recently available is the profile of people seeking treatment for drug use disorders through the "Nigerian Epidemiological Network on Drug Use" (NENDU). The Network was established in 2015 as part of the European Union funded and UNODC implemented project 'Response to drugs and related organized crime in Nigeria'. The Network comprises 18 reporting facilities, including 10 national hospitals (1 national, 6 neuro-psychiatric, and 3 teaching hospitals), 1 non-governmental hospital, and 7 state commands of the NDLEA that provide counselling services to drug users. According

64 Federal Republic of Nigeria, NDLEA Side event of the Commission on Narcotics Drugs, 2017.

65 Federal Republic of Nigeria, NDLEA 2016 Annual Report, Lagos, Nigeria, 2016.

66 Nigeria, National drug control master plan (NDCMP) 2015-2019.

67 Federal Ministry of Education, FMOH, NDLEA, NAFDAC, UNODC, Results of the 'Unplugged' Randomized Control Trial (RCT) in Nigeria, 2018.

to NENDU, between January and December 2016, there were 990 treatment episodes recorded by the participating drug treatment facilities. Cannabis (45 per cent) is the substance most frequently reported among treatment entrants, followed by opioids (36 per cent) and alcohol (11 per cent). The use of other psychoactive substances reported among people in drug treatment include cocaine (3 per cent), crack cocaine (2 per cent), sedatives-hypnotics (3 per cent) and amphetamine-type-stimulants (0.3 per cent). The majority (60 per cent) of drug treatment episodes were inpatient and mostly male (95 per cent). The pharmaceutical opioids reported in drug treatment included tramadol, codeine, and, to a lesser extent, pentazocine.

Availability, access and control of narcotic drugs, psychotropic substances and precursor chemicals for medical and scientific purposes

Being a signatory to the International Drug Conventions that stipulate availability of controlled medicines for medical and scientific purposes, while preventing their diversion and misuse, Nigeria is also addressing issues regarding access and control of narcotics and psychotropic substances for medical and scientific purposes. Controlled medicines, especially schedule I narcotics, have remained largely unavailable and inaccessible for medical use in several developing countries, including Nigeria. In order to improve the provision of these life-saving medications, and to ensure adequate controls are in place, the Federal Ministry of Health and NAFDAC in collaboration with UNODC formally launched the National Policy for Controlled Medicines in early 2018. This initiative also involved the development of related documents required to implement the National Policy – including National Guidelines for Quantification of Narcotic Medicines and National Guidelines for Estimation of Psychotropic Substances and Precursors. With the support of the EU funded and UNODC implemented project, FMOH and NAFDAC carried out the first national survey in 2017 using these documents and the first scientific estimate of the controlled medicines and precursors required in Nigeria is now available. According to the estimates, the national requirement of pharmaceutical opioids is 21 tons, including 13 tons of tramadol, 6 tons of precursors such as ephedrine and pseudoephedrine, and 21 tons of psychotropic substances including sedatives and hypnotics. A second survey is planned for 2019 which will ensure the robustness of Nigeria's estimated need of narcotic medicines, psychotropic substances and precursors for medical and scientific purposes.

Legislative and policy frameworks

International Drug Conventions

Building on its 1935 Dangerous Drugs Act, Nigeria has been a party to all UN international conventions on narcotic drugs and psychotropic substances. Nigerian policies in drug control are developed with due 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;
- 1988 United Nations Convention Against Illicit Traffic in Narcotic and Psychotropic Substances, ratified in 1989;
- 2000 United Nations Convention against Transnational Organized Crime, as well as its Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, and its Protocol against the Smuggling of Migrants by Land, Sea and Air, ratified in 2001; and the Protocol against the Illicit Manufacturing of and Trafficking in Firearms, Their Parts, Components and Ammunition, ratified in 2006;
- 2003 United Nations Convention against Corruption, ratified in 2004.

Nigerian Legislation

- **National Drug Law Enforcement Agency (NDLEA) Act No. 48 of 1989 (as amended)** which established the NDLEA to be responsible for preventing illicit cultivation, production, manufacture, trafficking in, and abuse of drugs.
- **National Agency for Food and Drug Administration and Control Act No. 15 of 1993** which set-up the NAFDAC, a parastatal under the Federal Ministry of Health to authorize (control) the importation and exportation of narcotic drugs, psychotropic and other controlled substances, to ensure that their uses are limited to medical and scientific purposes. NAFDAC is also mandated to collaborate with NDLEA in measures to control drug abuse in the country.
- **Money Laundering (Prohibition) Act, 2011 (as amended)**, addresses the problem of drug money laundering.
- Other relevant legislation include the **Dangerous Drugs Act, 1935**; **Indian Hemp Decree, 1966** (as amended); **Food and Drugs Act, 1976** (as amended); and the **Counterfeit and Fake Drugs and Unwholesome Processed Foods (miscellaneous provisions) Act, 1999**.

National Drug Control Master Plan 2015–2019

Nigeria has promoted continuity in strategic instruments to respond to the evolving drug situation: from the first National Drug Control Master Plan (NDCMP) launched in 1999, through the second one for the period 2008 – 2011 (extended to 2013), to the current plan for the five year period 2015-2019. The development of the NDCMP 2015-2019 was supported by the European Union funded and UNODC implemented project “Response to drugs and related organized crime in Nigeria” after extensive consultations at the state and national level. It aims to contribute to the enhanced health, security and well-being of all Nigerians. It contains four thematic pillars, namely drug law enforcement, drug demand reduction, access and control of narcotics and psychotropic substances for medical and scientific purposes, and the coordination pillar. NDCMP implementation and monitoring is supported by the same project and so far three annual reports have been produced and its mid-term evaluation has been completed. The NDCMP 2015-2019 has provided the critically needed focus to drug control activities in Nigeria by setting out measurable targets for the various government agencies responsible for drug control.

Institutional Framework

National Drug Law Enforcement Agency (NDLEA)

The enactment of the NDLEA Act 48 of 1989 led to the establishment of National Drug Law Enforcement Agency (NDLEA). The Act stipulates that the Agency has the responsibility of controlling illicit drug cultivation, abuse, possession, manufacturing, production, trafficking in narcotic drugs, psychotropic substances and chemical precursors. The Agency has established seven (7) directorates and fourteen (14) autonomous units and offices that work together to carry out its drug control mandate. The Agency operates through commands in each of the 36 states and the Federal Capital Territory (FCT) Abuja. In addition to these, ten Special Area Commands (SACs) are located at the nation’s international airports, sea ports and land borders⁶⁸.

68 Federal Republic of Nigeria, NDLEA 2016 Annual Report, Lagos, Nigeria, 2016.

National Agency for Food and Drug Administration and Control (NAFDAC)

In 1993, the NAFDAC Act No. 15 was passed establishing the National Agency for Food and Drug Administration and Control (NAFDAC). NAFDAC is mandated to regulate and control the importation, exportation, manufacture, distribution, advertisement, sale and use of food, drugs, chemicals, cosmetics, medical devices, detergents and packaged water. It is headed by a Director General and has 14 Directorates.

Federal Ministry of Health

Acknowledging that drug use disorders are a public health issue, in 2016, the Federal Ministry of Health, established the Drug Demand Reduction (DDR) Unit in the Department of Hospital Services. This Unit oversees and coordinates drug treatment service delivery in Nigeria in accordance with the National Health Act, 2014. The Unit also coordinates the Nigerian Epidemiological Network on Drug Use (NENDU) along with NDLEA.

The Department of Food and Drugs Services was established in 1993 following the excision of National Agency for Food and Drug Administration and Control (NAFDAC) from the then Food and Drug Administration and Control (FDAC) department. The Department formulates national policies, guidelines and strategies on food and drugs, and ensures ethical delivery of pharmaceutical services nationwide.

Nigerian Prisons Service

The Nigerian Prisons Service derives its operational powers from the Prisons Act of 1972. The Nigerian Prisons Service falls under the Federal Ministry of Internal Affairs and has as its head a Controller General who runs the system through Zonal and State Headquarter offices. The Controller General is assisted by six Deputy Controller Generals who head six Directorates into which the prisons are broadly divided. As of 11 April 2018, the total prison population was 75,772 (74,186, male and 1,586 female)⁶⁹. Of the total 75,772 prisoners, a majority (68 per cent) were awaiting trial. There are 240 prison facilities in Nigeria comprising maximum and medium security prisons, satellite prisons, and borstal institutions for juveniles. The official capacity of the prison system is 50,153⁷⁰ whereas the prison occupancy was 42 per cent higher than its capacity in 2018.

69 Nigerian Prisons Services, *Summary of inmate population by convict and awaiting trial persons as at 3 December, 2018* <http://prisons.gov.ng/statistics>.

70 World Prisons Brief, *World prison brief data: Nigeria* <http://www.prisonstudies.org/country/nigeria>.

Other Law Enforcement Agencies

Other law enforcement agencies involved in drug supply reduction include Nigeria Police Force (NPF), Nigeria Customs Service (NCS), the Economic and Financial Crimes Commission (EFCC) and Nigeria Immigration Service (NIS).

Civil Society Organizations

Civil society organizations addressing substance misuse-related issues were established in the late 1980s in Nigeria.⁷¹ The 1990s witnessed a proliferation of CSOs in the country, not only in the area of substance misuse, but also in various other fields - human rights, health, and rural development. The report on the “Assessment of Civil Society Organizations and Networks on Drug Prevention, Treatment and Care in Nigeria (2015)” which analysed responses from 60 CSOs working in the area of drug prevention, advocacy and treatment, found that most of the CSOs were relatively young having been founded and registered less than twenty years ago. The majority of these CSOs (more than 80 per cent) are located in three geographic zones of the country namely the South-West, South-South, and North-Central. Only 22 of these provide drug treatment and rehabilitation services, while a majority worked on creating awareness on the dangers of drug use in the community. Only 9 CSOs reported receiving any funding from government in the past three years and most received funding from private donors or generated income internally. In spite of the challenges facing CSOs working on drug issues in Nigeria, their clients report generally positive experiences and rate the services offered to them very highly.

While there was a CSO network operational in the mid-1990s called the NGO Network on Drug Demand Reduction in Nigeria (NNDDR) this could not be sustained. A new network called the Community Intervention Network on Drugs was formed in 2016 and a second network called the Civil Society Network on Substance and Drug Abuse (CSNetSDA) was formed in 2017. Community networks of drug users have been established in some states in Nigeria, and there are a few national networks but their influence on national policymaking so far seems to be limited.

Inter-Ministerial Committee on Drug Control (IMC)

To effectively involve the different stakeholders in drug control activities, the Federal Government of Nigeria constituted the Inter-Ministerial Committee on Drug Control (IMC) in 1994. The committee is headed by the Chairman and Chief Executive of NDLEA and has members drawn from 35 government ministries and agencies. The IMC produced the first National Drug Control Master Plan (NDCMP) in 1999, a second NDCMP 2008-2011 (extended to 2013) and the current NDCMP 2015-2019 with the support of the European Union funded and UNODC implemented project ‘Response to drugs and related organized crime in Nigeria’. The IMC has the responsibility to coordinate the implementation, monitoring and evaluation of outcomes of the NDCMP 2015-2019, as well as being responsible for the development of the NDCMP 2020-2024.

Drug treatment services

Drug treatment services in Nigeria are mainly based in tertiary hospitals, whereas some non-governmental organizations (NGOs) and faith-based organizations offer limited services. Inpatient and limited outpatient services are offered in some hospitals and drug units. However these services are typically not available free of cost and therefore are difficult for drug users to access. Informal religious/faith-based drug treatment programmes also exist in the country. The National Drug Law Enforcement Agency (NDLEA) also offers drug counselling services at its state commands across the country.

71 Isidore Obot, *Assessment of Civil Society Organizations and networks on Drug Prevention, Treatment And Care in Nigeria*; UNODC Nigeria, 2015.

8. ANNEX

The national survey on drug use was implemented with the leadership of Federal Ministry of Health in Nigeria. The National Steering Committee and the Technical Working Group provided the overall guidance and oversight for implementation of the surveys. The members of the NSC and TWG included representatives from FMOH, CRISA, NBS, National Drug Law Enforcement Agency (NDLEA), National Agency for Food and Drug Administration and Control (NAFDAC), National Agency for the Control of AIDS (NACA), Ministry of Budget and National Planning, Population Council, Market Research Council (MRC), World Health Organization (WHO), and UNODC.

Ethical Clearance

Ethical clearances were obtained from the National Health Research Ethics Committee for the household survey on 20 May 2016 and for the high-risk drug use and key informants survey on 20 March 2017. Essentially for the drug use survey the ethical considerations included informed consent to participate in the survey, and anonymity and confidentiality of the information provided by the respondents.

Methodology

National Household Survey on Drug Use and Health

The NHSDUH covered all 36 states of the Federation and the Federal Capital Territory (FCT), Abuja. The target population were male and female members of households, aged 15-64 years.

The household survey methodology was based on the National Bureau of Statistics (NBS) National Integrated Survey of Households (NISH). The NISH sample design is a 2-stage, replicated and rotated cluster sample with enumeration areas (EAs) constituting the first stage sampling units or Primary Sampling Units (PSUs). The households constitute the second stage units or Secondary Sampling Units (SSU). The NISH Master Sample (MS) was constructed from the sampling frame of the EAs used for the Population and Housing Census of the Federal Republic of Nigeria conducted in 2006, and provided by the National Population Commission (NPopC). In the NISH Master Sample, each state has 200 EAs which were randomly drawn in 20 independent replicates. Each replicate was made up of 10 EAs.

The first stage of selection was the selection of EAs in each state and the Federal Capital Territory (FCT) in which a total of 70 enumeration areas, taken from 7 replicates were selected. The selection of EAs was done such that they cut across both urban and rural areas of the state. This gave a total of 2,590 EAs to be covered throughout the country.

The second stage of selection involved selection of households. A cluster of 15 households was systematically selected per EA from the list of households available. This resulted in a total of 1,050 households to be sampled within each state and FCT Abuja. Subsequently, this design yielded a total sample size of 38,850 households nationally covering both urban and rural areas in each state.

For each household selected, field staff identified and ranked all residents aged 15-64 according to their age. Using a grid based on the number of the house in the unit, as well as size of the household, one respondent was randomly chosen from eligible household members. This method allowed for the random selection of a household member with built-in variation in the age distribution, as well as to avoid oversampling of household heads or the spouses of household heads. The final interviews in the household were face-to-face interviews using CAPI (computer assisted personal interviewing) hand-held devices.

In order to account for potential over-sampling in areas of low population density and under-sampling in higher density areas, the answers from individual respondents were weighted to redistribute the sample population to reflect known ratios of gender, urban and rural population distribution, as well as by province.

Formative Research

Cognitive testing for questionnaire development

Drug use in many countries is a highly stigmatized behaviour which could result in under-reporting of the drug using behaviour among the general population. In order to ensure the questionnaire used in the household survey was culturally appropriate, different questions within the instrument were worded in a manner that would elicit the desired responses from the respondents, cognitive testing of the set of questions to be used in the household survey was conducted.

The cognitive testing examined the ways in which respondents interpret, consider and ultimately answer the questions on self-reported substance use and use of drugs by others. Cognitive testing also helped identify potential response errors based on the response categories in the questions. Overall the exercise helped in understanding:

- Item comprehension (i.e. is the terminology used in the questions was understandable and appropriate for asking about the concept in the question); whether respondents understood the questions;
- Appropriateness of pre-existing response options; whether the respondent made distinctions between the categories provided, and why the respondent chose a specific category.
- Whether different respondents answered the same question using similar response categories, and if so, what categories were most relevant;
- What respondents were thinking and feeling when they were formulating their responses to the questions.
- How people responded to the items if posed as open-ended questions – this was useful in the construction of the final, standardized response categories.

The sampling for cognitive testing was purposive while the selected group of respondents reflected a balance of gender, age, socio-demographic characteristics and substance use. The cognitive testing was implemented in three locations: Ibadan in Oyo State, Kaduna in Kaduna State, and Enugu in Enugu State. These states represent three geopolitical zones – South-West, North-West, and South-East - and some of the major population groups in Nigeria i.e. Yoruba, Hausa, and Igbo. Nationally, 93 people in these locations participated in the cognitive testing. The outcome of the cognitive testing helped improve both the wording of the questions and response categories. In addition, the results of the cognitive testing helped formulate the questions that would be asked on estimating the size of the social network among the general population.

Pilot-test

The survey was pilot tested in 6 states, one state from each geo-political zone. For the purpose of the pilot, 480 households were covered across the states which are large enough to allow for adequate planning for the survey and finalization of the survey instrument. Again the pilot test helped identify and rectify many of the field work and logistic issues in implementation of the household survey.

Training of the field staff

Considering the sensitivity of the household survey, experienced field staff from NBS state offices were engaged as field interviewers and supervisors. Training sessions for

the interviewers and supervisors included an overview of the survey and its objectives, techniques of interviewing, field procedures, a detailed description of all sections of the household questionnaire, role playing, mock interviews and field practice.

Quality assurance monitoring of survey

The monitoring of the household survey was done by an independent company, the Market Research Consultancy (MRC). For the monitoring they used 4 monitors under the supervision of a senior monitor in each state and FCT Abuja, with central monitoring coordination activities under a committee led by the Project Director. MRC had randomly selected the EAs. Of the 200 EAs per state, 35 EAs spread across urban and rural areas were monitored. MRC covered a minimum of 10 HH per EA, for a total of 300 HH per state and 13,000 HH nationally.

The field work monitoring was focused on accompaniments and back checks without re-asking questions on the questionnaire from respondents to maintain the confidentiality and ethical issues surrounding the study. While MRC did not verify the actual data collected, it worked to ensure that agreed procedures were complied with and, where infractions were noted, to ensure these were highlighted and corrected while fieldwork was still going on in order to ensure the integrity of the entire exercise. In the spot assessments and accompaniments that MRC had conducted and scored for quality, they reported an overall quality score of 4.2 out of 5 for the field work of the household survey.

High-risk drug user survey

The Centre for Research and Information on Substance Abuse (CRISA) implemented the high-risk drug user survey. The main objective of this survey was to provide a wide range of information on more problematic pattern of drug use and related problems at the state and national levels. High-risk drug users were defined in this study as those (a) who used drugs (opioids, cocaine and amphetamines) in the past 12 months and (b) used those in the past 30 days as well as (c) used them at least 5 times in the past 30 days. In other words high-risk drug use in this survey involved high frequency of use.

Specifically this survey ascertained information on the pattern of high-risk drug use, including poly drug use, injecting and other risky behaviour, severity of dependence among high-risk drug users; social and demographic profiles of high-risk drug users; social and health consequences of high-risk drug use (especially criminal activities, arrests and imprisonment, HIV and other infections); accessibility and utilization of drug dependence treatment

services and other health and social services by high-risk drug users. Data collected from this survey on treatment history and arrests, in addition to drug use patterns, were required for multiplier benchmark methods to estimate size of the high-risk drug user population.

Because drug users constitute a hidden and hard-to-reach population and without a census-based sampling frame, it is difficult to estimate the parameters of this population in Nigeria. Therefore the respondent driven sampling (also known as chain referral sampling) was used to select respondents for this study. This kind of sampling is particularly suited for a study of this nature because, among other things, it helps in tracing the diffusion of information within social networks and in delineating patterns of association. In implementation of the RDS the seeds were selected purposively, based on understanding of networks. Each seed was allowed to recruit no more than 3-4 eligible respondents from his/her network. A system of dual incentives was employed to encourage participation and the recruitment waves continued until the allotted sample size was reached in a particular area. Due to the incentives given there were also problems with “site contamination” i.e., high-risk drug users also referred for interviews other drug users (like cannabis, alcohol, tobacco only users) who did not meet the inclusion criteria. As a result, in those instances and locations the desired sample size was not met and therefore was compensated for elsewhere.

Data collection was organized in both urban and rural areas of all 36 states and the Federal Capital Territory. For this survey, data collection took the form of a structured interview in which the interviewer spoke with the respondent in a confidential atmosphere. Participation was strictly voluntary. Data was collected from a sample of 200-250 high-risk drug users in each state, yielding a national sample of 9,344 high-risk drug users as respondents.

Interviewers were selected based on their familiarity with drug use issues and experience in working with high-risk drug users. Carefully selected interviewers in each state conducted the survey. The high-risk drug user survey was piloted within 3 pre-selected states and across both urban and rural areas, by interviewing five drug users in each state.

Throughout the data collection phase, quality assurance of the high-risk drug user survey was carried out by experts and government counterparts who were members of the Technical Working Group responsible for providing guidance and oversight for the surveys and were trained to carry out this monitoring to ensure the integrity of the data collection.

Key informant study

In addition to the problem drug user survey, CRISA also conducted key informant interviews. Key informants were individuals who, by nature of their role and position within the community, were able to provide important information on drug use patterns, trends, networks and community perceptions of drug use and its associated problems. Key informants included local community police officers, other law enforcement officials, service providers for drug treatment, health officials (including pharmacists), local religious leaders, village elders, civil society organizations and/or teachers. Between 50-75 key informants in each state were interviewed, yielding a national sample of 2,787.

Secondary data collection

The importance of collecting reliable secondary data lies in the use of this information for size estimation of high-risk drug users at the state level through the benchmark/multiplier method. Data collected as a benchmark at the community level included data on the number of people who had received treatment for drug dependence and people arrested by police for drug related offences.

Data collection forms were developed to collect secondary data from the following sources:

- Reports of the Nigerian Epidemiology Network of Drug Use (NENDU),
- National Drug Law Enforcement Agency (NDLEA),
- Civil society organization reports,
- Information from hospitals, drop-in centres and other treatment facilities.

Limitations

Data collected on drug treatment and arrests in the states were of varying quality, therefore the records available by state were not sufficient to enable population size estimation at the state levels.

Prevalence estimation

The illicit nature of drug use, coupled with the social stigmatization of this behaviour, poses particular challenges for determining the extent of drug use in a population. As a result, many respondents in population-based surveys have motives to conceal their drug using behaviour.

In this study, national estimates of past-year drug use were based on the triangulating information from the following surveys:

- National Household Survey on Drug Use and Health (N=38,850);

- High-risk Drug User Survey (N=9,344); and
- Secondary data collected from treatment centres and drug-related arrest statistics.

A. Direct Estimation of drug use prevalence self-reported in the National Household Survey on Drug Use and Health

The main household survey collected information on self-reported illicit drug use as well as non-medical use of pharmaceutical drugs (use without a doctor's advice or an explicit medical purpose).

Using these self-reported data, weighted to the general population, the initial estimates were calculated for the different drug types.

B. Network Scale-up Method for indirect estimation of cannabis

Very few people in the household survey disclosed information on cannabis use as compared to triangulated data on its prevalence from the other sources. Therefore, to estimate cannabis use nationally and within Nigerian states, the Network Scale-up Method (NSuM) was employed. In addition to self-reported use, in the household survey respondents were asked to provide information on the number of people (of known population groups) they knew personally - technically referred to as "alters". The definition of knowing someone personally and the type of known population groups such as number of teachers they knew personally, was developed through focus group discussions and cognitive testing. Information on a respondent's network size, as averaged across each social group, was used to generate a scale-up estimator. The scale-up estimator was applied to the mean number of people a respondent knows who used cannabis.

In order to first assess the validity of the estimator calculated, descriptive characteristics of alter populations were compared against demographic attributes of respondents to uncover systematic biases that may disproportionately influence estimator size.

Further, back estimation of known populations using the null scale-up estimator and adjusted estimators was carried out to assess the accuracy of predicting population sizes. Adjusted estimators included various iterations of scale-up estimators calculated following removal of problematic alters and/or outliers. The null estimator and adjusted iterations were evaluated using performance ratios and mean absolute error calculations. The results of validity testing were used to adjust the final network scale-up estimator to facilitate accurate estimation of target population size.

Given the high stigma associated with drug use in Nigeria, the generalized scale-up estimator was determined to be the most appropriate NSuM method in this population. Therefore, post-estimation adjustments were utilized, specifically adjustment for transmission error and degree error. Data collection of the necessary inputs for these post-adjustments was not built into the main household survey or problem drug use survey. Instead, transmission error and degree error adjustments specific to drug user populations were collated from the published literature.

C. Multiplier Benchmark Method

The national proportion of high-risk drug users who had been in treatment in the past year was calculated for each drug type. The secondary data collection survey from treatment centres across Nigeria contained information on the number of high-risk drug users who received drug treatment in the past year. The inverse of the proportion, (i.e. if one out of ten of drug users were treated, the inverse of the proportion would be 10/1 or ten) who had been in treatment was multiplied by the number who had been in treatment to estimate the number of problem drug users overall by drug type and those injecting drugs.

Methodology employed to estimate the prevalence of each drug type

Cannabis: Sum of the total number of users identified from the household survey, including the Network Scale-up Method and number of high-risk drug users who also used cannabis.

Pharmaceutical opioids: Self-reported from household survey and combined with high-risk drug user estimates of prescription opioid use using the Multiplier Benchmark Method.

Heroin: Self-reported from the household survey and combined with high-risk drug user estimates of heroin use using the Multiplier Benchmark Method.

Cocaine: Self-reported from the household survey and combined with high-risk drug user estimates of cocaine use using the Multiplier Benchmark Method.

Amphetamines: Self-reported from the household survey and combined with high-risk drug user estimates of amphetamine use using the Multiplier Benchmark Method.

Tranquilizers/Sedatives: Self-reported from the household survey as the non-medical use of prescription drugs was more readily reported than the use of other drugs considered "illicit".

Ecstasy: Self-reported from the household survey

Cough syrups: Self-reported data from the household survey as this was readily reported.

Hallucinogens: Self-reported data from the household survey

Solvents/inhalants: Self-reported data from the household survey



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