Original Article

Awareness and Acceptance of Harm Reduction Services in a Nigerian Psychiatric Hospital: Patients' and Family Caregivers' Perspective

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Abstract

Introduction: There are burgeoning data on harm reduction services (HRSs) as a viable alternative to the traditional means of dealing with substance abuse in the developed countries. Despite the numerous benefits, its awareness and acceptability in developing economies such as Nigeria have been constrained by sociocultural and political factors. However, the specific patients' and caregivers' barriers to its uptake have not been evaluated in Nigeria. **Aim:** This study aimed to examine the awareness and acceptability of HRS among patients and caregivers in Enugu, South-Eastern Nigeria. **Materials and Methods:** This study was a descriptive survey of patients with substance use disorders and their family caregivers at Enugu. Awareness and acceptance of HRS were assessed using questions adapted from the harm reduction survey. **Results:** The majority of patients and caregivers (76.5% and 88.2%, respectively) were not aware of HRS. Compared to family caregivers, the patients were more likely to rate themselves more favourably disposed to accepting HRS ($U = 2750.00$, $p < 0.001$). The common reasons given for accepting HRS among the patients were centered on autonomy and the unrealistic nature of abstinence. The reasons for rejection by family caregivers were hinged on encouraging use, community resistance, and scandals to the family. **Conclusion:** This study highlighted the low awareness of both patients and their caregivers to the availability of HRS as a treatment option in Nigeria. It is hoped that these findings will provide some invaluable data to policy makers and clinicians in designing policies and in public education to improve service utilization by the public.

Keywords: Acceptance, awareness, barriers, harm reduction, services

Introduction

The burden of substance use disorders in Nigeria is huge and could be considered an emerging epidemic with myriad consequences in the various domains of the society.[1,2] Of importance is that the population most affected constitute largely the workforce of any country with attendant effects on the economy.[1] Despite its implications for the individuals and their families and the country at large, there is a large unmet need for treatment, as majority of those who have the problem do not access the available services.[3] Harm reduction strategies (HRS) as a viable alternative to the traditional abstinence-based method of dealing with substance abuse is gaining popularity in the developed countries. In addition, studies on HRS have shown robust empirical support in reducing the negative consequences associated with substance use.[4-6] It has been defined "as policies, programs, and practices designed to reduce negative physical, social, and economic consequences resulting from substance use without requiring abstinence as a primary treatment goal."[7] Harm reduction services (HRS) are increasingly being recognized across the continuum of health-care services.

HRS is generally lacking in most countries in the sub-Saharan Africa;[8] however, a recent global report from the harm

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reduction international indicates that the sub-region has made some progress in the HRS with about 10 countries in the region having explicit policy documents supporting it in 2018.[8] It appears from this report that countries in Southern and Eastern African are more receptive to HRS than West African countries. Despite the high prevalence of use of drugs such as heroine (63%) and cocaine (70%) among intravenous drug users, as well as the unsafe practices such as sharing and re-use of needles in Nigeria,[8] HRS has been resisted for several reasons including sociocultural and political factors. However, in 2018, the Federal Ministry of Health began a consultation on the development of guidelines on the use of methadone for drug rehabilitation treatment.[9] In addition, the health minister also set up a task force for the implementation of HRS in the country.[9] HRS echoes the increasingly global outcry that substance use problems should be viewed in light of public health. In response to this, the National Drug Law Enforcement Agency in partnership with other organizations developed the National Drug Control Master Plan.[10] A paradigm shift from over-concentration in the supply-reduction-centered activities to demand-reduction activities was one of the achievements of this partnership.[10]

Despite the numerous benefits of HRS and some shift in policies toward the public health approach to drug use, the awareness of the end-users and their caregivers, acceptability and utilization has a weak evidence base in Nigeria. In addition, the specific patients' and caregivers' barriers to its acceptance have not been evaluated in Nigeria. Such data will drive policies and public mental health education on the shift in the management of substance abuse disorders in Nigeria. Hence, this study was done to examine the following research questions:

1. Do patients and family caregivers admitted to the drug de-addiction unit of a Nigerian Psychiatric Hospital know about HRS?
2. What is the level of acceptance of HRS among patients and family caregivers?
3. What are the reasons for the acceptance/rejection of HRS by the patients and their family caregivers?

Materials and Methods

The study was a descriptive survey carried out among inpatients and their family caregivers at the Federal Neuropsychiatric Hospital (FNH), Enugu, which is one of the eight specialist psychiatric hospitals established by the Federal Government of Nigeria. It is located within Enugu metropolis and provides mental health care for the South Eastern part of Nigeria and neighboring geopolitical zones. The hospital has a bed capacity of about 300. There are 6 open wards, 2 private wards, and an emergency ward. It is one of the United Nations Office on Drug and Crime regional centres for the treatment of persons with substance use disorder. Patient participants were those admitted for substance use disorders (cannabis, opioid, alcohol, and multiple substance dependence). The study utilized a total population sample with a convenience sampling technique to recruit all in-patients admitted for drug dependence within the 1-year period of the study (June, 2018 to June, 2019). Ethical approval was obtained from the Ethics and Research Committee of the institution. The international ethical standard was strictly adhered to according to Helsinki Declaration. All participants were interviewed when it was adjudged by the managing team that the patient was clinically stable (i.e. that the patient was in a stable state of functioning, in clear consciousness without need for chemical restraint and increase in medication dosage). Consent was obtained from all the study participants, and it was established by a consultant psychiatrist that these participants had the capacity to make the decision at the time.

To assess patients'/family caregivers' awareness and acceptance of harm reduction services as a treatment option in substance use disorders, the harm reduction survey was used.[11] The questions were both closed and open-ended as the participants were free to add other reasons if not indicated in the options. The harm reduction survey is a questionnaire designed from a qualitative research that assessed the availability, acceptability, and barriers to four harm reduction services, namely needle exchange program, free condom sharing, methadone replacement, and moderate drinking. In addition, the survey also assesses general understanding of harm reduction. The pilot of the survey was conducted with some patients, relatives, some health workers in the drug treatment unit, and the researcher. As a result, an additional option was added to the reasons for rejecting harm reduction (i.e. "it brings shame to the family"). The questions assessed both patients' and caregivers' awareness of HRS, the HRS they are aware of, acceptance of HRS as a treatment option in substance use disorders, reasons for the acceptance or rejection of HRS. In addition, each participant was asked to rate on an 11-point scale (0 – very unfavorable and 10 – very favorable) how they felt about non-abstinence as a treatment goal. Patients and their relatives that looked after the patients in the ward or who intermittently visited the patients were interviewed in a convenient room within the ward. The questionnaire was either self-administered or read aloud for the patient and their caregiver to indicate the answer as it applied to him/her. It took an average of 5 min to answer the questions. Data were entered into the Statistical Package of Social Sciences (IBM-SPSS, Armonk, NY: IBM Corp) version 20. Categorical questions were described using the frequency tables while the 11-point rating was summarized using the mean and median descriptive statistics. Mann–Whitney U-test was used to compare the rating on acceptance of non-abstinence-based regimen between patient and caregiver participants.

Results

Participants

The patients were mostly young (mean age of 30.5 [±6.8] years), mostly males 30 (88.2%), not living with a partner 16 (47.1%), with more than six years of education 34 (100.0%). A majority had a diagnosis of cannabis dependence and the age

at first use was in the adolescence [Table 1]. The caregivers were mostly in their middle age (mean age of 44.5 years), married 23 (67.6%), and two-third of them were nuclear family members, as shown in Table 2.

Awareness of HRS among patients and caregivers

The proportion of patients and caregivers that have heard of HRS was 8 (23.5%) and 4 (11.8%), respectively. Among those who were aware, controlled drinking and free condom were most popular, 8 (100.0%) for each, whereas only 2 (50.0%) and 0 (0.0%) of the caregivers were aware of moderate drinking and free condom sharing, respectively [Table 3].

Table 1: Sociodemographic and clinical characteristics of the study participants (*n*=34)

Variables	Frequency, *n* (%)	Mean (SD)
Age		30.5 (6.8)
Age at first use		19.9 (6.6)
Duration of use (years)		7.4 (3.2)
Gender		
Male	30 (88.2)	
Female	4 (11.8)	
Marital status		
Single	12 (35.3)	
Married	18 (52.9)	
Separated/divorced	4 (11.8)	
Education		
None	0	
Primary	18 (52.9)	
Secondary	12 (35.3)	
Tertiary	4 (11.8)	
Diagnosis		
Cannabis dependence	21 (61.8)	
Alcohol dependence	7 (20.6)	
Opioid dependence	2 (5.9)	
Multiple substance use	4 (11.8)	

SD: Standard deviation

Table 2: Sociodemographic characteristics of the caregiver participants (*n*=34)

Variables	Frequency, *n* (%)	Mean (SD)
Age (SD) (years)		44.6 (12.4)
Gender		
Male	9 (26.5)	
Female	25 (73.5)	
Marital status		
Single	7 (20.6)	
Married	23 (67.6)	
Separated/divorced	4 (11.8)	
Educational status		
No formal	1 (2.9)	
Primary	7 (20.6)	
Secondary	8 (23.5)	
Tertiary	18 (52.9)	
Relationship to patients		
Nuclear	24 (70.6)	
Extended	10 (29.4)	

SD: Standard deviation

Acceptance of HRS among patients and caregivers

A majority of the patient participants (64.7%) accepted other treatment options aside abstinence. However, only 17.6% of the family caregivers accepted a non-abstinence-based treatment goal as shown in [Table 4]. Patients rated themselves more favorable to acceptance of non-abstinence' based treatment regimen (median score of 9), whereas family caregivers rated themselves unfavorable to accepting non-abstinence-based treatment regimen (median score of 0) (U = 2750.00, $P < 0.001$), as shown in Table 5.

Reasons for acceptance/rejection of HRS

The most common reasons given by the patients for acceptance were that "it respects their decision" and "abstinence being unrealistic" (54.5% and 45.5%, respectively). For family caregivers, the reasons given for acceptance were mostly centered on disease reduction and abstinence being unrealistic for some drug users. For both patients and family caregivers, the most common reasons for rejecting non-abstinence-based treatment options were that they encourage drug use and are not acceptable by the community. In addition, family caregivers also noted that it brings shame to their family [Table 4].

Discussion

The main highlights of the findings of this survey of HRS among patients and family caregivers are: first, the majority (76.5% and 88.2%), respectively, of the patient and caregiver participants were not aware of harm reduction services as treatment options for substance use. Second, patients were more favourably disposed to accepting non-abstinence-based treatment goals than family caregivers. Third, the common reasons given by patients for accepting HRS were that it respected their decision and that abstinence was unrealistic (54.5% and 45.5%, respectively), and fourth, both patients and caregiver participants cited encouragement of use and community concerns as reasons for rejection of HRS.

The findings of this study suggest that the majority (76.5%) of the patients and their family caregivers (88.2%) were not aware of HRS as a treatment option in substance abuse/dependence. Our findings are contrary to reports from Western countries, especially Canada and Australia.[12,13] In these countries, most studies, polls and surveys have shown increased public awareness and approval of different HRS.[12,13] The differences in the perception of HRS as a treatment modality in various countries may be explained by several factors. First, the belief in the causation of diseases is important in determining the treatment sought. Societies that hold the biomedical model of addiction may be biased toward accepting evidence-based methods of treatment such as HRS. This is in contrast to those who hold supernatural or moral views as seen among Nigerians in this study. Second, the availability and accessibility of HRS in some countries could lead to increased contact with the end-users which indirectly dispels the myths about such

Table 3: Awareness of harm reduction strategies among patient/caregiver population (*n*=34)

Variables	Frequency, *n* (%)
Patients	
Ever heard about harm reduction services (*n*=34)	
Yes	8 (23.5)
No	26 (76.5)
Type of harm reduction services heard (*n*=8)	
Needle and needle exchange program (NSP)	4 (50.0)
OST	6 (75.0)
Controlled/moderate drinking	8 (100.0)
Free condom	8 (100.0)
Caregivers	
Ever heard of harm reduction services (*n*=34)	
Yes	4 (11.8)
No	30 (88.2)
Type of harm reduction services heard (*n*=4)	
Needle and needle exchange program (NSP)	0
OST	2 (50.0)
Controlled/moderate drinking	2 (50.0)
Free condom	0

OST: Opioid substitution therapy, NSP: Needle and syringe program

services and increase their acceptance in such societies. The non availability of HRS in Nigeria as shown in the present study may perpetuate ignorance about the usefulness of this treatment modality; the end effect may be non acceptance driven by myths rather than facts. Third, the communalism in African societies as against individualism in some western countries may also affect the differences in the perception of HRS. In other words, in communal societies, events or services are examined with the prism of the cultural context of the society. Therefore, individuals' perception tends to mirror the collective thinking of their cultural milieu. It is likely that in Nigeria where addictive behaviours are largely abhorred, participants from this setting may respond in a way that is acceptable to their society even when it contrasts with their inner wishes.

However, this is consistent with the recent observation that HRS is generally lacking in Sub-Saharan Africa and the political resistance of the Nigerian government to HRS.[8] The lack of awareness among patients and family caregiver participants could be explained by diverse factors. First, the clinicians' attitude to HRS may have reduced their ability to freely discuss HRS as an option to abstinence from substance de-addiction. Despite the paradigm shift from paternalism to shared decision making (where patients are supported to consider options, to achieve informed preferences), a recent report shows that though many clinicians talk about it, only a few practice it.[14] In one study, Carlberg-Racich[7] found that the receptiveness of HRS among service providers was mixed with the most skepticism being expressed by physicians. The unwillingness of clinicians to discuss HRS as an option in substance abuse treatment may have limited the awareness of both patients and family caregivers with respect to harm reduction services.[7] Other plausible reasons may be related to the culturally influenced perception of drug problems.[15,16] When considering the reasons why someone might take drugs, psychological and moral explanations generally prevail, primarily the assumption that the person is "weak" or "immoral."[15] Thus, the general public often sees problematic drug use as an individual problem and not what society should be dragged into.[15] Such negative stereotypes/perceptions could potentially affect the dissemination of information regarding HRS. In addition, political resistance and legislative constraints may limit media participation in HRS.[17] All these factors may decrease access to HRS information with attendant consequences on public awareness.

Despite the low awareness of the study participants to HRS, a majority (64.7%) of the patients were willing to accept HRS more than their family caregivers (17.6%). This is consistent with the finding of Carlberg-Racich who reported that patients were more receptive to harm reduction interventions from their service providers and even expressed gratitude for harm reduction services information and/or supplies.[7] However, some authors have observed varied attitudes towards HRS among players in the addiction field.[11] These variations in the attitude of patients, family members and even service providers may be related to their cultural background, availability of HRS, specific HRS and legislations.[11] The unwillingness of the family caregivers to accept HRS may be explained by the lack of knowledge and socio-cultural factors. For example, the commonly cited reasons by family members for rejecting HRS were hinged on the thinking that HRS encourages drug use (85.7%), community rejection (53.6%), and fears for the family name (35.7%). In addition, the understanding of the cause of substance dependence which in this study, most family members believe is a moral weakness may also limit their acceptance of any treatment options other than abstinence. Furthermore, the lack of enthusiasm or even the rejection of harm reduction services on the part of caregivers may be explained in part by the fact that the HRS programs examined in this study do not reliably relate to their relatives' drug problems, since majority of the studied population had cannabis dependence. Public stigma to substance use and indeed other mental health problems in the traditional African society may also decrease the chances that family members will accept any other treatment options that are not abstinence. Sociological studies have identified several factors that may limit acceptance of new methods of treatments or any other innovation.[18] For example, Rogers identified five processes underlying the adoption of a new technology; knowledge, persuasion (attitudes), decision, implementation, and confirmation.[18] It is likely that most caregivers in our study are yet to understand the principles of HRS as shown in their poor awareness to make an informed decision about its benefits.

Concerning the reasons given for acceptance or rejection of HRS, this study found that most patients' acceptance of HRS was based on the reasons of autonomy and the feeling that abstinence was an unrealistic goal; whereas caregivers' rejection of HRS was based on fears of encouraging use and

other sociocultural reasons (perceived community resistance and dents to the family name). This result re-echoed both clinical and research observations that most patients would like to be involved in making decisions about their care.[14] Furthermore, the belief that abstinence was unrealistic goal by the patient is also in keeping with the principles of HRS that considered multiple treatment outcomes other than a narrow abstinence based options. In buttressing this point, Denning[19] wrote that, "Treatment programs that require abstinence for entry and only allow abstinence as a treatment goal are, in themselves, harmful because they create barriers to treatment for many individuals who might otherwise be helped." Similar to this finding, some other studies have identified community resistance to be the most common external barrier to acceptance of harm reduction services.[11] An additional reason given was the fear of dents to the family name. This is particularly important in the traditional African society, where the worth of a family is judged by their level of obedience to the societal norms. In addition, social exchange between the family and other members of the community in most African societies may be constricted or even waived for families with relatives considered to be deviants (e.g. criminality, substance use, and other mental disorders).

Table 4: Acceptance of harm reduction as a treatment option by patient and caregiver participants (*n*=34)

Variables	Frequency, *n* (%)
Patients	
Would you accept other treatment options aside abstinence (*n*=34)	
Yes	22 (64.7)
No	12 (35.3)
Reasons for acceptance (*n*=22)	
Can reduce disease	2 (9.1)
Enables clients to be more productive	2 (9.1)
Decrease criminality	0
Respects my decision	12 (54.5)
Allow access to counseling	0
Reduction of unwanted pregnancy	0
Abstinence unrealistic	10 (45.5)
Reasons for rejecting harm reduction services (*n*=12)	
It encourages use	10 (83.3)
Not acceptable in the community	7 (58.3)
Caregivers	
Would you accept treatment options for your relative other than abstinence (*n*=34)	
Yes	6 (17.6)
No	28 (82.4)
Reasons for acceptance (*n*=6)	
Can reduce disease	3 (50.0)
Enables clients to be more productive	1 (16.7)
Decrease criminality	0
Allow access to counseling	0
Reduction of unwanted pregnancy	0
Abstinence unrealistic	3 (50.0)
Reasons for rejecting harm reduction services (*n*=28)	
It encourages use	24 (85.7)
Not acceptable in the community	15 (53.6)
Destroys family name	10 (35.7)
Caregiver's perception of the cause of SUD (*n*=34)	
Moral weakness	24 (70.6)
Supernatural causation	9 (26.5)
Medical/biological causation	0
Not sure	1 (2.9)

SUD: Substance use disorder

Limitations

The relatively small sample size in our study may have limited the diversity of opinions. In addition, social desirability bias toward such culturally sensitive question may have affected the responses of the study participants. Similarly, selection bias with few number of female participants may have skewed the responses. Another important limitation is also related to participants selected. Among the patients studied, the largest group (almost 62%) were people with cannabis dependence. However, among the harm reduction services examined, there were none that directly addressed this group of drug users. This may have affected the responses of the patients and their caregivers.

Conclusion

The findings of this study show low awareness of HRS as a treatment option in Nigeria among the patients and their caregivers. However, the finding that most patients are receptive to HRS offers some optimism that with sustained public education and comprehensive government policies, HRS may be acceptable to most Nigerians.

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Table 5: Rating of the acceptance of the harm reduction services by the patients and caregivers participants (*n*=34)

Variables	Mean (median) score	*U*, *p*
Patients		
How do you feel about nonabstinence as a treatment goal for some drug users?	7.7 (9.0)	2750.00, <0.001
Caregivers		
How do you feel about nonabstinence as a treatment goal for some drug users?	2.7 (0.0)	

0: Very unfavorable, 10: Very favorable

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Conflicts of interest

There are no conflicts of interest.

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