

Developing Curriculum for the Training of Non-Specialist in Addiction Studies in Nigerian Universities: The Journey of Nigerian ICUDDR Team

OLA, B. A.¹, OLIBAMOYO, O.¹, AUDU, M.², EZENWA, M.³, GOAR, S. G.², AUWAL, S.⁴, ORJIAKOR, T. C.⁵, AGWOGIE, M.⁶

1 | Lagos State University College of Medicine, Department of Behavioural Medicine, Ikeja, Lagos, Nigeria

2 | University of Jos, Department of Psychiatry, Plateau, Nigeria

3 | Nnamdi Azikwe University, Department of Psychology, Awka, Anambra, Nigeria

4 | Bayero University Kano, Department of Psychiatry, Kano, Nigeria

5 | University of Nigeria, Department of Clinical Psychology, Nsukka, Nigeria

6 | Global Initiative on Substance Abuse, Lagos, Nigeria

Citation | Ola, B. A., Olibamoyo, O., Audu, M., Ezenwa, M., Goar, S. G., Auwal, S., Orjiakor, T. C., & Agwogie, M. (2021). Developing curriculum for the training of non-specialist in addiction studies in Nigerian universities: The journey of Nigerian ICUDDR team. *Adiktologie*, 21(4), 251–259. <https://doi.org/10.35198/01-2021-004-0004>

BACKGROUND: This article describes the need to develop a workforce to address the public health burden of drug use in Nigeria. Central to workforce development is the development and implementation of a substance use curriculum. **AIMS:** The authors present a review of the proposed curriculum for a multi-professional course in addiction currently being developed in four Nigerian universities. It also highlights the opportunities, partnerships formed, and lessons learned in the review process. **METHODS:** This case study is based on the results of research that included a desk review of multi-professional addiction studies course development in the education system. In addition, the study team reviewed the Universal Treatment Curriculum (UTC) and Universal Prevention Curriculum (UPC). In-depth interviews and focus group discussions were conducted with Nigerian stakeholders

in the addiction treatment field. **PARTICIPANTS:** Key stakeholders in the addictology field in Nigeria. **RESULTS:** This joint exercise raised awareness about the need to contextualize Western inputs into local realities and establish a theory-driven process for identifying barriers and opportunities that might arise in developing a Nigerian addiction studies curriculum. The study also provided an overview of the relationships and collaborative work amongst partnering institutions. **CONCLUSIONS:** Through this activity, the study team proposes a blueprint curriculum for addiction studies in the Nigerian higher education system. The proposed curriculum was developed through evidence-based interdisciplinary efforts that involved the International Consortium of Universities in Drug Demand Reduction in accordance with the Bologna Declaration.

Keywords | Addiction – Curriculum – Healthcare – Professionals – Nigeria

Submitted | 28 April 2021

Accepted | 14 September 2021

Corresponding author | Professor Bolanle Adeyemi Ola, MBChB, FWACP, Ph.D., Lagos State University College of Medicine, Department of Behavioural Medicine, Ikeja, Lagos, Nigeria

bolanle.ola@lasucom.edu.ng

● 1 INTRODUCTION

This work presents an overview of the burden of drug use problems in Nigeria and the need to develop a workforce to address this public health challenge. Central to workforce development is the development and implementation of a substance use curriculum. The study team used a checklist to assess the progress in curriculum development so far. They also discussed rationales and different levels of needs for the curriculum.

1.1 The burden of substance use and coordinated response

Drug use is an increasing source of concern in Nigeria. In 2017, the past-year prevalence of drug use stood at 14.4% (14.3 million people), compared to a global rate of 5.6% (United Nations Office for Drugs and Crimes [UNODC], 2018). Top drugs of concern used in Nigeria, as reported by the UNODC (2018), included cannabis and non-medical use of prescriptive opioids, particularly tramadol and codeine. These drugs have been linked to diverse health and social problems including national insecurity in Nigeria (Ezenwa et al., 2020). A coordinated response to the drug menace in Nigeria is needed and should entail strategies, policies, and plans for service delivery in primary, secondary, and tertiary prevention. The World Health Organization provides a health system building block framework for planning and monitoring responses to health problems (World Health Organization [WHO], 2010). The six major areas covered in the health systems building block include health service delivery, health workforce, health information systems, access to essential medicines, health systems financing, and leadership and governance. Although all these areas are critically important, we focus building the health workforce and strengthening the human resources required to combat problem drug use in Nigeria. The goal is to develop competency-based roles with continuing education and transitioning to addiction specialist roles.

1.2 Capacity building

Human resources for health (HRH) is a popular theme in global health. Generally, health workforce crises exist in low-and-middle-income countries such as Nigeria, as the ratio of health workers to the population is low (Adeloye et al., 2017). For Nigeria, the low health workforce ratio is aggravated by a growing population, systemic problems that drive workers to leave the field, and clashes among the different professions within the health workforce (Adeloye et al., 2017; Pacqué-Margolis et al., 2011). The results are a weakened health workforce and a consequent negative impact on the country's health.

Fortunately, Nigeria has a National Policy for Mental Health Services that works to improve care for people with mental, neurological, and drug use problems (Abdulmalik et al., 2016). Sadly, the policy exemplifies the shortage of mental health workforce with fewer than 150 psychiatrists, a ratio of five mental health nurses for every 100,000 Nigerians, and also few other professionals (e.g., neuro-clinical psychologists and

social workers) who render mental health services (Abdulmalik et al., 2016). Hence, Nigeria faces a dire need to strengthen HRH specific to mental health problems and particularly for drug use problems. Building capacity in HRH for substance use problems will help improve health workers' ability to deliver mental health-related care to clients with other illnesses with mental health implications (such as HIV).

Human resources building will involve developing capacity for evidence-based substance abuse legislation and policies, pre-service training curriculum, in-service training with locally contextualized tools, continuing in-service training and mentorship, capacity building for monitoring and evaluation, and linkages with international partners (Hanlon et al., 2018; Mugisha et al., 2017; Wainberg et al., 2017). Addiction specialists (psychiatrists) in Nigeria are the only professionals in drug addiction treatment clinics and harm reduction and rehabilitation programs with an understanding of substance use issues and an official education. However, their training in addiction studies occurs as part of postgraduate subspecialization fellowship in psychiatry. The fellowship focuses exclusively on the biological and psychological aspects of substance use and addiction phenomena and considers both psychological and pharmacological approaches to the solution of the problem (Professor T. Sheikh, personal communication, December 2019). Given the limited number of psychiatrists, clinical psychologists, and substance abuse counselors, there is an expected opportunity for task sharing (Mugisha et al., 2017). Task sharing transfers the skills to deliver the substance abuse prevention and care continuum to appropriately trained and supervised general health workers. Thus, an urgent need exists for the few Nigerian specialists to develop a multi-professional course for non-addiction specialists. Such a course would invariably lead to a widely accepted national certification in substance use treatment appropriate for professions with regulatory bodies such as nurses and social workers that offer an accredited certificate from the national regulatory institution. In addition, there is evidence that mental health training programs for other non-mental health professionals delivered at least short-term benefits (Booth et al., 2017). To improve the professionalization of addiction treatment in Nigeria, a specific program focused on addiction in higher education (degree and non-degree) is under development (Gakunju & Murimi, 2015). Partnerships and mergers with international certification systems are being explored to save cost and time (Gakunju & Murimi, 2015). An addiction studies program will undoubtedly have an immense impact on the professionalization of the Nigerian addiction treatment field. University-based programs need to encompass the comprehensive infrastructure of the addiction study field (Lososova et al., 2020). Six different structural mechanisms are required to support university education in addictions, and these include specialized journals, research centers, professional societies, training, and education programs and institutions (Lososova et al., 2020).

● 2 METHODOLOGY

2.1 Curriculum development

In developing such a broad curriculum, a team of Nigerian addiction specialists from universities in Jos, Lagos, Kano, and Enugu who have worked together under the umbrella of the International Consortium of Universities in Drug Demand Reduction met for several sessions to formulate the aims and learning outcomes of a competency-based curriculum based on Beattie's curriculum model (Beattie, 1977). The team of specialists considered the development of a substance misuse curriculum for non-addiction specialists and explored different philosophies, conceptual models, and orientations that might prove useful. The team used concept mapping to identify the key educational program concepts required to meet the course aims and learning outcomes. Also, the team discussed the benefits of professional development using Clark and Hollingsworth's Interconnected Model of Professional Growth (IMPG; Clarke & Hollingsworth, 2002). The IMPG elucidates three domains in which faculty can achieve long-term change through collaborative curriculum design: (a) change in knowledge, beliefs, and attitude (domain of personal); (b) change in professional experimentation (domain of practice); and (c) the collaborative process, producing salient outcomes for faculty and students.

The need to promote a collaborative culture among faculty and staff of each university was discussed and found useful. In addition, the team recognized potential obstacles that might arise between developing and implementing the curriculum. A stakeholder analysis that incorporated these obstacles was conducted to inform the breadth and depth of the curriculum.

● 3 RESULTS

3.1 Models of Curriculum and the choice of Beattie's Model

Curriculum models considered include the subject-based (Morrison, 1940), objective-based (Tyler, 1949), expressive (Schmidt, 1993), problem-based (Barrows, 1986), and the humanistic-educative approach (McNeil, 2009). The team evaluated these models, weighing the merits and demerits of each.

While the subject-based model allows content to exemplify key concepts, criteria, and procedures that best represent the structure of a body of knowledge, it does not specify the key concepts and learning outcomes. Due to this flaw, the team rejected this as the subject-based model for substance use curriculum for non-specialists in Nigeria. Similarly, the objective-based model provides content useful for vocations and when a learner needs to know what tasks to be done in the workplace. However, it does not consider the biopsychosocial framework.

The expressive model focuses on content selected to provide the learner with worthwhile learning activities, usually of an exploratory or problem-solving nature. The lecturer and the learner have the freedom to explore issues of particular interest. However, the expressive model does not provide required

knowledge and skills. A learner is expected to have acquired these in an instructional context beforehand to explore the issues and problems raised by expressive objectives.

The problem-based curriculum model cannot identify learning outcomes with high levels of specificity because students are responsible for searching out the knowledge they need. Students' need for knowledge might not reflect reality, such as the need for knowledge of the specific psychoactive substances that high priority in the learner's local setting. Learners are typically expected to work on one sub-problem at a time in small teams using experiential learning methods.

In a nutshell, the team did not select any of these curriculum models as they were deemed inappropriate as a framework for developing a substance use curriculum for non-specialists in Nigeria. Precisely, none of the curriculum models could meet the philosophy and goals of building capacity for training in substance use treatment peculiar to Nigeria.

In contrast, Beattie's model was selected based on the humanistic-educative approach in curriculum building. This approach creates an environment that promotes reflective learning, critical thinking, creativity, interpersonal relationships, and attitude change through process learning. In addition, the model encourages interaction processes around the curriculum content rather than upon the content itself. This interaction facilitates multidisciplinary collaboration. In addition, Beattie's model provides a holistic framework and culturally sensitive care that is well suited to developing substance use education. It constructs a curriculum around essential knowledge and encourages learners to explore worthwhile educational areas in substance misuse and the processes in working with other disciplines, persons who use psychoactive substances, and their families and friends.

Components of Beattie's Model

The key steps in Beattie's model include drawing up a map of key subjects, compiling a schedule of basic skills needed by the non-specialist, assembling a portfolio of meaningful experiences to guide learning, and constructing an agenda of important cultural issues.

3.2 Stakeholder identification and engagement

To map the key subjects, the team needed to host innovation fora (focus group discussions and in-depth interviews) with participants chosen through key stakeholder analysis across Nigeria. We used WhatsApp, Skype, etc., to convene the stakeholders and review curricula for pre-service training of non-addiction specialists, especially general doctors, nurses, social workers, and pharmacists. The team also generated and revised key subjects/topics that would be included in the non-specialist curriculum. Also considered were pilot/existing programs and institutional partnerships. In this process, the team considered model curricula of the Universal Treatment Curriculum (UTC) and Universal Prevention Curriculum (UPC) to identify cultural gaps to expect when incorporating them in

our new curriculum (Ayu et al., 2017). This step highlighted a promise of improving curricular quality and adoption rates. Thus, the innovation fora dispersed information and current knowledge to participants and recommended modules that would address Nigeria's substance problems and other shortcomings in existing courses while consolidating, to a degree, the UPC and UTC curricula.

3.3 What skills are needed for non-specialist addiction programs?

We used the five-step engagement process (Friedman and Miles, 2006). First, at the International Society of Substance Use Professionals (ISSUP) conference in Nairobi in 2017, contingents from eight Nigerian universities across the six geopolitical zones in Nigeria met to set the vision for future engagements and reviews. Second, a committee that included all the authors was organized to map stakeholders via a collaborative process of brainstorming and discussions. In addition, the members selected engagement mechanisms that included emails, ICUDDR meetings, and meetings via WhatsApp. Third, the group determined the logistics for the engagements along with the rules of engagement. Fourth, stakeholders across the 12 universities that showed interest were engaged via WhatsApp meetings in Nigeria and during ICUDDR meetings in Ethiopia. These meetings identified opportunities across various participating institutions and determined actions for follow-up and subsequent engagements. Minutes recorded during all meetings served as the data for decision-making and action plans.

The team identified that the non-specialist curriculum in Nigeria in education and training in substance misuse should enlist a sound knowledge of pharmacology, epidemiology, medicine, public health, health education and prevention, health psychology, social policy and context, treatment issues, and legal aspects. This knowledge base is an essential requirement in the early recognition and management of substance misuse. Although it may not be practical to convey all the key areas of knowledge about the effects of psychoactive substances, other perspectives that a non-specialist curriculum needs to include are content on effective theoretical models, the social context of substance misuse, pregnancy, and childcare; the role of non-addiction specialists and addiction specialist workers, early recognition and minimal intervention, detoxification, health-related harms, and service provision. Due to the interface between substance use problems and sexual health, learners need to know the problems and issues relevant to HIV/AIDS and hepatitis. Essentially, the curriculum should be based on a biopsychosocial view of human functioning and should consist of courses that focus on behavior, practice, policy, seminar, and participatory research.

The team recognized that non-specialists would engage with basic- and intermediate-level courses. Basic level courses will include physiology and pharmacology of drugs; the continuum of care; co-occurring disorders; screening, intake, assessment, and treatment planning; case management; crisis intervention; ethics; the science of prevention, and theories of prevention; prevention methodology; and interventions in prevention. On

the other hand, the master's and Ph.D. level courses will consist of pharmacology and substance use disorders; managing medication-assisted treatment programs; working with families; special population groups; theories of counseling; trauma-informed care; recovery management, continuing care, and wellness; applied prevention methodology; and applied interventions in prevention.

3.4 How long should the training last?

First, the basic level (diploma) will require two semesters full time or 1,500 hours of supervised work with 120 contact hours of education. The master's (clinical) level will require two years of full-time or 3,000 hours of supervised work with 240 contact hours of education. The Ph.D. will require four years of full-time or 6,400 hours of supervised work with 400 contact hours of education.

During deliberations, the team resolved that the curriculum would be consistent with and supportive of the curriculum for health care professionals. For instance, for nursing, pharmacy, and social work, the curriculum will be sensitive to the systems theory upon which these disciplines are based. Thus, it will underscore the interrelationships and interactions between a variety of systems, including individuals, families, groups, organizations, and communities in terms of primary, secondary, and tertiary prevention. The ecological approach, a subset of systems theory, will also be useful since it is more specific to individuals and family systems. Thus, all courses are developed through a system or ecological perspective and the adoption of a strengths perspective.

Second, the curriculum should consider skill development. This involves specifying the skills or practical competence areas required for effective professional practice. Here, it is worthwhile to assess and consolidate the health care professionals' generic skills (at the diploma level) before proceeding to more advanced skills (at the master's and Ph.D. levels). The basic level skills in substance use treatment will involve basic counseling, while the advanced level skills will consist of enhancing motivational interviewing skills, cognitive behavioral therapy, contingency management, skills for screening co-occurring disorders, clinical supervision for substance use disorder (SUD) professionals, intermediate clinical skills and crisis management, case management skills and practices, and enhancing group facilitation skills.

A competency-based approach to curriculum development and the teaching-learning process will focus on a specific set of skills that each learner must master (Frank et al., 2010; Nousiainen et al., 2017). Identified sets of clearly articulated competencies will serve as a road map for the learner's destination and, most importantly, what s/he will be able to do once they get there (Nousiainen et al., 2017). At each level of the diploma, master's, and Ph.D., the core competencies will be graded and in scaffolds. The domains of competence will include analytic assessments, basic public health skills in SUD, cultural competency skills, community dimensions of practice skills, management skills, and policy development skills. Students will need

to achieve competencies in each domain at one of the three levels: awareness, knowledge, and proficiency.

The awareness level is a basic level of mastery of the competency. The learner can identify the concept or skill but may have limited ability to perform the skill. The awareness level will fit into the stepped care approach in the WHO optimal mix of services (WHO, 2010). At the knowledge level, the learner has an intermediate level of mastery of the competency. Here, the learner can apply and describe the skills in prevention and treatment. At the proficiency level, the learner can synthesize, critique, or teach the skill. Thus, the curriculum for the diploma, master's, and Ph.D. aligns with a continuum of competencies at three levels of health practice: the generalist role (diploma level), specialist/manager role (master's level), and consultant role (Ph.D.). It is assumed that job descriptions will reflect the components for each level.

Third, the team looked at students' lived experience as a component of the curriculum. This part of the curriculum is organized around the learners' interests, experiences, and learning needs. Our approach to the curriculum design is based on the belief that adult learners are themselves a rich resource for learning and will learn best when new learning is related to their experiences (Knowles, 1970). Recognizing personal experience asserts learners' rights to "autonomy and authentic learning." Authentic learning underpins the personal experience as a source of meaningful incidents and encounters and as a starting point for inquiry and reflection (Cooper & Heenan, 1980).

Lastly, the team deliberated on the agenda of cultural issues. This approach to the curriculum will focus on social, political, and ethical issues. It is based on the view that profound, long-term disagreements exist around the topic of health. Divergent views reflect deeper value conflicts and political dilemmas, and these should be placed at the center of the curriculum for the professional education of the non-addiction specialists (i.e., nurses, doctors, health educators, and others) as they move along the continuum of learning.

Evaluation is an important component of the curriculum. Evaluation systems are part of curriculum development and should be built into the educational program. This process should not only assess the learning and teaching activities but also the course impact on professional competence. Using the CIPP (context, inputs, processes, and products) model, which is based on Stufflebeam's work (Stufflebeam, 2000; 2014), the team recognized that evaluation of the program's context, inputs, processes, and products would be worthwhile.

● 4 DISCUSSION

In the past, the education of addiction professionals in Nigeria was limited to undergraduate medical schools and focused exclusively on the biological and physiological aspects of substance use and addiction phenomena. Thus, most addiction professionals likely had limited knowledge of drug use issues before starting to work in the field. Those who attempted to overcome the gaps in knowledge and skills in addiction had to attend occasional and unsystematic training events and courses arranged by NGOs and other organizations. Given these realities, many stakeholders will need to know the particularities of addictology to identify and address addiction problems effectively.

Similar to some European countries in the last decade, Nigeria lacks a tertiary institution that grants degrees specifically in the field of addiction studies. To address this gap, we had first and initial contacts with ICUDDR on the Universal Prevention and Treatment Curricula, similar to the steps taken in the article by Henrique et al (2019). After a thorough conceptualization using Clark and Hollingsworth's Interconnected Model of Professional Growth (Clarke & Hollingsworth, 2002), we reached an effective understanding of the problems of addiction treatment workforce. In line with the findings from our series of engagements, we present a proposed curriculum for different levels of specialization addiction training courses that builds on the Bologna Process and focuses on prevention and treatment. The target audience is professionals with prior or no work experience in the addiction treatment field. Thus, our proposal details curricular adjustments in the Nigerian context and the needs of stakeholders (general doctors, nurses, social workers, and pharmacists) in addiction.

Our study shares similarities with findings from European countries. First, we used key informant interviews to develop insights on the training level and proficiency of the Nigerian addiction workforce. We found significant gaps in relation to addiction prevention and treatment work, just as Ostaszewski et al. (2018) found gaps among the workforce among different levels of professionals. In line with Kirtadze, Otiashvili, and Javakhishvili (2010), our proposal considers the development of programs with different formats, scales, and frames.

Second, our methods are comparable to the works of Henriques and his colleagues in 2019, who developed a university addiction curriculum following a review of addiction training and findings of lack of formal, structured addiction training for different professionals. Third, it is noteworthy that the context-responsive approach was key in developing their curricula. Similarly, in Nigeria, we considered the importance and relevance of factors such as cultural orientations, local needs, and proficiency in developing blueprints for different levels of in-training and in-service professionals.

Similarly, our proposed curriculum focuses on learning outcomes as in the perspectives of Charvat et al. (2012). We did not re-invent the wheel but used a panel of experts to propose an adaptation of the Universal Prevention Curriculum and Universal Treatment Curriculum in alignment with Henrique

(2019), who described the formation of a consortium of European specialists to adapt UPC into a university program. The decision to form a consortium decision was based on securing and maintaining interest in quality standards and policy (Henrique et al., 2019).

The fact that addiction science has not been developed as a university program in Nigeria reflects the low estimation of addiction science as a strategy for addressing the burden of drug use in the country. Not surprisingly, this situation aligns with Pavlovská et al. (2017) who highlighted the low priority placed on addiction studies when they reviewed the number of academic study programs provided in 25 European universities. Just like these authors, our sessions identified pioneering efforts in Nigerian universities that are developing addiction-specific programs.

To accommodate non-specialists in our proposed curriculum, in line with Charvát et al. (2012), we have highlighted interdisciplinarity issues. We also created pathways to overcome a single disciplinary perspective that is not appropriate in real practice and navigate practical difficulties with addiction education and training programs, especially in terms of pedagogy, practical assessment, and evaluation of the knowledge, skills, and competencies of different levels of professionals. The issue of interdisciplinarity came up in a series of meetings and helped to facilitate the consideration of networking opportunities between universities, training institutes, and other relevant international agencies and bodies (e.g., ISSUP and ICUDDR).

In contrast to the realities in other nations that have dedicated governmental bodies tasked with developing educational programs and addressing addictive behaviors and dependencies (Henriques et al., 2019), Nigerian universities currently work in silos with poor linkages with the Nigerian Ministry of Health. This gap can be addressed in Nigeria systematically by developing drug strategies that provide a framework for coordinated responses including tertiary-based educational interventions to drug problems. Nurturing addiction knowledge, skills, and attitudes needs to be a continuous educational process that empowers stakeholders with different levels of qualifications or professional experiences to perform evidence-based interventions.

Our proposed university-based addiction pedagogical practice integrates real clinical training components with the real needs of potential employers and the labor market. This perspective allows for providing high-quality and sustainable service, developing the workforce, and providing different kinds of education programs that are compatible and transferable (Pavlovská, Miovský & Vacek, 2018).

Many universities around the world including those in Africa offer addiction studies programs based on the adaptation of UTC/UPC similar to our proposed model (Pavlovská, Miovský & Vacek, 2018). Our approach for addiction education and training in Nigerian universities followed the Bologna reform as observed in European countries (Enders & Westerheijden, 2011). Within this perspective, considering a continuum of three levels of higher education of addiction studies (i.e., diploma, master's,

and doctorate levels) provides the key to building the requisite trust for successful learning mobility, cross-boundary academic cooperation, and forum for international dialogue (Enders & Westerheijden, 2011). This approach has been used in university-based addiction programs in Czech Republic (Miovsky et al., 2016) and South Africa (Pasche et al., 2014). In other words, we envision a continuum of service provision accessible to a broad range of stakeholders that will stimulate the expansion of a competent addiction workforce in Nigeria.

Our case emphasizes that the key ingredients for success in addiction curriculum development include a focus on specialized learning in addiction that overlays generic undergraduate professional training, a core commitment to competency-based teaching, and collaborative interdisciplinary relationships. This aligns with the perspective of Adams and colleagues (2017) that positive impacts in addressing addiction problems and burdens Nigeria will depend on ongoing and sustainable cooperation and participation of education providers, government agencies, and addiction services.

While implementing this proposed curriculum is outside the scope of this discussion, factors that will likely ease its implementation have been considered in a series of meetings involving key persons in the development of this curriculum. Such factors include support and buy-ins from institutions, regulatory and accreditation bodies, investment in the training by government bodies, and collaborative relationships across agencies (Adam et al., 2017; Pasche et al., 2014).

In regard to professional specialization, the proposed curriculum was developed to allow for addiction specialization in Nigeria within the existing addiction care professions (for example, doctors, psychologists, social workers, and counselors) or within the training of addiction specialists as independent professionals. Both pathways are not mutually exclusive because the different professions currently involved in the addiction field in Nigeria will remain relevant after addictology's ascent as a profession (Butler, 2011; Miovsky et al., 2016).

Lastly, for the proposed curriculum for university-based addiction programs to realize its potential and impact on addiction workforce development in Nigeria, employment opportunities must be available, allowing addiction professionals from such programs to work independently in the clinical setting according to their level of competencies. The addictology graduates from such programs do not represent competition for any of the existing professions, since they cannot replace a doctor or any other existing profession.

This study has its limitation. A non-probability sampling of stakeholders and participants may have biased the report. Also, the study could have benefitted from a mixed-method analysis rather than qualitative analysis. However, the majority of the participants have prior reliable experience in working in the addiction field. Further, in-depth interviews and focus group discussions provided quality and in-depth information to establish a curriculum. Lastly, the authors of the study participated in the stakeholders' meetings leading to the curriculum development and are unable to ensure complete impartiality.

Future studies may consider conducting a stakeholders' needs assessment in developing a tailor-made curriculum for them.

● 5 CONCLUSION

In summary, a blueprint curriculum for addiction in the higher education system in Nigeria has been proposed via evidence-based interdisciplinary efforts that involved the International Consortium of Universities in Drug Demand Reduction in accordance with the Bologna declaration. This description of the development of an interdependent appropriate curriculum for diploma, master's, and Ph.D. courses in Nigeria may be of interest to universities in other locations that want to establish a nationwide approach to addiction education and training.

Authors' contributions:

BAO designed the study, initiated the write-up and subsequent development of the draft, OO, MA, ME, SG, SA, TCO, and MA contributed to the methodology and cooperated in the write-up of the final version of the manuscript.

Declaration of interest:

No conflict of interest.

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