Community-Based Substance Use Prevention: Public Health, Law Enforcement, and Civil Society Collaboration

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Abstract: Substance use prevention requires coordinated action beyond the health sector because substance use is influenced by individual, family, social, economic and environmental factors. This article examines opportunities and challenges in collaboration among public health institutions, law enforcement agencies, schools and civil society organisations in Nigeria. It adopts a practice-based reflective approach informed by professional experiences, including a Drug Prevention, Treatment and Care training programme involving 43 Nigeria Security and Civil Defence Corps personnel in October 2021 and a teacher capacity-building workshop involving 15 participants in August 2024. It also considers tobacco-control engagement and community health outreach as examples of public health–enforcement and community collaboration. The experiences illustrate opportunities for institutional capacity-building and cross-sector engagement, while highlighting challenges involving fragmented responsibilities, resource constraints, stigma, referral gaps and limited monitoring. The activities are not presented as evaluated interventions, and no causal or effectiveness claims are made. The article proposes a six-step practice-informed framework — Community, Connect, Coordinate, Refer, Support and Measure — to guide collaborative prevention planning. It concludes that sustainable prevention requires community participation, clearly defined institutional roles, accessible referral pathways, continuity of support and systematic evaluation.

Keywords: Substance use prevention; community engagement; public health; law enforcement; civil society; multisectoral collaboration; school-based prevention; Nigeria.

1. INTRODUCTION

Substance use is a complex public health and social challenge with implications for individuals, families, communities and national development. Its consequences may extend beyond direct health effects to include family disruption, educational difficulties, social exclusion, economic hardship, violence and contact with the criminal justice system.

Although health services play a central role in prevention, treatment and care, the factors influencing substance use extend across several sectors. Family relationships, peer networks, educational environments, employment opportunities, community safety, social norms and access to services may all influence vulnerability and resilience. Addressing these factors requires coordinated action involving institutions and groups with different responsibilities and areas of expertise.

The United Nations Office on Drugs and Crime (UNODC) and World Health Organization (WHO) recognise the importance of evidence-informed prevention across developmental stages and settings. Their International Standards on Drug Use Prevention emphasise the role of families, schools, communities and broader social environments in strengthening protective factors and reducing risk (UNODC and WHO 2018).

In practice, however, prevention activities may remain fragmented. Public health agencies may organise awareness campaigns, law enforcement agencies may focus on drug-related offences, schools may respond to behavioural concerns through disciplinary procedures, and civil society organisations may conduct community-based activities. While each approach may have value, their contribution can be constrained when they operate without adequate coordination or referral arrangements.

This article examines how public health, law enforcement and civil society can contribute complementary strengths to community-based substance-use prevention in Nigeria. It draws on selected professional experiences to identify opportunities, institutional challenges and practical considerations for collaboration. The intention is not to present the activities as proven interventions, but to reflect on what they reveal about the organisation and delivery of prevention efforts.

2. APPROACH AND SOURCES OF PRACTICE-BASED REFLECTION

This article adopts a practice-based reflective approach informed by my professional experiences in

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public health, substance-use prevention, law enforcement and multisectoral collaboration in Nigeria. It is not an empirical research study, systematic review or formal programme evaluation.

The reflection draws on selected professional activities, including:

1. The Drug Prevention, Treatment and Care (DPTC) capacity-building programme organised for NSCDC personnel in October 2021.
2. A teacher capacity-building workshop organised by ISSUP Nigeria FCT (Abuja) Chapter in collaboration with EFSEA Adolescents Health and Nutrition Centre in August 2024.
3. Professional experiences in tobacco-control awareness, compliance monitoring and intersectoral engagement.
4. Community medical outreach and referral-related experiences, including work in underserved communities.

Programme details are based on my direct involvement and available programme information. Relevant international guidance and Nigerian policy documents are used to situate the experiences within broader prevention and institutional contexts.

I distinguish between documented programme information, my professional observations and recommendations derived from reflection. The examples were selected because they illustrate opportunities for collaboration; they are not intended to represent all prevention activities in Nigeria. No causal relationship between the activities and changes in substance-use outcomes is claimed.

3. WHY MULTISECTORAL COLLABORATION MATTERS IN SUBSTANCE-USE PREVENTION

Substance-use prevention requires attention to the conditions that influence behaviour and wellbeing. Information about the risks associated with substances is important, but information alone may be insufficient where individuals face social pressures, family difficulties, poor access to services, stigma or limited opportunities for positive engagement.

A comprehensive prevention approach therefore requires the participation of different sectors.

3.1. Public health

Public health contributes prevention science, health promotion, surveillance, risk communication, service planning and the identification of population needs. Health professionals can provide evidence-informed information, identify people who may require assessment and connect individuals with appropriate treatment and support.

The public health approach also emphasises prevention at population level, including the strengthening of protective environments and reduction of risk factors. It recognises that prevention should be sustained and adapted to the needs of different populations.

3.2. Law Enforcement

Law enforcement agencies have important statutory responsibilities relating to public safety, crime prevention and the enforcement of applicable laws. Their operational presence in communities may also provide opportunities to recognise social and health concerns that require responses beyond enforcement.

Appropriately trained law-enforcement personnel can contribute to prevention by understanding substance-use risks, avoiding stigmatising assumptions, recognising when health or social support may be required, and facilitating appropriate referral within established institutional arrangements.

This does not mean that law-enforcement personnel should assume clinical responsibilities. Rather, training can help them understand the relationship between substance use, health, social vulnerability and public safety, while respecting professional boundaries.

3.3. Civil Society Organisations

Civil society organisations may have established relationships with communities, young people, families and vulnerable populations. Their strengths can include advocacy, community mobilisation, peer engagement, health education and the ability to reach groups that may not readily access formal institutions.

A systematic review of community coalitions for adolescent substance-use prevention identified the importance of coalition infrastructure, stakeholder involvement and implementation processes. However, it also noted that many studies did not adequately describe coalition activities or measure their influence on prevention outcomes (Hutchison and Russell 2021).

This finding reinforces the need to distinguish between establishing a partnership and demonstrating

that the partnership produces meaningful results. Civil society organisations can contribute to reducing stigma and encouraging people to seek help, particularly when activities are developed with communities rather than simply delivered to them.

3.4. Schools, Families and Community Institutions

Schools provide opportunities to promote protective factors, strengthen life skills and identify students who may require additional support. Families influence social development, communication and behaviour, while community and faith-based institutions may provide trusted spaces for engagement.

Research on school-based interventions suggests that prevention can benefit from stronger connections between classroom learning, the wider school environment, teachers, students and families (Tancred *et al.* 2018).

These stakeholders should be considered part of a wider prevention network, with clearly defined roles and access to appropriate professional support. Teachers, parents and community leaders should not be expected to diagnose or independently manage substance-use disorders.

4. CAPACITY BUILDING: MOVING LAW ENFORCEMENT BEYOND ENFORCEMENT ALONE

One of the practical lessons from my experience has been the importance of equipping law-enforcement personnel with knowledge that goes beyond enforcement.

A particularly relevant example was the Training on Sensitization on Drugs and Drug Prevention, Treatment and Care (DPTC) for personnel of the Nigeria Security and Civil Defence Corps (NSCDC), held at the NSCDC Auditorium, Abuja, from 6–8 October 2021.

The initiative originated from my personal engagement with the United Nations Office on Drugs and Crime (UNODC) Country Office, following a similar capacity-building programme organised for an NGO network with which I was associated. This engagement provided an opportunity to extend the training initiative to NSCDC personnel within the framework of the European Union-supported project, *Response to Drugs and Related Crimes in Nigeria*.

The three-day programme trained 43 NSCDC personnel, all drawn exclusively from within the Corps. No personnel from other law-enforcement agencies participated in this particular training.

Topics included an overview of the drug situation in Nigeria; supply reduction, drug demand reduction and harm reduction; causes of substance use and associated stigma; special populations of people who use drugs; advocacy; and specific issues relating to law enforcement.

UNODC provided the resource persons and facilitated their associated arrangements, while NSCDC provided logistical support and covered other local organisational expenses.

The training created an opportunity for participants to engage with substance use from a broader perspective. Rather than viewing the issue exclusively through the lens of drugs, offences and enforcement, participants were exposed to the prevention, treatment and care dimensions of the problem.

This distinction matters. A law-enforcement officer does not become a health professional because of a training programme. Nor should health professionals be expected to perform law-enforcement functions. The value of cross-sectoral training lies in helping each sector understand the responsibilities and contributions of the others.

For law-enforcement personnel, this can mean recognising that a person affected by substance use may need more than an enforcement response. Depending on the circumstances, there may be opportunities for prevention, referral, treatment or other forms of support.

The experience illustrates how individual professional initiative, international development partnerships and institutional cooperation can create opportunities for prevention capacity-building within law-enforcement organisations. However, it should be understood as an example of capacity-building activity rather than evidence of improved institutional performance, since systematic post-training assessment and longitudinal follow-up data were not available.

5. SCHOOLS AND TEACHERS AS PREVENTION PARTNERS

Schools are important settings for substance-use prevention because they provide opportunities to engage young people, strengthen protective factors

and identify students who may require additional support. Teachers, however, should not be expected to diagnose substance-use disorders or replace qualified health professionals. Their contribution is better understood in terms of awareness, early identification of possible concerns, supportive engagement and appropriate referral.

An example of engagement with the school sector was a teacher capacity-building workshop organised on 9 August 2024 at Fortune Victory and Peace School, Pigba Kasa, Apo, Abuja. The workshop was organised by ISSUP Nigeria FCT (Abuja) Chapter in collaboration with EFSEA Adolescents Health and Nutrition Centre. It had 15 participants from the school, while all facilitators were drawn from ISSUP Nigeria FCT (Abuja) Chapter.

The workshop addressed several areas of substance-use prevention. These included understanding substance use, the different types of substances and their effects; recognising possible signs and symptoms; understanding risk factors and vulnerability, including family history and peer influence; and identifying students who might be at risk.

Participants were also introduced to prevention strategies, including resilience, coping skills, positive social connections, constructive behaviours and activities. Other sessions addressed responding appropriately to possible substance-use concerns among students, providing support, referral options and the appropriate role of school discipline.

The programme further considered the importance of a supportive school environment, including positive school culture, open communication, trust, parental and community involvement, and the teaching of practical life skills. These included assertiveness, boundary-setting and refusal techniques, with attention to how such skills might be integrated into school activities and the curriculum.

The workshop was facilitated through the professional contributions of ISSUP Nigeria FCT Chapter members. It did not have dedicated external or institutional funding and relied on limited individual support. This illustrates a practical challenge facing community-based prevention initiatives: professional commitment can create opportunities for engagement, but sustained activities require institutional ownership, adequate resources and continuity.

The workshop should not be interpreted as evidence that a single training session improved teachers' ability to prevent substance use or reduced substance use among students. No systematic pre- and post-training assessment, longitudinal follow-up or student-level outcome evaluation was available. Rather, the activity provides an example of how civil society and professional networks can engage schools and introduce teachers to prevention concepts, supportive responses and referral considerations.

For school-based prevention to be sustained, capacity-building should be linked to school policies, parent engagement, access to appropriate referral services and continuing professional development. Teachers need clear guidance on recognising concerns, maintaining confidentiality, avoiding stigmatising responses and connecting students to qualified support when necessary.

6. TOBACCO CONTROL AS AN EXAMPLE OF PUBLIC HEALTH–ENFORCEMENT COLLABORATION

Tobacco control provides another practical illustration of the relationship between public health, regulation, enforcement and community engagement. Although tobacco control and other substance-use prevention activities are not identical, they share important implementation principles, including health education, regulatory action, compliance monitoring, stakeholder coordination and the protection of vulnerable populations.

Nigeria's National Tobacco Control Act 2015 provides a legislative framework for tobacco control. Its implementation requires cooperation among relevant government institutions, enforcement bodies, public health professionals, civil society organisations and other stakeholders.

My professional involvement in tobacco-control activities has included awareness, compliance monitoring and engagement with relevant institutions. These activities highlight the distinction between having a policy or law and achieving its effective implementation.

In research presented at the 1st Africa Law Enforcement and Public Health Conference in Pretoria in December 2024, I examined awareness and implementation of smoke-free provisions of the 2015 Tobacco Control Act in outdoor and indoor recreational facilities in Abuja. The findings indicated gaps between awareness and implementation, including limited awareness of specific provisions and incomplete compliance with relevant requirements.

The assessment reported that 59% of facility managers were aware of the provisions, 52% informed customers about them, 25% allowed smoking, and 51% displayed signage. Although 67% were aware of designated-area-only requirements, only 7% were aware of the specific provisions assessed.

These findings relate to the particular facilities and assessment described and should not be generalised to all recreational facilities in Abuja or Nigeria. They nevertheless illustrate why public education, clear communication of regulatory requirements, routine monitoring and appropriate enforcement need to be connected.

Public health institutions contribute technical knowledge and interpretation of health requirements. Enforcement agencies contribute operational capacity and support compliance with applicable laws. Civil society organisations can contribute advocacy, public awareness and accountability.

The broader lesson for substance-use prevention is that awareness activities are unlikely to be sufficient when they are disconnected from institutional responsibilities, service pathways and mechanisms for monitoring implementation.

7. COMMUNITY OUTREACH, TRUST AND REFERRAL

Community engagement is essential to prevention because interventions are more likely to be relevant when they respond to the experiences, priorities and needs of the people they are intended to reach.

Community medical outreach can provide an entry point for identifying health needs, engaging underserved populations and connecting individuals with appropriate services. It may also create opportunities for collaboration among health professionals, government institutions, civil society organisations and community leaders.

My experience in community health outreach, including work in Laminga, Nigeria, has reinforced the importance of approaching communities through engagement and service rather than relying exclusively on formal institutional contact.

In the context of substance-use prevention, community outreach should not be limited to the delivery of health messages. It should also consider whether individuals who disclose health or social concerns can access appropriate assessment, counselling, treatment or other support. Where referral is indicated, the receiving service, referral process and confidentiality arrangements should be considered before the activity takes place.

Trust is particularly important where substance use is associated with stigma, fear of discrimination or concern about punitive responses. Individuals may be reluctant to disclose substance-related problems if they believe that seeking help will automatically expose them to humiliation, exclusion or inappropriate treatment.

Public health professionals and civil society organisations can help create supportive environments in which people feel able to seek assistance. Law-enforcement personnel can contribute by understanding professional boundaries, respecting applicable rights and facilitating appropriate referral where this falls within their responsibilities.

Community trust should not be assumed simply because an organisation conducts an outreach activity. It is developed through respectful engagement, consistency, confidentiality, responsiveness and the availability of meaningful support.

8. COMMUNITY TRUST AND THE IMPORTANCE OF NON-STIGMATISING RESPONSES

Stigma remains a significant barrier to prevention, early identification and access to treatment. People who use drugs may experience discrimination in families, schools, workplaces, health facilities and communities. Stigmatising attitudes can discourage help-seeking and weaken the relationships required for effective prevention.

Law-enforcement agencies, health professionals, teachers and civil society organisations all have a role in avoiding language and practices that unnecessarily label or marginalise people.

A public health approach recognises that individuals affected by substance use may have different needs and circumstances. Some may require prevention information, others may benefit from brief intervention or counselling, while those experiencing substance-use disorders may need specialised treatment and continuing care.

The response should therefore be proportionate to the individual's needs and should distinguish between substance use, harmful patterns of use and substance-

use disorders. A person should not be assumed to have a disorder solely because of suspected or disclosed substance use.

Non-stigmatising engagement does not remove the legitimate responsibilities of law-enforcement agencies. It helps ensure that responses are appropriate, respectful and consistent with the respective roles of health and security institutions.

9. A PROPOSED SIX-STEP FRAMEWORK FOR COLLABORATIVE PREVENTION

Drawing on the professional experiences discussed in this article and established principles of community-based prevention and multisectoral collaboration, I propose a six-step framework: Community, Connect, Coordinate, Refer, Support and Measure. The framework is intended as a practical organising model for planning and strengthening collaborative prevention activities. It is not a validated intervention or an established measurement instrument.

The framework is intended to help stakeholders move from isolated awareness activities towards more coordinated and continuous prevention arrangements. Its indicators are suggestions for future programme monitoring; they are not outcomes reported from the 2021 or 2024 activities described in this article.

The framework may be adapted to different institutional and community settings. For example, a school-based initiative may begin with consultation involving teachers, parents and students, followed by identification of relevant health and social services. A law-enforcement-based initiative may begin with institutional capacity-building, followed by coordination with health professionals and the development of appropriate referral procedures.

The framework does not require every stakeholder to perform the same functions. Rather, it encourages stakeholders to identify their respective responsibilities and work towards shared prevention objectives.

Its practical value and effectiveness would need to be examined through prospective implementation, monitoring and evaluation.

10. CHALLENGES TO EFFECTIVE COLLABORATION

Although multisectoral collaboration is widely recognised as important for addressing complex public health challenges, putting it into practice can be difficult. Institutions may have different mandates, priorities, professional cultures and accountability arrangements. These differences can create boundaries that limit information-sharing, joint planning and continuity of activities.

Competition for visibility, recognition and limited resources may also affect collaboration. In some settings, institutions may participate in joint activities without agreeing on clearly defined responsibilities or mechanisms for sustained engagement.

A meeting, workshop or joint awareness campaign does not necessarily establish an effective partnership. Collaboration requires agreed objectives, clear roles, communication arrangements and mechanisms for reviewing progress.

Table 1: Proposed Six-Step Framework for Collaborative Substance-Use Prevention

Step	Proposed practical activities	Possible monitoring indicators
Community	Engage young people, families, schools, community leaders and other relevant groups to identify needs and priorities.	Number and diversity of consultations; documented community priorities.
Connect	Identify and map relevant health services, educational institutions, law-enforcement agencies and civil society organisations.	Updated directory of partners and available services.
Coordinate	Agree on shared objectives, institutional responsibilities, communication arrangements and referral procedures.	Documented roles, coordination meetings and referral protocols.
Refer	Establish appropriate pathways for connecting individuals requiring assistance with qualified health and social services.	Number of referrals made and, where ethically and lawfully recorded, completed referrals.
Support	Promote continuity of care through appropriate follow-up, family engagement and non-stigmatising support.	Evidence of follow-up arrangements and continuity of support, subject to confidentiality safeguards.
Measure	Review implementation, identify gaps, document lessons and use findings to improve activities.	Monitoring reports, documented lessons and improvement actions.

Another challenge is the gap between awareness and access to services. An officer or teacher may recognise that an individual needs assistance but may not know where to refer that person. Community organisations may have strong relationships with affected populations but lack the resources or professional capacity to provide appropriate services. Health facilities may offer relevant services but remain inaccessible to some communities.

These challenges are particularly relevant in Nigeria, where institutional responsibilities are distributed across federal, state and local government structures. The availability, accessibility and capacity of prevention, treatment and referral services may vary considerably across states and communities. Consequently, collaborative arrangements should be adapted to local service availability and institutional capacity rather than assuming that the same model can be implemented uniformly throughout the country.

The roles of the National Drug Law Enforcement Agency (NDLEA), Federal Ministry of Health and Social Welfare, NSCDC, state and local government authorities, educational institutions, health-service providers and civil society organisations should be considered within their respective mandates.

Effective coordination does not require institutions to abandon their statutory responsibilities. Rather, it requires them to identify where their responsibilities intersect and how they can work together without unnecessary duplication.

Sustainable collaboration also requires leadership that facilitates participation rather than allowing one institution to dominate the process. Clear communication, agreed referral procedures, appropriate confidentiality safeguards, regular review and continuity beyond one-off activities are essential.

11. IMPLICATIONS FOR PRACTICE AND POLICY

The experiences discussed in this article suggest several considerations for strengthening collaborative substance-use prevention in Nigeria.

First, law-enforcement personnel should be included in relevant prevention capacity-building initiatives. Their role in community engagement, public safety and the identification of drug-related concerns gives them opportunities to contribute to prevention. Training should, however, clarify professional boundaries and the distinction between enforcement, prevention, treatment and care.

Second, teachers should be supported as prevention partners rather than treated as substitutes for health professionals. School-based prevention should include appropriate training, supportive school policies, parent and community engagement, and clear referral arrangements.

Third, civil society organisations should be recognised as potential partners in prevention planning and implementation, not merely invited to participate in isolated activities. Their community relationships and ability to engage particular populations can complement the institutional responsibilities of government agencies.

Fourth, referral arrangements should be considered during the design of awareness and capacity-building programmes. It is insufficient to teach participants how to recognise a possible substance-use concern without also identifying appropriate services and explaining how individuals can access them.

Fifth, multisectoral committees and partnerships should have clear objectives, defined responsibilities, communication channels and mechanisms for reviewing progress. The relevant government institutions, including NDLEA and the Federal Ministry of Health and Social Welfare, should work with state and local structures, schools, health-service providers and civil society organisations in ways that reflect their respective mandates.

Sixth, programme monitoring should go beyond counting participants or activities. Where feasible and ethically appropriate, monitoring should consider changes in knowledge, the availability and use of referral pathways, continuity of support, stakeholder participation and the extent to which identified service gaps are addressed. Any collection of information about individuals seeking help should protect confidentiality and comply with applicable ethical and legal requirements.

Finally, prevention should be understood as an ongoing community process rather than a series of disconnected awareness events. The two capacity-building examples described in this article illustrate opportunities for engagement; they do not establish that the activities independently produced measurable changes in substance-use outcomes.

12. LIMITATIONS AND CONSIDERATIONS FOR FUTURE EVALUATION

This article has several limitations. First, it is based on selected professional experiences and programme activities rather than a systematic study of community-based substance-use prevention in Nigeria. The examples are illustrative and cannot be assumed to represent the experiences of all institutions, communities or prevention programmes.

Second, although participant numbers, programme topics and implementation arrangements are reported for the two capacity-building activities, systematic pre- and post-training assessments, longitudinal follow-up and formal outcome evaluations were not available. Consequently, the article cannot establish whether the activities resulted in sustained changes in participants' knowledge, attitudes, professional practices, referral behaviour or substance-use outcomes.

Third, my direct involvement in some of the activities provides practical insight but may also introduce limitations associated with professional perspective and retrospective interpretation. The discussion should therefore be understood as reflective analysis rather than independent evaluation.

Fourth, the proposed six-step framework has not been prospectively implemented and validated as a complete model. Its suggested indicators require further refinement and testing in different institutional and community settings.

Future work could examine the feasibility of applying the framework in selected communities or institutions, assess changes in participants' knowledge and practice, document the operation of referral pathways, and evaluate the sustainability of collaboration. Such work should use appropriate ethical safeguards, clear programme indicators and, where possible, independent evaluation.

13. CONCLUSION

Substance-use prevention is a complex public health and social challenge that cannot be addressed effectively by a single institution acting alone. Public health institutions contribute technical knowledge and service coordination; law-enforcement agencies contribute public safety, community engagement and relevant statutory functions; and civil society organisations contribute community relationships, advocacy and additional support. Schools, teachers, families and local leaders also have important roles.

The NSCDC DPTC training of October 2021 and the teacher capacity-building workshop of August 2024 provide practical examples of how professional initiative and collaboration can create opportunities to engage law enforcement and the education sector in substance-use prevention. They should not, however, be interpreted as evidence of improved institutional performance or reduced substance use, since systematic outcome evaluations were not available.

The proposed Community, Connect, Coordinate, Refer, Support and Measure framework offers a practice-informed way of organising collaborative prevention activities. Its value will depend on how it is adapted, implemented and evaluated in real-world settings.

Ultimately, the strength of a collaborative prevention system should not be judged only by the number of institutions represented at meetings or the number of awareness activities conducted. It should also be assessed by whether stakeholders establish workable referral pathways, sustain appropriate support, address service gaps and use credible evidence to improve their activities.

LIST OF ABBREVIATIONS

DPTC – Drug Prevention, Treatment and Care

NDLEA – National Drug Law Enforcement Agency

NSCDC – Nigeria Security and Civil Defence Corps

UNODC – United Nations Office on Drugs and Crime

WHO – World Health Organization

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CONFLICT OF INTEREST

The author declares that there are no conflicts of interest related to this research, authorship, or publication of this article.

AUTHOR CONTRIBUTION

Dr. Damian Chinedu Nzeh was solely responsible for the conception, development, interpretation, drafting and critical revision of this manuscript and approved the final version for submission.

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AI-assisted technology was used to support manuscript restructuring, language refinement and organisation of the revised text. The author reviewed and remains fully responsible for the accuracy of the factual information, interpretation, citations, references and final manuscript. AI tools are not authors or co-authors.

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