Tackling illicit drugs and substance use and addictions in Nigeria: The social cognitive model as a more effective alternative for rehabilitation

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ABSTRACT

Illicit drug use and substance abuse among Nigerian youth is on the rise. Among the highly abused drugs and substances are codeine, cannabis opioid, methamphetamine, tramadol, morphine, cocaine, paints, and super glue. Substance abuse has been known to be associated with increased incidences of mental health issues, prevalence of sexually transmitted diseases, domestic abuse, sexual violence, abortion, terrorism, and collapse in the social structure. Apart from underlying biological predisposing factors, the root cause of substance use may be psychosocial, socioeconomic, sociocultural, socio-religious, and sociopolitical, which could be difficult to address. However, the outcome affects mental, emotional and behavioral health. Evidence has shown that the punitive approach to tackling the problem is ineffective, and better opportunities may exist for health promotions. That is health promotion interventions that minimizes health-risk behavior of illicit substance use, abuse, and addiction, and promotes a healthy lifestyle or health-seeking behavior. Given the strong socio-cultural and highly communal context of Nigerian society, which is highly embedded in strong family and religious ties, the social cognitive model (SCM) for behavioral change offers a more resilient framework for an effective health promotion intervention against illicit drug and substance use. This article proposes and discusses the feasibility of a health promotion intervention based on the SCM of health behavioral change.

Keywords: *Illicit drug use, substance abuse, social cognitive model, behavioural change model, rehabilitation, Nigeria.*

INTRODUCTION

The poor health outcome traceable to the rising use of illicit drugs among Nigerian youths is of public health concern. An estimated 14.3 million Nigerians use illicit drugs and substances (United Nations Office on Drugs and Crime, UNODC, 2018). This estimate represents a prevalence of about 14.4%, among persons of age 15-64 years (UNODC, 2018). Ogusola et al (2020) found a drug use prevalence rate of 33% among Lagos University students, amongst these, marijuana (~ 46%) was the most abused drug, and coffee (~ 43%) was the most widely used drug. It is estimated about 11% of drug users suffer from addiction (Olajire, 2019). Among the highly abused drugs are codeine,

cannabis opioid, methamphetamine/, amphetamine/dexamphetamine, tramadol, morphine, cocaine, methaqualone (Mandrax), fencamfamine (Glucoenergan or Reactivan), and diazepam (Jatau et al., 2021; UNODC, 2018). Other abused substances include paints, and superglue (Nwagu et al., 2020). Jatau et al. (2021) reported 20–40% and 20.9% drug abuse prevalence among Nigerian students and youths respectively. Illicit drugs use is one of the health-risk behaviors associated with an increase in mental health issues, increased or sustained prevalence in sexually transmitted diseases including HIV/AIDS, domestic abuse, rape, abortion, violent crimes, terrorism, and collapse in the social structure (Olajire, 2019).

The approach to resolving the problems of drugs and substance abuse and addiction must promote mental, emotional, and behavioural (MEB) health and well-being, as well as reduce the occurrence of incidence of MEB disorders in the community. It must also attempt to prevent recruiting from young persons, especially children, adolescents, and young adults who are usually easily swayed by peer pressure and social symbols or trends (Bassett, 2016). Apart from underlying biological factors that may predispose some individuals to MEB health, the root causes of illicit drug use and substance abuse could be psychosocial, socioeconomic, sociocultural, socio-religious, and sociopolitical, which may not be easily tackled in the prevailing difficult circumstances of the economy, politics, unemployment, natural disasters

(flooding), growing insecurity and frequent internal displacement or migration (Olajire, 2019; UNODC, 2018). This has placed a huge security, social and economic burden on society.

Despite the national, regional, and international measured such as arrest, imprisonment, treatment, rehabilitation, and reintegration, put in place to curb the trafficking, sale, and use of illicit substances, the problem seems not to be abating, and it is in fact on the upward trends (Olajire, 2019). In Nigeria, the traditional approach of law enforcement, arrest, and imprisonment to deter intending offenders appear not to be effective as more and more users and traffickers are emerging. The country has graduated from a transit country to a user country, and some of these substances are now being produced in-country (Olajire, 2019; UNODC, 2018). The sanction approach to fighting drug offenses, which does not incorporate rehabilitation and social support, has been observed to be counter-productive by many social scientists. This is because it promotes social exclusion, stigmatization, and probably reinforcement of health-risk behaviours. As could be deduced from National Drug Control Master Plans (NDCMP, 2015-2019 and 2020-2024) and the NDLEA enabling Act, which seems to demonize drug use and addiction, the Nigerian government at all levels has not adequately prioritized the adoption of rehabilitation and social-reintegration health promotions measures such as health education, counseling for the adoption of a healthy lifestyle, promotion of abstinence

or cessation, provision of an adequate and accessible facility for treatment and continuous care for drugs addicts, as well as adequate socioeconomic or welfare support (Olajire, 2019). Although the NDCMP 2020-2024 advocates more resources, protection of human rights, and access to primary and secondary levels of health services, only a few government tertiary healthcare facilities with rehabilitation centers provide limited services. Most rehabilitation services have been left in the hands of non-governmental organizations (NGOs) and faith-based organizations (FBOs). The problems of unaffordability, stigmatization, inaccessibility, and lack of health information on available services, persist (UNODC, 2018).

Despite the seemingly challenging situation, opportunities exist for minimizing health-risk behaviour of illicit substance use, abuse, and addiction, and promoting a healthy lifestyle. The outcome of developing and implementing such health promotion opportunities will largely depends on the effectiveness of working within a framework that mobilizes a strong multi-sectoral and multi-disciplinary collaboration among the key stakeholders, such as; the targeted communities where the use of illicit substances are highly prevalent; the international community and development partners for their cooperation in combating cross-border drugs trafficking, tracking of consumption volumes of frequently used illicit drug-substances, (UNODC, 2018), and their financial support for health promotion interventions towards alleviating

underlying MEB health issues and socio-economic factors in illicit drug use; research institutions and academia for their research activities towards providing verifiable scientific data that can guide appropriate health promotion interventions; NGOs, civic and advocacy groups, which provide useful resources and supports for community buy-in, advocacy and mobilization; the media, which provides traditional and virtual digital online and real-time platform for health promotion information, education and communication (IEC) transmission; and professional communicators to effectively integrate the demography, and religious and cultural values and norms of the targeted population as well as the interest of other stakeholders (Govender, 2005, p. 42; Schiavo, 2007).

Behavioral Change Models in MEB Health

There have been several approaches and models for health behaviour change promotion. These include the ecological model, health belief model (HBM), trans-theoretical model (TTM), theory of reasoned or planned action, and social cognitive model (SCM) (Anugwom, 2020). The Nicotine Exit (NEXit) work of Mossena et al. (2016) on promoting tobacco-smoking cessation among young persons in Sweden, using smartphone-based short message service (SMS) text messages could be easily explained by TTM of health promotions. However, one of the limitations of the trans-theoretical model is that it often does not take into account the 'social context'

(socio-economic status or gradients) of the individuals involved in the targeted population. Some more contextual health promotion strategies on substance abuse and addiction have used integrated youth services (IYS), a collaborative framework that integrates activities of different organisations to provide holistic care that often combines mental health, illicit substance use and addictions, sexual and reproductive health, essential care and other socio-cultural issues which may play a role in determining health or access to health (Halsall et al., 2020). The IYS approach fits contextually very well into the social cognitive model, including integrated support from families, friends/ peers, and technology, and tends to give a more personalized intervention, as well as gives room for differences in individual progression (Halsall et al., 2020, p. 2). It however has to be implemented with careful integration to ensure respect for personal and socio-cultural values and norms at all times.

Social Cognitive Model (SCM)

The SCM is expressed in seven constructs, which include 1) self-efficacy, a belief in one's ability to control and execute behaviour within a given context; 2) behaviour capability, a detailed understanding of behaviour and the ability to exhibit or perform it; 3) expectations, an outcomes or outputs of the change in behaviour in question; 4) expectancies, the assigning of value to the outcome of behaviour and which is important in sustaining the behaviour; 5) self-control, the regulation,

and monitoring of the behaviour of the individual; 6) observational learning, the act of watching others performing the desired behaviour and the outcomes therein as well as modeling that behaviour in question; and 7) reinforcements, the incentives and rewards seen as eliciting, encouraging and sustaining behaviour change in the individual (Bartholomew et al., 2001 as cited in Anugwom, 2020). The strength of the SCM lies in its consideration of the social context of the individual. Any health promotion that will be effective and produce a long-lasting effect in the Nigerian community should consider and incorporate the social context of Nigerians. Key among the social context include poor health literacy; poor access to health care facilities and services; poor internet connectivity; low internet access; gender discrimination and inequality; widening social gradients between the poor and the rich; rising unemployment; rising out-of-school children; huge adolescents and young adults population; worsening economic conditions; nepotism; rising insecurity and terrorism; natural disaster such as flooding, drought, disease outbreaks; internal displacement due to insecurity; migration; general poverty; cultural and religious beliefs; etc. Keeping the above context in mind a health promotion like the IYS which could be based on SCM, may be effective in promoting behavioural change against illicit use of drugs and substances, and addiction, in the Nigerian context.

METHODOLOGY

Intervention Design and Framework

The key primers of illicit substance use and abuse include recreational drug use, peer pressure, psychological pressure, stress, mental illness, and family history (biological factor). Users primed by these factors usually end up in addiction. Health promotions targeted at illicit drug use must address lifestyles that tend to reinforce these MEB health-risk factors in individuals. Furthermore, most drug users have very low health literacy and often experience societal exclusion. Hence the programmes that address exclusion and stigmatization should be integrated. Adolescents, youths, and young adults are the most vulnerable group to drug abuse and addiction, and health promotion intervention must target this population group to achieve desired and long-term goal of treatment, prevention, and reduction of incidents of MEB (Basset, 2016). Most health promotion intervention programmes targeted at adolescents, youths, and young adults work well if incorporated into school programmes, from elementary school for prevention of underage non-medical drug use and substance abuse, and delay in recreational use/abuse of drugs and substances under the influence of peer pressure; through high school to the university for cessation or reduction of use, and treatment or rehabilitation from excessive drug use, abuse, and addiction, as well as promoting of MEB health and wellbeing. Hence an effective community-based MEB health promotion programme should be multipronged and targeted at specific age-range segments of the community. It should incorporate sensitization in early childhood, and prevention of underage and adult non-medical use of drugs (Bassett, 2016). In line with the above concept, a university-based intervention programme targeted at adolescents and young adults in Nigerian universities will be appropriate. It will integrate several preventive, treatment, or management as well as social support. The preventive strategy will include the provision of adequate and understandable information on the health risks of substance abuse as well as the predisposing MEB issues, and socio-environmental factors. Treatment and management will encompass both behavioural change interventions and interventions targeted at associated diseases such as free screening and treatment for HIV/AIDS, hepatitis C virus (HCV), tuberculosis (TB), and malaria infections. Social support will include a scholarship covering tuition, housing, and feeding; learning of life-skills; as well as other psychological counseling supports (WHO and UNODC, 2020). The duration of intervention should be two years or two academic sessions. The overall goal of the programme will be to achieve significant prevention of and cessation of non-medical drug use and abuse among students aged 15 to 29 in Nigerian universities at the end of the programme.

Outcome measures

i. Primary outcome measures: Self-reported cessation of use/abuse of drugs and substances over a period of 12-52 weeks.

ii. Secondary outcome measures: Biochemical testing confirmation of cessation of non-medical drug or substance use/abuse after 12-52 weeks cessation.

Implementation plan

Using the seven constructs of the SCM, the intervention could be implemented as exemplified thus; (see details in Table 1-7):

1) **Self-efficacy:**
Behavioural Objective: At the end of September 30th 2025, 90% of participants will be aware of how to set personal or individual health goals and achieve them, the health risks associated with identified abused drugs or substances, their predisposing environmental and social factors in the university or immediate community environment (Table 1).

2) **Behaviour capability:**
Behavioural Objective: At the end of September 30th 2025, 90% of participants will be aware of the desired health-promoting behaviour, approach to achieving it, with the belief of being able to undertake the process (Table 2).

3) **Expectations:**
Behavioural Objective: At the end of September 30th 2025, 80% of participants will have a positive change towards cessation of drugs and substance abuse, with the belief that drugs and substance abuse are associated with negative MEB health and wellbeing (Table 3).

4) **Expectancies:**
Behavioural Objective: At the end of September 30th 2025, 80% of participants will associate cessation with short- and long-term MEB health benefits and other related health benefits (Table 4).

5) **Self-control:**
Behavioural Objective: At the end of September 30th 2025, 60% of participants would have ceased or reduced the use of drug abused, while practicing learned behaviour in a sustainable manner (Table 5).

6) **Observational learning:**
Behavioural Objective: At the end of September 30th 2025, 60% of participants would have been integrated into care groups that enable model support and learning to sustain the new behaviour and self-control (Table 6).

7) **Reinforcements:**
Behavioural Objective: At the end of September 30th 2025, 60% of enrolled participants would have not used or ceased (reduce) from using at least one identified previously used or addicted drugs/substances for non-medical purpose for a period of one year, or based on standards such as 'Russell Standard' for smoking cessation (Table 7).

DISCUSSION AND IMPLICATION

The proposed intervention will address the ~33% of university students involved in non-medical use of drugs and substance abuse. The intervention incorporates the promotion of mental, emotional or psychological, and behavioural health and well-being, while also providing ancillary treatment services for associated health issues in HIV/AIDS, HCV, TB and malaria, as well as social support that could address socioeconomic problems of poverty and lack. The problem of lack is high among students who often are fending for themselves. This stress could be reduced by providing bursaries, scholarships, and learning life-skills supports. The perceived major challenge with the intervention is the huge resource outlay. Apart from the financial resource, the health professionals needed must be engaged full-time for teaching, counseling and monitoring of participants' progress. There may also be challenges with recruiting participants due to associated stigma. Hence the programme should be initially approached from a general health fitness, and well-being programme before streamlining to drugs and substance abuse issues. The university authorities should also be fully involved in formulating and promoting policies that prohibit non-medical drug use and substance abuse, as well as in developing programmes that provide support for better MEB health and wellbeing (Ogu et al., 2021). The strength of the intervention will be the consideration of socio-economic status of participants, provision of needed socioeconomic supports including life-skills, and the provision of a wholistic health service to address related health issues such as HIV/AIDS, HCV, TB and malaria.

Limitation

This study represents a proposal for implementing a social cognitive behavioral change model for tackling illicit drug and substance abuse. The success of such an intervention may be affected by other intervening real-life socio-demographic, socio-economic, and socio-political factors.

CONCLUSION

Drug and substance abuse is a global problem. The problem is on the rise in Nigeria with the country now upgraded to a user country and not just a transit country. This has resulted in rise in violent crimes and infectious diseases among adolescents, youths and young adults, which are mostly affected. Violent crimes like rape, kidnapping, robbery and terrorism as well as MEB health issues are at an all-time high. The situation is fueled by the current poor economic situation of high youth unemployment (about 65%), inflation (>20%), internal displacement and insecurity. A multi-prong intervention that could prevent antisocial behaviours and promote mental, emotional and behavioural health will be helpful in addressing drug and substance abuse. The proposed intervention will provide participants with the required knowledge on the health-risk behaviour, the benefits of the targeted health-promoting behaviour, mechanisms for adopting, coping with, and sustaining the new behaviour including setting goals and motivation for

success. The intervention also includes social supports to address socioeconomic and socio-environmental factors that may predispose participants to antisocial disorders.

ACKNOWLEDGMENT

Conflict of Interest

Ethical Approval and Consent

Ethical approval and participants' consent were not applicable because the study did not include any primary data or participants.

Sources of fund

Author Contribution

HOE conceptualized, conducted the literature review, and developed the manuscript.

TABLES

Table 1: SCM Implementation Plan for Self-efficacy:

Learning Objective	Content	Learning Process	Duration
At the end of September 30th 2025, 90% of participants will learn about setting, achieving and managing health goals, and predisposing environmental factors to drugs and substance use and abuse.	Health educator will deliver lectures on: 1) Self-assessment, setting of personal goals and objectives and working to achieve them; self-motivational processes for accomplish set goals. 2) Various substances use and drug abuse, associated health and social risks, associated predisposing environmental and social factors; how to avoid or minimize predisposing factors, and possible substitute behaviours; 3) Antisocial personality disorder (ASPD), and how to overcome it.	Participants are engaged to: 1) Identify drugs and substances being abused or addicted to; discourse the associated health-risks and social-risks, predisposing promoting environmental factors, substitute behaviours for better MEB health, possible support required for adoption of new behaviours; 2) Understand available or accessible treatment and social support system. 3) Set required behavioural goals, objectives, milestones, including quit date; learn coping mechanisms and accessible support models; engage participants in motivational counseling sessions 4) Take samples for baseline biochemical testing data.	60 minutes weekly for three months.

Table 2: SCM Implementation Plan for Behaviour capability

Learning Objective	Content	Learning Process	Duration
At the end of September 30th 2025, 90% of participants will be adequately knowledgeable about the desired for cessation of substance use and non-medical drug use/abuse and the activities involved or required towards achieving them.	Health educator will deliver lectures on 1) Various drug abuse and substances use; associated health- and social-risk, associated predisposing environmental and social factors. 2) How best to avoid predisposing factors, and possible substitute behaviours; and available support models. 3) Activities required to perform tasks in behavioural change.	Participants are engaged to 1) Link substances being abused or addicted to baseline biochemical data measures, health and social risks; 2) Identify the predisposing factors; understand substitute behaviours for better MEB health; understand support required for adoption of new behaviours. 3) Practice or perform tasks or activities identified for the new behavior and required support model, include life-skills, fun-games and use of substitute substances.	60 minutes weekly for the first three months.

Table 3: SCM Implementation Plan for Expectations

Learning Objective	Content	Learning Process	Duration
At the end of September 30th 2025, 80% of participants will be able to associate activity performance for drugs and substance abuse of with efforts and outputs.	Health Professionals to teach: 1) The model for cessation, coping mechanisms and support systems. 2) Use of substitute food or supplements products and behaviours will be taught. 3) Self-assessment methods for assessing progress on activities involved in the cessation of drug abuse and substance use.	Participants will be engaged to: 1) Coping mechanisms, and use of substitute behaviours and food substances. 2) Link new behavioural activity and efforts with output and outcome, to improve efforts and performance.	60 minutes of activity weekly for first two months.

Table 4: SCM Implementation Plan for Expectancies

Learning Objective	Content	Learning Process	Duration
At the end of September 30th 2025, 80% of participants will be able to associate activities required in the cessation of substance use and drug abuse with short- and long-term benefits.	Health Professionals will teach: 1) Health- and social-risk associated with drugs and substance abuse for all identified substances. 2) The health and socio-economic benefits of cessation from abuse of substances and drugs will also be taught. 3) The model for cessation, coping mechanisms and support will be taught and demonstrated. 4) Use of substitute food or supplements products and behaviours will be taught.	Participants will be engaged to 1) Identify short-term benefits and long-term benefits of the desired new behaviour. 2) Perform required behavioural activities based on expected outputs and outcome.	60 minutes weekly from 3rd to 6th month.

Table 5: SCM Implementation Plan for Self-control

Learning Objective	Content	Learning Process	Duration
At the end of September 30th 2025, 60% of participants will adopt new health-promoting behaviour of cessation from drugs and substance use and abuse, and be able to self-regulate tempting behaviours.	Health Professional will teach 1) How to self-regulate and avoid temptation to go back to old behaviour 2) Conscious behavioural self-control and attention diversion from pull towards the health-risk behaviour. 3) Full-disclosure and self-reporting. 4) Re-emphasize health implication of drugs and substance abuse, associated health and social risks, as well as the benefits of adopting new behaviour in of cessation from substance abuse in promoting MEB health and other ancillary health and social issues.	Participant will engage to 1) Demonstrate self-control towards health-risk behaviours by systematic reduction of substance or drug use and adoption of health-promoting and enjoyable substitute behaviours such as physical exercises, life skills, completion games and concerts to promote self-reporting and full-disclosure, towards overcoming stigma, accepting treatment and embrace positive behaviour. 2) Learn mitigating anti-social behaviours, while developing acceptable social behaviours. 3) Re-emphasize related health and social issues implicated by poor MEB health and abuse of substances and drugs.	60 minutes daily from the 4rd to 9th month of programme

Table 6: SCM Implementation Plan for Observational learning

Learning Objective	Content	Learning Process	Duration
At the end of September 30th 2025, 60% of participants would have memorized the required activities in for cessation and coping mechanisms, and be able to mimic and self-report progress in those activities.	Health communicator will deliver course content on: 1) Required activities for cessation and coping mechanisms 2) The importance and benefit peer-group support and or other model support to learn and sustain new behaviour of avoidance or cessation from drugs and substance abuse.	Participants are engaged to 1) Learn, memorize, mimic and practice new behaviour and the coping mechanisms such as physical exercises, rewarding and non-violent games like treasure hunts, yoga, etc.; 2) Identify and use substitutes medication or foods, etc.; 3) Integrate into chosen support model, and effectively engage mentor and counselor; 5) Practice self-reporting and full-disclosure.	60 minutes every fortnightly for the last 6 months

Table 7: SCM Implementation Plan for Reinforcements

Learning Objective	Content	Learning Process	Duration
At the end of September 30th 2025, 60% of enrolled participants will attest to that cessation of abused substance(s) and are motivated by better MEB health and wellbeing including better social network, academic performances, socioeconomic status, personal discipline and feeling of better self-worth.	The Health educator/ counselor will provide counsel on: 1) Observed or reported improvement in MEB and related health due to new behaviour. 2) Emphases changes in biochemical parameters due to new behaviour to reinforce behaviour.	Engage participants to identify: 1) Changes in MEB and other health issues since commencing programme; 2) Positive implications of the observed changes 3) Continuing and sustaining the activities producing the positive changes, and manage influence of peers. 4) Sustain self-disclosure and reporting, and well as boost self-worth and dignity.	60 minutes session every month FOR the last 4 months.

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