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**DRUG AWARENESS NEEDS ASSESSMENT
FOR GUATEMALA**

FINAL REPORT

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Development Associates, Inc.
2924 Columbia Pike
Arlington, VA 22204

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EXECUTIVE SUMMARY

INTRODUCTION

USAID/Guatemala, the Embassy of the United States of America, and the Government of Guatemala have become increasingly concerned about the use and abuse of narcotic substances in Guatemala. As a initial step in formulating an approach to the problem, the USAID/Guatemala Mission contracted with Development Associates to conduct a drug awareness needs assessment in three urban centers (Quetzaltenango, Escuintla, and Guatemala City) to determine the prevalence of substance abuse.

The most consistent, reliable and cost effective method for arriving at an estimate of levels of drug use within a population within a given time frame, i.e. drug prevalence, is through a survey using a probabilistic sample. The survey conducted by Development Associates and presented in this report was such a probabilistic survey, similar in approach and content to those carried out in various other countries throughout the world under USAID auspices. The questionnaire used in the survey was based on the instrument which had been used by Development Associates in its 1986 survey in Peru. That instrument in turn was based on the NIDA household survey. In effect, the questions used in the survey were drawn from sources that had been developed over a period of almost two decades of research. As is always the case, the specifics of the approach taken were adapted to the Guatemalan cultural context.

In addition to the prevalence survey, the Mission also authorized a study of those institutions that are entirely or partially devoted to the prevention of drug abuse. A study was also conducted of agencies engaged in treatment and rehabilitation.

CHARACTERISTICS OF THE SAMPLE POPULATION

The study sample was limited to those 12 to 45 years of age. The age range distribution for the entire sample generally approached that of the projected population in Guatemala. Guatemala has a predominantly young population, thus the descending percentages. The youngest group was the largest (the 12-14 age group) while the oldest group (the 40-45 year group) was the smallest in size. It was anticipated that the proportion of middle level individuals would be higher in urban than in rural areas. The distribution for the study sample corroborated that supposition. For the entire sample, the middle level was 47.8% as compared to 46.2% for the lower level. The 6.1% in the upper level about equalled the suggested national range for that category.

As the proceeding description indicates, the sample included in this study was selected to represent the population of three cities in Guatemala, Guatemala City, Quezaltenango and Escuintala. These cities include approximately 53% of the total urban population of the country. Given that the sample used was a random sample, and given that adjustments made in the distribution of the sample by sex, the sample is representative of the population of these three cities. To the extent that the three cities have the same social characteristics as other cities in the

country, an inference can be made that results in these three cities are likely to be replicated in other urban areas, although there is no way that the statistical confiability of such an inference can be tested.

DRUG PREVALENCE IN GUATEMALA CITIES

Looking at the lifetime prevalence by cities and taking into account confidence intervals, there are very few differences between the three urban centers examined. There is less tobacco, analgesic and alcohol use reported in Escuintala than in the other two cities, but slightly more cocaine/crack use (although this difference is a marginal one). Quezaltenango has the highest level of alcohol use while Guatemala City displays the highest level of marijuana use, both within the respective confidence intervals. Guatemala City also has the highest level of stimulant use. Overall the pattern of drug prevalence indicates that the drug users are more likely to be male than female, upper class than middle or lower class, and with the exception of inhalants, likely to be at least 20 years of age.

While an examination of lifetime prevalence provides an overview of the extent of drug use among those studied, looking at the pattern of current use (use within the last thirty days, also referred to as 30 day prevalence) indicates the intensity of the problem in a given moment in time. It is clear that a high proportion of the users admit to being current users. This includes around 60% of the marijuana users, roughly half of those who use alcohol and analgesics and around a third of those who are users of sedatives, stimulants, inhalants and opiates. Stated in other terms, there are large numbers of active drug users among the population admitting to having ever been involved in such use.

With exception of analgesics, males are more likely to be current users of all substances than females. Current users of substances such as alcohol, marijuana and opiates are more likely to be older than 20 years, current marijuana users, in fact, seem to be concentrated in the 25-39 age bracket. Current inhalant users are most likely to be younger than users of other substances, with considerable numbers in the age brackets 12-14 and 15-19.

Looking at socio-economic levels and current use patterns, there are some differences between lifetime prevalence(ever used) and current use patterns. While upper class Guatemalans are more likely to have tried marijuana, inhalants and cocaine than other social groups, they are far less likely to be current users. With all three substances, there is a higher likelihood that upper class subjects will have tried a drug, but a far lower likelihood that they are present users.

Frequency of use was dichotomized into two levels: 11 or more times in a lifetime (high use) versus 1 to 10 times in a lifetime (low use). These data are for the persons who used a particular substance reported at least once and do not include non-users. Males show greater percentages of high frequency users for tobacco, alcohol, marijuana, hypnotics, and hallucinogens. Females show greater percentages of high frequency users for cocaine/crack and opiates. Males and females show about equal percentages of high frequency users for analgesics, stimulants,

sedatives and inhalants.

The percentage of high frequency users of tobacco, marijuana, analgesics, and sedatives is about the same for all three levels of SES. Upper SES respondents show the greatest percentages of high frequency of use of alcohol, cocaine/crack, hypnotics, and stimulants and the least percentages of high frequency of use for opiates, hallucinogens, and inhalants. Middle SES respondents show the greatest percentages of high frequency of use of opiates and the least percentages of use of alcohol and stimulants. Lower SES respondents shows the greatest percentages of high frequency of use for hallucinogens and inhalants and the least percentages of high use for cocaine/crack and hallucinogens.

Although the percentages differ, the pattern for tobacco and alcohol is similar and show the lowest percentage of high frequency users in the 12-14 age group, a sharp increase in the 15-19 age group, and a fairly level percentage of high frequency users in the age groups thereafter. The pattern of frequency of use for marijuana shows a different pattern: The highest frequency of use is in the 12-14 age group, followed by the 15-19, 20-24, and 25-29 age groups (all in the 32-35 percent range) and then dropping down further in the 30-34, 35-39, and 40-45 age groups (all in the 18-21 percent range). These data suggest that high frequency marijuana use has been increasing over the last ten years compared with before then. The pattern for hallucinogens is similar to marijuana, but even more pronounced, suggesting that the use of hallucinogens has been undergoing an ever more recent and/or rapid growth in high frequency use than marijuana, especially among adolescents and youth.

Hypnotics, stimulants, and sedatives all show gradual rises in frequency of use with peaks in later age groups. These data suggest that the use of these substances gradually becomes established with increased age and/or that their high use may have been waning somewhat in recent years.

The pattern for analgesics is fairly flat across age groups, with not more than a gradual rise. This suggests that high analgesic users are established early (early to mid teens and before) and high use of this category of drug only gradually increases with age. Also the data suggest that analgesics use has been fairly stable over the last several decades.

Finally, it should be noted that the patterns for high frequency cocaine/crack use, opiate use, and inhalants use are quite erratic, so nothing definitive can be gleaned from these data. Quite likely the erratic nature of these data is due to the low Ns associated with the use of these substances, which make the data too unreliable to show clear patterns.

Very high percentages (90 percent or more) of respondents indicated that the use of any of the following six substances was risky: inhalants, tobacco, LSD, stimulants, marijuana, and alcohol. Perceived risk was fairly high for most of the rest of the substances, although a sizeable minority (33 percent) did not perceive the use of hallucinogens to be risky. A sizeable minority of respondents also said they did not know if the use of cocaine, analgesics, and/or hypnotics was risky.

Of those that have used tobacco, the highest percentage first used it between 15 and 19 years of age, with most doing so between 12 and 24 years of age. The pattern of first use of alcohol is very similar to that for tobacco, with the highest percentage first using alcohol between 15 and 19 years of age, most doing so between 12 and 24 years of age, and relatively few doing so before age 12 or after age 24. The data regarding those who have used analgesics is strikingly different from first use of tobacco or alcohol, in that virtually all who have used analgesics did so for the first time before age 12. The pattern of first use for sedatives is quite different; although the largest percent of first users is in the 11 year old and younger age category, the distribution of first use is relatively flat across age. The pattern of first use of hypnotics is somewhat like tobacco and alcohol in that the greatest percentage of first use occurred between ages 15 and 19, but the distribution is a little more skewed toward the twenties, which suggests that hypnotics are generally tried for the first time somewhat later than tobacco or alcohol. While the exact percentages are different, the pattern of first use of stimulants by age category is very similar to that for hypnotics.

The pattern of first use of marijuana is quite similar to that for tobacco and alcohol, but much more clearly focused between 12 and 24 years of age and more strongly peaking in the years between 12 and 24. None of the respondents in this survey indicated first use of hallucinogens after age 24, virtually all of these first used hallucinogens before age 20, and more than half said they did so before age 12. Age of primary onset, and hence the focus for primary prevention, of inhalant use seems to be the late pre-teens and early teens. The pattern of first use of opium product is fairly similar to hypnotics, as described above, first use occurs virtually always after age 14 and before age 30. Finally, there appears to be a pattern of first use of cocaine/crack occurring predominantly in later teens and early twenties (15 to 24 years of age), with some starting in early teens (12 to 14 years of age).

Those high on the indigenous indicator are least likely to have ever used tobacco or marijuana, while those who are low on the indicator are most likely of the three groups to have used the three substances. The same is the case for cocaine/crack but in this case given the low number of cases this may not be a reliable estimate. For inhalants and hallucinogens as well, those in the low indigenous category have the highest lifetime prevalence of the three groups.

Around 11.7% of those sampled indicated that they had problems as a consequence of the use of any of the substances included in the study. Most frequently mentioned problems were health related (feeling nervous or having general health problems) followed by having been involved in fights either as aggressors or as victims. Only as very few (1.3%) however felt the necessity to seek treatment for their drug problems.

INSTITUTIONAL STUDY

Guatemala City

All nine of the institutions visited are presently conducting some type of drug abuse prevention

activities. They are extremely interested, and dedicated to their work, and are getting some satisfaction from their initial activities. Using volunteers, a minimum of salaried personnel, and scarce financial resources, they are trying to do the best they can to obtain results with their programs.

Most of the organizations exert their major efforts on research and the training of volunteers so the programs can increase their outreach. As a group, the institutions cover a variety of activities in the drug field. Individually, in addition to financial resources, the institutions need organizational development assistance in formulation of specific, achievable program objectives. Definition of work strategies, information and its systematization, and internal organizational controls must be strengthened in most of them.

The organizations are becoming conscious of the need for the exchange of knowledge, experiences, and abilities. They would like to see the establishment of a solid interinstitutional network in the near future. One organization that appears capable of coordinating such a network is the National Council for the Prevention of Alcoholism and Drug Addiction. Although it is in its incipient stages it has achieved some success in bringing the various institutions together for mutual technical collaboration.

In general, the nine organizations have some trained personnel to carry out their proposed functions. None has enough to conduct a large program. All of them need more personnel and intense, systematic training in several aspects of an educational campaign. Advanced training in most of the fields now covered in the programs will be required if their stated objectives are to be achieved.

In summary, it is important to emphasize that there are institutions involved (partially or totally dedicated) in drug addiction prevention. This is a major step forward in any effort to inaugurate a solid campaign in Guatemala. Nine institutions is a useful base on which to build such an action campaign since it demonstrates a serious concern for the problem.

Quetzaltenango

Two local institutions were identified as presently having some drug prevention activities in their programs. (1) Asociación para el Desarrollo del Potencial Humano (ADEPH) - Association for the Development of Human Potential, and (2) Fundación de Orientación Social (FUNORSO) - Foundation for Social Orientation. The ADEPH drug program was organized in 1989 with the assistance of the Quetzaltenango Lions Club. ADEPH considers that a drug prevention campaign is required and that its focus must be integral, not just directed toward the symptoms of the problem.

FUNORSO, the other institution, works with groups that request their services. They use a forum approach with the help of lawyers, physicians, and an ex-addict instructor. Basically, the director of FUNORSO is the person in charge of all of the activities: promotion, conduct, and supervision

of the activities.

A third institution, the Quetzaltenango Episcopal Church, provides information through talks given to the street youth in a special program. The representatives noted that they, themselves, need training and more information before they can conduct a more solid program. They are sincerely interested in drug use prevention.

At the present time, there is no institution that could manage a large campaign in Quetzaltenango. The limited missions, structures, experience, capacity, and financial resources require considerable strengthening before any comprehensive tasks could be assigned to any Quetzaltenango institution. They do have, however, the potential for development.

Escuintla

A considerable search was made for drug abuse prevention programs in the vicinity of Escuintla, but only one was discovered: Radio Ritmo FM - FM Rhythm Radio Station. The station has a special music program for youth on weekends and at night. Between selections, the station imparts information on drugs, the risks, and the consequences of their abuse. The station conducts this campaign purely because of the concerns of the personnel for the young people of the community. It has no special financial resources for its work.

Escuintla appeared to have the least well organized effort on drug abuse prevention. It may be, however, that with the assistance of the radio station, the police, and other concerned organizations, a worthwhile campaign could be designed and carried out.

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

Drug Prevalence in the cities sampled:

1. A variety of drugs are used by the population studied including tobacco, alcohol, marijuana, various categories of psychoactive medicines (analgesics, sedatives, stimulants), and cocaine/crack.
2. Overall lifetime prevalence of these drugs is not high, however, current use (use within the last thirty days) is high, particularly when compared with drug use in other Latin American contexts (e.g. Peru).

3. Initiation of use of some drugs, including such gateway drugs as tobacco and alcohol as well as marijuana, takes place at a relatively early age. There are, for example, instances of initiation of use of tobacco, alcohol and marijuana earlier than 12 years of age with the bulk of those using having tried initially between 12 and 20 years of age.
4. Males rather than females are more likely to be drug users.
5. Class is no barrier to drug use. There were users from all class levels, upper, middle and lower class. However, upper class males were more likely to experiment with drugs such as marijuana, cocaine/crack and inhalants, while lower class males were more likely to be current users of those drugs.

Institutional Basis for Drug Prevention

1. There are sufficient organizations interested in drug awareness and education to form the beginnings of a network to cover a major portion of Guatemala's population.
2. However, all those organizations lack basic human and financial resources, program expertise in drug abuse prevention and relevant administrative and management capabilities to operate effective drug awareness and education programs.
3. While all the organizations display weaknesses, it would appear that The National Council for the Prevention of Alcoholism and Drug Addiction, a public sector agency, and the Foundation for the Prevention of Drug Addiction, a private sector agency, are both worthy of further exploration as key players in a drug prevention effort.

Recommendations

If USAID/Guatemala wishes to develop a drug abuse awareness and education initiative, then it needs to take into account the following recommendations, based on the results of this needs assessment:

Regarding the institutional basis for drug abuse prevention activities:

Recommendation One: an in-depth analysis be made of the two organizations, "The National Council for the Prevention of Alcoholism and Drug Addiction" and the Foundation for the Prevention of Drug Addiction" to determine their respective roles in providing leadership in a national drug awareness and education effort.

Recommendation Two: On the basis of the analysis in recommendation one, USAID provide the necessary support to ensure the success of the organizations in the role assigned to them. This support should include provision of the necessary training and technical assistance and information resources to place the agencies in the mainstream of prevention programming. This should also include assistance in the development of networking skills both within the country and outside the country among other agencies interested in and involved in drug abuse prevention.

Regarding the Design and Implementation of Drug Prevention Activities:

Recommendation Three: Based on the data generated in the survey, in the design of drug abuse prevention programs, emphasis needs to be placed on:

1. Targeting pre-teens and young teenagers with prevention messages regarding a wide range of substances including tobacco and alcohol.
2. Assuring that prevention messages are directed at such important secondary targets as parents and teachers as a means of reaching young potential users.
3. Placing immediate emphasis on efforts at reaching the relatively large numbers of current users of drugs in the population.
4. Placing special emphasis on prevention efforts directed at males who are such a high proportion of both current users and those who have ever used drugs.
5. Targeting all social classes, but differentiating where possible efforts to reflect the differences in drug prevalence patterns, e.g. the high level of current users among the lower class and the higher number of experimenters among the upper class.

Recommendation Four: In the implementation of drug prevention activities, resources be directed at continuing to monitor the nature and extent of drug abuse through epidemiological research and of attitudes toward the drug abuse problem through appropriate attitudinal studies.

RESUMEN EJECUTIVO

INTRODUCCION

La USAID/Guatemala, la Embajada de los Estados Unidos de Norteamérica, y el Gobierno de Guatemala están cada vez más preocupados acerca del uso y abuso de las sustancias narcóticas en Guatemala. Como un primer paso en la formulación de un enfoque para abordar este problema, la Misión de la USAID/Guatemala contrató a Development Associates para llevar a cabo un diagnóstico de las necesidades en materia de concientización sobre los narcóticos en tres centros urbanos (Quetzaltenango, Escuintla y Ciudad Guatemala) a fin de determinar la prevalencia del abuso de las sustancias.

El método más constante, más confiable y más eficaz en función de costos para llegar a una estimación de los niveles de consumo de drogas en una población, dentro de un marco cronológico determinado, es decir, una determinación de la prevalencia de las drogas, es a través de una encuesta que emplee una muestra probabilística. La encuesta llevada a cabo por Development Associates y presentada a través del presente informe fue en efecto una encuesta probabilística, de enfoque y contenido similares a las llevadas a cabo en varios otros países en todo el mundo bajo los auspicios de la USAID. El cuestionario empleado en la encuesta se basó en el formulario utilizado por Development Associates en la encuesta que se llevó a cabo en Perú en 1986. Aquel instrumento estaba basado, a su vez, en la encuesta NIDA de viviendas. En efecto, las fuentes de las preguntas utilizadas en la encuesta se obtuvieron de trabajos de investigación que habían sido desarrollados sobre un período de casi dos décadas. Tal como es el caso siempre, los aspectos específicos del enfoque asumido fueron adaptados al contexto cultural de Guatemala.

Además de la encuesta de prevalencia, la Misión autorizó un estudio de aquellas instituciones dedicadas total o parcialmente a la prevención del abuso de las drogas. También se llevó a cabo un estudio de las organizaciones dedicadas al tratamiento y a la rehabilitación en este campo.

CARACTERISTICAS DE LA POBLACION DE LA MUESTRA

La muestra del estudio se limitó a las personas entre 12 y 45 años de edad. La distribución de la muestra total por edades se aproximó, en términos generales, a la población proyectada en Guatemala. Guatemala tiene una población predominantemente joven, hecho que explica los porcentajes descendientes. El grupo más joven fue el grupo más grande (el grupo etario de 12-14 años) mientras que el grupo de mayor edad (el grupo etario de 40-45 años) fue el grupo más reducido. Se había previsto que la proporción de personas ubicadas al nivel medio sería mayor en las áreas urbanas que en las áreas rurales. La distribución de la muestra del estudio sirvió para corroborar ese supuesto. Para la muestra entera, el nivel medio fue del 47.8% en comparación con el 46.2% para el nivel inferior. El 6.1% en el nivel superior fue aproximadamente igual a la amplitud nacional recomendada para esa categoría.

Tal como lo indica la descripción anterior, la muestra incluida en este estudio fue seleccionada con el propósito de que fuera representativa de la población de tres ciudades en Guatemala: Ciudad Guatemala, Quetzaltenango y Escuintla. Estas ciudades abarcan aproximadamente un 53% de la población urbana total del país. Dado que la muestra utilizada fue una muestra aleatoria y dado los ajustes efectuados en la distribución de la muestra por sexo del respondiente, la muestra es representativa de la población de estas tres ciudades. En la medida en que las tres ciudades tengan las mismas características sociales que otras ciudades del país, se puede inferir que es probable que los resultados obtenidos en estas tres ciudades se repitieran en otras áreas urbanas, aunque no existe ninguna forma para comprobar la confiabilidad estadística de tal inferencia.

PREVALENCIA DE LAS DROGAS EN LAS CIUDADES DE GUATEMALA

Observando la prevalencia vitalicia por ciudades y tomando en cuenta los intervalos de confianza, existen muy pocas diferencias entre los tres centros urbanos estudiados. Se reporta un uso menor de tabaco, analgésicos y alcohol en Escuintla que en las otras dos ciudades, aunque se reporta un uso levemente mayor de cocaína/crack (bien que se trata de una diferencia marginal). Quetzaltenango tiene el nivel más alto de consumo de alcohol, mientras que Ciudad Guatemala arroja el nivel más alto de consumo de la marihuana, ambos dentro de los intervalos de confianza respectivos. Ciudad Guatemala también refleja el nivel más alto de uso de estimulantes. En términos generales, el patrón de prevalencia de las drogas indica que es más probable que los consumidores de drogas sean del sexo masculino que del sexo femenino, sean de la clase alta que de la clase media o baja y, con la excepción de las sustancias inhaladas, tengan por lo menos 20 años de edad.

Aunque un estudio de prevalencia vitalicia brinda una apreciación general del grado de consumo de drogas entre la población bajo estudio, una observación del patrón de uso actual (uso en los últimos treinta días, conocido también como la prevalencia de 30 días) indica la intensidad del problema en un momento determinado. Está claro que una alta proporción de los consumidores admiten ser consumidores actuales. Esto incluye aproximadamente un 60% de los consumidores de marihuana, aproximadamente la mitad de los que consumen alcohol y analgésicos y más o menos un tercio de los que son consumidores de sedantes, estimulantes, sustancias inhaladas y narcóticos. Dicho de otra manera, existen grandes cantidades de consumidores activos de drogas entre la población que admiten haber participado en tal consumo de drogas.

Con la excepción de los analgésicos, las personas del sexo masculino tienen una mayor probabilidad de ser consumidores actuales de todas las sustancias que las del sexo femenino. Los consumidores actuales de sustancias tales como el alcohol, la marihuana y los narcóticos tienen una mayor probabilidad de ser mayores de 20 años; en efecto, los consumidores actuales de marihuana parecen estar concentrados en el grupo etario de 25-39 años de edad. Los abusadores actuales de las sustancias inhaladas tienen una mayor probabilidad de ser

más jóvenes que los consumidores de otras sustancias, observándose una aglomeración considerable en los grupos etarios de 12-14 años y 15-19 años.

Al examinar los niveles socioeconómicos y patrones actuales del uso, se observan algunas diferencias entre la prevalencia vitalicia (uso alguna vez) y los patrones del uso actual. Aunque los guatemaltecos de la clase alta tienen una mayor probabilidad de haber probado la marihuana, las sustancias inhaladas y la cocaína que otros grupos sociales, tienen una probabilidad mucho menor de ser consumidores actuales. Con las tres sustancias, existe una mayor probabilidad de que los integrantes de la clase alta habrán probado una droga determinada, pero una probabilidad mucho menor de que sean consumidores actuales.

La frecuencia del uso se dividió en una dicotomía de dos niveles: 11 o más veces durante toda la vida (nivel de consumo alto) y 1 a 10 veces durante toda la vida (nivel de consumo bajo). Estos datos corresponden a las personas que reportaron haber usado una sustancia determinada por lo menos una vez y no incluyen a los no consumidores. El grupo de los hombres refleja porcentajes mayores de consumidores de alta frecuencia en lo referente al tabaco, el alcohol, la marihuana, las sustancias hipnóticas, y los alucinógenos. El grupo de las mujeres muestra porcentajes mayores de consumidores de alta frecuencia en lo referente a la cocaína/*crack* y los narcóticos. Los hombres y las mujeres muestran porcentajes aproximadamente iguales de consumidores de alta frecuencia en lo referente a los analgésicos, estimulantes, sedantes y sustancias inhaladas.

El porcentaje de consumidores de alta frecuencia del tabaco, la marihuana, los analgésicos y los sedantes es aproximadamente igual para todos los tres niveles socioeconómicos. Los respondientes provenientes del nivel socioeconómico más alto reflejan los mayores porcentajes de alta frecuencia del consumo de alcohol, cocaína/*crack*, sustancias hipnóticas y estimulantes y los porcentajes menores de alta frecuencia del consumo de narcóticos, alucinógenos y sustancias inhaladas. Los respondientes del nivel socioeconómico medio reflejan los mayores porcentajes de alta frecuencia del consumo de narcóticos y los porcentajes más bajos del uso de alcohol y estimulantes. Los respondientes del nivel socioeconómico bajo muestran los porcentajes más altos de alta frecuencia del consumo de alucinógenos y sustancias inhaladas y los menores porcentajes del consumo frecuente de cocaína/*crack* y alucinógenos.

Aunque los porcentajes difieren entre sí, el patrón correspondiente al tabaco y el correspondiente al alcohol son similares y muestran el porcentaje más bajo de usuarios de alta frecuencia en el grupo etario de 12-14 años, un aumento marcado en el grupo etario de 15-19 años, y un porcentaje bastante nivelado de usuarios de alta frecuencia en todos los siguientes grupos etarios. El patrón de frecuencia del uso correspondiente a la marihuana muestra un patrón distinto: La frecuencia más alta de uso se observa en el grupo etario de 12-14 años, seguido de los grupos etarios de 15-19 años, 20-24 años y 25-29 años (todos en la amplitud del 32-35%), con una baja posterior en los grupos etarios de 30-34 años, 35-39 años y 40-45 años (todos en la amplitud del 18-21%). Estos datos sugieren que el consumo de alta frecuencia de la marihuana ha ido en aumento durante los últimos diez años en comparación

con el período anterior. El patrón correspondiente a los halucinógenos es similar al de la marihuana, aunque es aún más pronunciado, lo cual sugiere que el uso de los halucinógenos ha venido experimentando un crecimiento cada vez más reciente y/o cada vez más acelerado en el uso de alta frecuencia en comparación con la marihuana, especialmente entre los adolescentes y los jóvenes.

Las sustancias hipnóticas, los estimulantes y los sedantes reflejan alzas paulatinas en la frecuencia de uso, alcanzándose picos en los grupos etarios de edad más avanzada. Estos datos sugieren que el uso de estas sustancias gradualmente llega a establecerse con el aumento en la edad y/o que su uso frecuente puede haber estado en disminución durante años recientes.

El patrón correspondiente a los analgésicos es bastante nivelado a través de los grupos etarios, limitándose a un aumento gradual. Esto sugiere que los usuarios frecuentes de los analgésicos se establecen a una temprana edad (de 12 a 16 años y más jóvenes) y que el uso frecuente de esta categoría de droga aumenta sólo gradualmente con la edad. Además, los datos sugieren que el uso de los analgésicos se ha mantenido bastante estable a través de las últimas décadas.

Finalmente, debe señalarse que los patrones del uso de alta frecuencia de la cocaína/*crack*, uso de narcóticos y uso de sustancias inhaladas son bastante irregulares, de manera que no puede obtenerse nada definitivo en relación con estos datos. Con toda probabilidad, la naturaleza irregular de estos datos se debe al bajo número de casos asociados con el uso de estas sustancias, que tienen el efecto de hacer que los datos sean demasiado desconfiables para mostrar patrones claros.

Porcentajes sumamente altos (90 por ciento o mayores) de respondientes indicaron que el consumo de cualquiera de las seis siguientes sustancias era arriesgado: sustancias inhaladas, tabaco, LSD, estimulantes, marihuana y alcohol. El riesgo percibido fue bastante alto para la mayoría de las demás sustancias, aunque una minoría de magnitud regular (33 por ciento) no percibía como arriesgado el uso de los halucinógenos. Una minoría de respondientes de magnitud regular también indicaron que no sabían si era arriesgado el uso de la cocaína, los analgésicos y/o las sustancias hipnóticas.

De los que han usado el tabaco, el porcentaje más alto lo usó por primera vez entre los 15 y 19 años de edad, haciéndolo la mayoría entre los 12 y 24 años de edad. El patrón correspondiente al primer uso del alcohol es muy similar al del tabaco, observándose el porcentaje más alto de los que consumieron alcohol por primera vez entre los 15 y 19 años de edad, haciéndolo la mayoría entre los 12 y 24 años de edad, y haciéndolo relativamente pocos antes de la edad de 12 años o después de la edad de 24 años. Los datos relacionados con los que han consumido analgésicos son notablemente diferentes de los correspondientes al primer uso del tabaco o alcohol, en que virtualmente todos los que han usado analgésicos lo hicieron por primera vez a la edad de 12 años. El patrón del primer uso de los sedantes es del todo diferente; aunque el porcentaje más grande de los que los consumieron por primera

vez se encuentra en la categoría de 11 años de edad y menores, la distribución del primer uso es relativamente nivelado a través de las edades. El patrón del primer uso de las sustancias hipnóticas es un tanto parecido al del tabaco y el alcohol en que el porcentaje más grande de primer uso ocurrió entre las edades de 15 y 19 años, aunque la distribución es un poco más asimétrica hacia los 20 años, lo cual sugiere que las sustancias hipnóticas por lo general se prueban por primera vez a una edad un tanto mayor de lo que es el caso con el tabaco o el alcohol. Aunque los porcentajes precisos son diferentes, el patrón del primer uso de los estimulantes por grupo etario es muy similar al correspondiente a las sustancias hipnóticas.

El patrón del primer uso de la marihuana es muy similar al que corresponde al tabaco y el alcohol, aunque está concentrado mucho más claramente entre las edades de 12 y 24 años y alcanza un pico más marcado entre 12 y 24 años. Ninguno de los respondientes en esta encuesta indicaron que habían usado los alucinógenos por primera vez después de la edad de 24, virtualmente todos ellos los habían probado antes de la edad de 20 años, y más de la mitad respondieron que lo hicieron antes de cumplir los 12 años. La edad del primer uso, y de allí el punto focal para la prevención primaria del uso de las sustancias inhaladas parece ser de 11 a 15 años. El patrón del primer uso de productos derivados del opio es bastante similar al de las sustancias hipnóticas, tal como se describe anteriormente; el primer uso ocurre virtualmente siempre después de la edad de 14 años y antes de la edad de 30 años. Finalmente, parece existir un patrón del primer uso de cocaína/crack que ocurre predominantemente entre los 16 y los 23 años de edad, aunque algunos inician el uso entre los 12 y 14 años de edad.

Los que están situados en un nivel alto del indicador de la calidad de indígena tienen una menor probabilidad de haber usado alguna vez el tabaco o la marihuana, mientras que los que están situados en un nivel bajo en el indicador tienen la mayor probabilidad de los tres grupos de haber usado las tres sustancias. Lo mismo se aplica al caso de la cocaína/crack pero en este caso, dado el bajo número de casos, puede ser que esto no constituya una estimación confiable. También para el caso de las sustancias inhaladas y alucinógenos, los que están situados en la categoría más baja del indicador de la calidad de indígena tienen la prevalencia vitalicia más alta de los tres grupos.

Aproximadamente un 11.7% de los integrantes de la muestra indicaron que tenían problemas como consecuencia del uso de alguna de las sustancias incluidas en el estudio. Los problemas más frecuentemente mencionados fueron los problemas relacionados con la salud (el sentirse nervioso o el padecer de problemas de la salud en general) seguidos del haber estado involucrado en peleas, sea como agresores o como víctimas. Sin embargo, solamente muy pocos (1.3%) percibían una necesidad de buscar tratamiento para sus problemas del abuso de las drogas.

ESTUDIO INSTITUCIONAL

Ciudad Guatemala

Todas las nueve instituciones visitadas actualmente están llevando a cabo alguna clase de actividades de prevención del abuso de las drogas. Están sumamente interesadas y dedicadas a su trabajo, y están percibiendo cierto nivel de satisfacción de sus actividades iniciales. Empleando voluntarios, un mínimo de personal asalariado y recursos financieros escasos, están procurando hacer lo mejor que puedan para obtener resultados a través de sus programas.

La mayoría de las organizaciones dedican sus mayores esfuerzos a la investigación y a la capacitación de voluntarios para que los programas puedan ampliar su alcance. Como grupo, las instituciones abarcan una variedad de actividades en el campo de las drogas. Individualmente, además de los recursos financieros, las instituciones necesitan recibir asistencia en el desarrollo organizativo para la formulación de objetivos específicos y alcanzables para sus programas. La mayoría necesitan fortalecer la definición de sus estrategias de trabajo, lo mismo que la información y la sistematización de la misma, y los controles organizativos internos.

Las organizaciones se están volviendo conscientes de la necesidad de participar en un intercambio de conocimientos, experiencias y capacidades. Quisieran ver en un futuro cercano el establecimiento de una sólida red interinstitucional. Una organización en particular que parece tener la capacidad para coordinar una red de esta índole es el Consejo Nacional de Prevención del Alcoholismo y Drogadicción. Aunque se encuentra en sus etapas iniciales, ha cosechado ciertos éxitos en sus esfuerzos por reunir a las diversas instituciones para efectos de establecer una colaboración técnica mutua.

En términos generales, las nueve organizaciones cuentan con cierto nivel de personal calificado para llevar a cabo sus funciones propuestas. Ninguna tiene suficiente para la realización de un programa de gran alcance. Todas necesitan más personal y más capacitación intensa y sistemática en los diversos aspectos de una campaña educativa. Se requerirá capacitación avanzada en la mayoría de los campos actualmente cubiertos bajo los programas si han de alcanzar sus objetivos declarados.

En resumen, es importante hacer hincapié en el hecho de que existen instituciones dedicadas (parcial o totalmente) a las actividades de prevención de la drogadicción. Esto constituye un excelente primer paso en cualquier esfuerzo por inaugurar una sólida campaña en Guatemala. Nueve instituciones constituyen una valiosa base en la cual podría armarse una campaña de acción de ese tipo por cuanto demuestra una seria preocupación con respecto al problema.

Quetzaltenango

Se determinó que dos de las instituciones locales actualmente cuentan con algunas actividades de prevención de las drogas en sus programas: (1) la Asociación para el Desarrollo del Potencial Humano (ADEPH), y (2) la Fundación de Orientación Social (FUNORSO). El programa antidrogas de ADEPH se organizó en 1989 con la asistencia del Club de Leones de Quetzaltenango. ADEPH considera que una campaña de prevención del abuso de las drogas es necesaria y que su punto focal debe ser integral y no estar dirigido exclusivamente hacia los síntomas del problema.

La otra institución, FUNORSO, trabaja con grupos que solicitan sus servicios. Emplean un enfoque en base a los foros, con la ayuda de abogados, médicos, y un instructor que es un drogadicto rehabilitado. Básicamente, el director de FUNORSO es la persona encargada de todas las actividades: promoción, realización y supervisión de las actividades.

Una tercera institución, la Iglesia Episcopal de Quetzaltenango, proporciona información mediante charlas impartidas a los jóvenes callejeros a través de un programa especial. Los representantes observaron que ellos mismos necesitan recibir capacitación y más información antes de poder poner en marcha un programa más sólido. Están sinceramente interesados en la prevención del abuso de las drogas.

Actualmente, no existe una institución que pudiera administrar una campaña de gran alcance en Quetzaltenango. Se tendrían que fortalecer las limitadas misiones, estructuras, experiencia, capacidad y recursos financieros antes de que pudieran asignarse tareas de tipo general a alguna de las instituciones de Quetzaltenango. Sin embargo, las instituciones existentes tienen el potencial para ser desarrolladas.

Escuintla

Se buscó detenidamente la existencia de programas de prevención del abuso de las drogas en el área general de Escuintla, pero solamente se dio uno: el de Radio Ritmo FM. Esta emisora tiene un programa especial de música para los jóvenes que se transmite los fines de semana y por las noches. Entre las selecciones musicales, la emisora imparte información sobre las drogas, los riesgos que acarrearán y las consecuencias del abuso de las mismas. La emisora conduce esta campaña como consecuencia exclusiva del interés de su personal en el bienestar de los jóvenes de la comunidad. No cuenta con recursos financieros especiales para la realización de su trabajo.

Escuintla parecía tener el esfuerzo menos organizado en lo relacionado con la prevención del abuso de las drogas. Podría ser, sin embargo, que con la asistencia de la emisora, la policía, y otras organizaciones interesadas podría diseñarse y ejecutarse una campaña que fuera de utilidad para la comunidad.

CONCLUSIONES Y RECOMENDACIONES

Conclusiones

Prevalencia de las Drogas en las Ciudades Encuestadas

1. La población estudiada consume una variedad de drogas, incluyendo el tabaco, el alcohol, la marihuana y diversas categorías de medicinas psicoactivas (analgésicos, sedantes, estimulantes y cocaína/*crack*).
2. La prevalencia vitalicia general de estas drogas no es alta; sin embargo, el uso actual (uso dentro de los últimos 30 días) es alto, particularmente cuando se compara con el uso de las drogas en otros contextos latinoamericanos (por ejemplo, Perú).
3. El inicio del uso de algunas drogas, incluyendo tales drogas precursores como el tabaco y el alcohol, así como también la marihuana, ocurre a una edad relativamente temprana. Existen, por ejemplo, casos del inicio del consumo del tabaco, alcohol y marihuana antes de la edad de 12 años, habiendo probado por primera vez estos productos la mayoría de los que los consumen entre las edades de 12 y 20 años.
4. Los del sexo masculino tienen una mayor probabilidad de ser consumidores de drogas que los del sexo femenino.
5. Las clases sociales no constituyen barrera al consumo de las drogas. Se observaron consumidores en todas las clases sociales: clase alta, clase media y clase baja. Sin embargo, los hombres de la clase alta tenían una mayor probabilidad de experimentar con drogas tales como la marihuana, la cocaína/*crack* y las sustancias inhaladas, mientras que los hombres de la clase baja tenían una mayor probabilidad de ser consumidores actuales de esas drogas.

Base Institucional para la Prevención del Abuso de las Drogas

1. Existen suficientes organizaciones interesadas en la concientización sobre el abuso de las drogas y en la educación acerca de la prevención para formar la base de una red que podría cubrir una porción considerable de la población de Guatemala.
2. Sin embargo, todas esas organizaciones carecen de recursos humanos y financieros básicos, competencia programática en la prevención del abuso de las drogas y capacidades administrativas y gerenciales aplicables para operar

programas eficaces de concientización y educación en el campo del abuso de las drogas.

3. Aunque todas las organizaciones reflejan debilidades, parecería ser que el Consejo Nacional de Prevención del Alcoholismo y Drogadicción, un organismo del sector público, y la Fundación de Prevención de la Drogadicción, una entidad del sector privado, son dignos de un estudio adicional como protagonistas clave de un esfuerzo de prevención del abuso de las drogas.

Recomendaciones

Si la USAID/Guatemala desea desarrollar una iniciativa en el campo de la concientización y educación sobre el abuso de las drogas, entonces necesita tomar en cuenta las siguientes recomendaciones, las cuales están basadas en los resultados de este diagnóstico de necesidades:

Con respecto a la base institucional para las actividades de prevención del abuso de las drogas:

Recomendación Uno: Se debería llevar a cabo un análisis a fondo de las dos organizaciones -- el Consejo Nacional de Prevención del Alcoholismo y Drogadicción y la Fundación de Prevención de la Drogadicción -- a fin de determinar sus funciones respectivas en términos de la dirección competente de un esfuerzo nacional en el campo de la concientización y educación sobre el abuso de las drogas.

Recomendación Dos: En base al análisis mencionado en la Recomendación Uno, la USAID proporcionaría el apoyo necesario para asegurar el éxito de las organizaciones en las funciones que le sean asignadas. Este apoyo debería incluir el suministro de la capacitación y asistencia técnica necesarias, así como de los recursos de información requeridos para situar a las organizaciones en la corriente principal de la programación de las actividades de prevención. Tal apoyo también debería incluir asistencia en el desarrollo de redes de intercambio, tanto dentro como fuera del país, entre otras organizaciones interesadas e involucradas en las actividades de prevención del abuso de las drogas.

Con respecto al diseño y ejecución de actividades de prevención del abuso de las drogas:

Recomendación Tres: En base a los datos generados en la encuesta, en lo referente al diseño de programas de prevención del abuso de las drogas, se necesita hacer hincapié en la necesidad de:

1. Dirigir mensajes de prevención relacionados con una amplia variedad de sustancias, incluyendo el tabaco y el alcohol, a los jóvenes entre las edades aproximadas de 10 y 15 años.
2. Asegurar que los mensajes de prevención se dirijan a tales grupos meta de importancia como los padres y los maestros como forma de alcanzar a los consumidores potenciales jóvenes.
3. Hacer énfasis inmediato en los esfuerzos por alcanzar las cantidades relativamente grandes de consumidores actuales de drogas en la población.
4. Asignar énfasis especial a los esfuerzos de prevención dirigidos hacia las personas del sexo masculino que constituyen una proporción tan alta tanto de los consumidores actuales como de los que alguna vez han usado las drogas.
5. Dirigir los esfuerzos hacia todas las clases sociales, aunque diferenciando, hasta donde sea posible, los esfuerzos con el propósito de reflejar las diferencias en los patrones de prevalencia del abuso de las drogas, es decir, el alto nivel de usuarios actuales entre la clase baja y el nivel más alto de personas que experimentan con las drogas entre la clase alta.

Recomendación Cuatro: En la ejecución de las actividades de prevención del abuso de las drogas, se deberían dirigir recursos hacia los esfuerzos por continuar las actividades de monitoreo de la naturaleza y alcance del abuso de las drogas a través de la investigación epidemiológica y de las actitudes con respecto al problema del abuso de las drogas a través de estudios apropiados sobre las actitudes.

I. INTRODUCTION

USAID/Guatemala, the Embassy of the United States of America, and the Government of Guatemala have become increasingly concerned about the use and abuse of narcotic substances in Guatemala. As a initial step in formulating an approach to the problem, the USAID/Guatemala Mission contracted with Development Associates to conduct a drug awareness needs assessment in three urban centers (Quetzaltenango, Escuintla, and Guatemala City) to determine the prevalence of substance abuse. Based on the results, the Mission and other agencies would then determine whether an educational campaign should be funded.

The field work was carried out from April 21 to July 10, 1990. The analyses of the responses were subsequently done in the Arlington, Virginia, offices of Development Associates and the report submitted to USAID/Guatemala.

In addition to the prevalence survey, the Mission also authorized a study of those institutions that are entirely or partially devoted to the prevention of drug abuse. That research resulted in a directory of the institutions and overall descriptions of their activities and capabilities in the prevention education field. Further, several of the organizations that conduct some form of rehabilitation for addicts were surveyed to determine the current status of that work. Finally, an inquiry was conducted into the forms of recording addiction cases in hospitals, clinics, and doctors offices.

The Development Associates research team produced three reports in country. The first consisted of a review of the literature on prevalence studies and presented the preliminary methodological approach. With the assistance of USAID/Guatemala, the Embassy, and the two sponsoring organizations, Rafael Landívar University and the Foundation for the Prevention of Drug Addiction, the research methodology and the sampling were refined; those were presented in the second report. The third report was devoted entirely to the study of the prevention institutions, rehabilitation, and drug case records.

The research and the report that derives from this research was the product of a team of specialists from Development Associates. Dr. Earl Jones was the team leader, directed the fieldwork and drafted the bulk of the report. Dr. Joel M. Jutkowitz was responsible for technical supervision of the project design and the editing of the final report. Key sections of the report were written by Eugenia Monterrosa, Dr. Harry Day and John Garcia. Allan Kellum and Dr. Mark Morgan undertook the data analysis. The field research staff and their affiliations are listed in Appendix I.

A. Survey Methodology

The most consistent, reliable and cost effective method for arriving at an estimate of levels of drug use within a population within a given time frame, i.e. drug prevalence, is through a survey using a probabilistic sample. (Such a sample is drawn from a given universe on a random basis in a manner which allows a measure of the degree to which it represents that universe.) The survey conducted by Development Associates and

presented in this report was such a probabilistic survey, similar in approach and content to those carried out in various other countries throughout the world under USAID auspices. As is always the case, the specifics of the approach taken were adapted to the Guatemalan cultural context.

1. The Questionnaire

The questionnaire used in the survey was based on the instrument which had been used by Development Associates in its 1986 survey in Peru. That instrument in turn was based on the NIDA household survey. In effect, the questions used in the survey were drawn from sources that had been developed over a period of almost two decades of research.

The final questionnaire (Appendix A) contained 86 items. The first 84 were those selected from the Peru survey. Each was modified as required to conform to Guatemalan terminology and to include only those substances known to be available in Guatemala.

The greatest variation between the Peru and Guatemala studies was the pharmaceutical substances covered. Both the substances sold and the brand names used varied significantly between the two countries accounting for the need to change the questionnaire's content. When medicines were known by more than one name, all such names were included.

Socioeconomic status was measured initially by quality of residence rather than income since the pretests showed that it was impossible to obtain accurate income data. USAID/Guatemala had experienced similar difficulties with other studies; only those that could dedicate large sums of money to exhaustive investigation could approach real income levels. The observation system to assess socioeconomic level worked satisfactorily in almost all cases. Special field assessments were done in the few cases where there was doubt about levels. Residence data were correlated with occupation (GOG census categories) and education as needed to further fix socioeconomic level.

Two items were added in order to assess whether or not the informants were indigenous to test two commonly held beliefs about indigenous drug use. Alcohol and hallucinogens were said to be more prevalent among the Indians and hard drugs less of a problem.

One of the new questions asked whether the informant spoke an indigenous language. The other was an interviewer observation item which noted if the respondent wore traditional Indian clothing. Together, they furnished a two level measure (indigenous by language and more traditionally oriented) that allowed this group to be assessed separately to determine if there were differences in drug use. The measures are not absolute, of course, but have functioned well in other

studies.

Some refinements were effected in the administration as a result of the pretests but no basic changes were made. A special training session for the supervisors and potential interviewers also revealed the need for some modifications; the procedures were changed accordingly. An important refinement was that although the general name for a category might be known by some informants, the common name or use for which a substance is taken was much more likely to evoke the desired responses. The botanical classifications of some substances are listed in Appendix B.

The inclusion of a substance in a category or grouping was made because the information gathered before the study suggested that the substance was viewed as having a particular effect, even if it did not have that effect from a pharmacological point of view. Further, many of the substances could be classified in more than one grouping (e.g. Temgesic, a synthetic is used like heroin). To avoid confusion, they were limited to a single grouping in the instrument, again according to the information obtained on perceived effect, rather than their chemical qualities. In the "other" response items, many persons named products included in other category lists. They also named many new ones that had not been included.

2. The Interviewers and Supervisors

The 20 interviewers and 6 supervisors were obtained through Rafael Landívar University, San Carlos University and the private firm of Consultores Agroindustriales. All of the interviewers had previous survey experience. Three Queché speaking interviewers were chosen from Quetzaltenango to assure communications with limited Spanish speaking individuals. Two Cakchiquél speakers were selected to help with that language in Guatemala City. The interviewers with these language capabilities were available to assist in all three cities when necessary. No interview was conducted entirely in the local languages but explanations in those languages were often necessary.

The supervisors had extensive experience in directing survey research. Their tasks, in addition to general supervision of the conduct of the survey, included assigning the residences in which the interviews were to be held, assisting when a refusal occurred, providing additional security for the interviewers, reviewing the completed questionnaires, and maintaining the records of the samples.

The interviewers and supervisors were trained on the specific questionnaire in three separate groups. Those from Quetzaltenango were trained in that city since the initial interviews were conducted there. One group of interviewers for Guatemala City received their training and began interviews in Guatemala City;

most of the interviewers from the universities were subsequently trained and joined the previous teams a few days later. The Escuintla team was made up of three of the Quetzaltenango interviewers and three university students that lived in that city.

The central staff carried out checks on the progress and accuracy of the interviewers by re-interviewing a sample from each. Only one serious problem, unanswered items, was discovered. After retraining and a second check, unsatisfactory interviewers were terminated. All of the others demonstrated care and capability for the work.

Two pretests were conducted. The first took place in Quetzaltenango; no serious problems resulted but some wording changes were made to more easily elicit the information needed. The second pretest was carried out in Guatemala City; only very minor additional changes were necessary, all of them regarding the names of substances.

3. The Samples

The lack of current data was a major obstacle to assurance of a representative sample. The census was published in 1980; the maps of the cities were drawn between 1977 and 1980. Only small samples had been drawn since, those in an effort to provide the population projections issued by the Office of Statistics.

Every known source was utilized in the sample preparation: Office of Statistics, census figures and maps from that same office, numbers known or estimated from the National Police, Social Work, the Ministry of Education, and several private, voluntary organizations working with segments of the population. The results are believed to be reasonably sound and of utility for the generalizations to be drawn from the prevalence survey.

a. The City Samples

The study team searched for more definitive data on the populations in the three cities. The census publication on projections from 1980 to 2000 suggested that there might be problems in assuming proportionate growth among the three. Further checks of documents and calculations led to the estimated population projections in the sample table that is included herein.

Further, the research with officers of the National Police, Social Work, and Child Hope resulted in reasonable estimates of the numbers of homeless. The most definitive numbers were those of minors in Guatemala City as the National Police conducted a survey in 1989; Child Hope also had contact statistics for youth. Social Work had some numbers on adults.

Further, their provision of services to the homeless led to estimates for the adult homeless population. (The homeless estimates are noted in parentheses in the sample table.) The Episcopal Church in Quetzaltenango helped provide some numbers there.

It must be borne in mind that these are estimates, not census counts. The homeless population shifts from one site to another frequently, sometimes every night. The difficulties of "counting" them are myriad. It is believed, however, that the numbers included are reasonable and conservative.

Table I.1
Population Estimates Used in Sample Recalculation

<u>City</u>	<u>1990 Projected</u>	<u>Homeless</u>	<u>Total</u>	<u>%*</u>	<u>Sample</u>
Guatemala	1,675,589	7,000	1,682,589	85.1	1,539 (6)
Quetzaltenango	189,773	1,000	190,773	9.6	173 (1)
Escuintla	104,200	700	104,900	5.3	95 (1)
Totals	1,969,562	8,700	1,978,262	100.0	1,807 (8)

* The percentage is the proportion for the particular urban area in relation to the recalculated total. Note also that the numbers in parentheses are included in the samples they follow.

These numbers reflect the projected growth rates: Guatemala 222%; Quetzaltenango 309%; Escuintla 261%. They were derived by subtracting the estimated populations of urban centers other than those in the study focus from the department projections. The Office of Statistics advised that the homeless had not been counted or estimated in 1980 nor for the projections. The numbers estimated from the several sources were therefore added to the projections before calculating the samples.

b. Samples within the Cities

The overriding factor in determining the samples within the cities was socioeconomic level. That is, the random samples were drawn by probable socioeconomic level (upper, middle, lower) and only then was an attempt made to apportion those numbers among blocks within the zones. (The sectors used in the sample and that appear in the sample control sheets in Appendix B were not officially designated.) In many cases, sectors had been utilized in similar sampling exercises by the Pro Family Association (APROFAM) and sometimes by the Central American Institute for Nutrition (INCAP). They were used and/or drawn to subdivide zones with mixed socioeconomic levels (almost all zones and many blocks were mixed) to enable proportionate, random sampling by level.

As with most of the other population variables, only outdated and often estimated data were available on socioeconomic levels, zones, and therefore sectors. The Office of Statistics studied income levels but did not attempt a grouping. Related studies suggested that the level breakdown is approximately upper=5%, middle=20%, lower=75% for the entire country. These are obviously very rough estimates but they were the most consistent found. The samples were drawn accordingly, despite the weaknesses inherent in these proportions.

As noted in an earlier context, each zone was divided into sectors of widely varying population numbers but that contained, as nearly as could be ascertained, a single level. That was rarely the case but the classification of the residences in the survey alleviated this problem somewhat although the final breakdown by socioeconomic level suggests that at least in the urban centers, the proportion of the middle economic level is much higher than for the country as a whole. All zones were sampled.

Escuintla had only one zone. Quetzaltenango had seven in 1980 but that had been increased to thirteen. Sectors were drawn in the latter cities that encompassed areas definitely within the urban centers. All of the Quetzaltenango zones were sampled.

c. Block and Residence Samples

A computerized random number table was used to select clusters (usually blocks) across socioeconomic classifications but with care to at least partially preserve proportions for each sector. Those were not absolute because of the emphasis on randomness by socioeconomic level.

Some blocks contained mixed socioeconomic level residences. Middle and lower were the most common mix but some upper level dwellings were encountered among both middle and lower level residences.

Every third residence and every third unit within a multifamily building was selected, beginning with rotated starting points on each block and within each multifamily dwelling. To assure that this randomization of residence was absolute, the supervisors assigned the starting points and houses and apartments. Residences that were vacant or that had been converted to solely commercial use, of course were deleted from the study and a new starting point determined thereafter. Extra samples were selected to account for losses from vacant, commercial, and destroyed houses. When a house had been subdivided, each part was counted.

d. Selection of Individuals

Individuals were chosen by the randomization method of "last person to celebrate a birthday". The first alternate (after two tries at locating the individual originally selected) was the birthday before the last. If neither of those resulted in a completed interview, a new residence was randomly chosen. (See the cover page of the questionnaire in Appendix A for the general tenor of the introduction and the format utilized in selecting the individual interviewees.)

Only 78 persons refused to be interviewed. Most cited domestic or business activities, social engagements, or that the time interfered with meals. Some gave no reason. The refusals amounted to 4.3% of the total sample. All refusals resulted in the selection of a substitute residence.

4. Data Entry and Analysis

The questionnaire was almost entirely self coding. Only age groupings required separate code assignment; those were accomplished by the dBase data capture program. New substances resulted in new codes (Every substance named, other than those in the instrument, is listed in Appendix D). Data entry took place at Consultores Agroindustriales. The data entry staff and supervisors conducted the basic error checks from response ranges entered as a part of the data entry program. Final cleansing of the data was accomplished at the Development Associates offices.

The analyses were accomplished through the Statistical Package for the Social Sciences. Because the sample had a higher proportion of females than that found in the universe sampled, global results were weighted to correct this imbalance. The content variables were analyzed as a whole for the country, by city and by demographic variables.

B. Cooperating Organizations

USAID/Guatemala, in addition to general guidance, also furnished important technical input to the survey. Drs. Baudilio López and Jorge Chang reviewed the questionnaire for general methodological suggestions and, specifically, to refine the lists of the several substances included in it. They also provided the substance classification in Appendix D. Lic. Gregorio Tum reviewed the instrument for general survey methodology and particularly to give advice on any problems that might arise due to indigenous languages.

General counsel and suggestions on the study methodology were also given by the US Information Service and the Drug Enforcement Agency of the Embassy. Those led to some important sources of information and some revisions of the substance lists.

The Landívar University Vice Rector, Lic. Luis Achaerandio S., reviewed the methodology and questionnaire in great detail and suggested some useful modifications. Assistance was also given on instructions for administering the instrument. Dr. Raymond Winnier of the Foundation for the Prevention of Drug Addiction also reviewed the questionnaire.

Rafael Landívar University in Guatemala City and Quetzaltenango provided many of the research staff utilized in the study: three supervisors and twelve interviewers. The private firm of Consultores Agroindustriales also recruited three supervisors and eight interviewers.

In addition, several other organizations provided invaluable assistance. The Pro Family Association (APROFAM) loaned the study team the maps for Guatemala, Quetzaltenango, and Escuintla; the maps made it possible to more definitively prepare the random samples.

The Minors Section of the National Police, Dr. Eduardo Arathom, Pharmacist Claudia Overón, and a panel of drug addict contacts were facilitated by the Guatemalan Association for Sexual Education (AGES), the National Police, and the Chamber of Industry. These assisted materially in ascertaining the street names of substances included in this study. Without that help, great difficulties could have been encountered.

The Office of Statistics of the Government of Guatemala performed a vital service in delineating the areas within the three cities and their projected growth. The latter effort was also helped by Child Hope, the National Police, and the government Social Work office.

Confusion on some plant names, caused by local application of the same name to differing species, had to be resolved. Lic. Francisco Monterroso, professor of botany at San Carlos University, helped identify them and their scientific names.

The Guatemalan Association for Sexual Education (AGES) in Guatemala City and Quetzaltenango provided work space, information, and advice on many administration details. Many of the staff members, because of their general consciousness of the degree of the problem and because of their programs for families and AIDS, cooperated on many tasks. They searched for the preliminary information, assisted with the final formulation of the questionnaire, and made it possible for that instrument to be printed in time for the first interviews. AGES/Quetzaltenango also provided office and training space for the work in that city.

The Section for Minors of the National Police helped the study effort in many ways: finding data, informants, and providing names of institutions to be included in the study. Further, the Section Chief sent letters of introduction to the police facilities in Quetzaltenango and Escuintla, whose members then helped avoid trouble because of misinformation in those cities.

II. CHARACTERISTICS OF THE SAMPLE POPULATION

A. Age Ranges of the Respondents

The study sample was limited to those 12 to 45 years of age. The age range distribution for the entire sample (shown in Table II.1) generally approached that of the projected population in Guatemala. Guatemala has a predominantly young population, thus the descending percentages. The youngest group was the largest (the 12-14 age group) while the oldest group (the 40-45 year group) was the smallest in size.

The Quetzaltenango samples are skewed toward the middle range, an artifact of the randomization. The sample for Guatemala City almost exactly reflects that of the general population. The samples were generally large enough to allow meaningful analyses by age groupings although in the two smaller cities, Quetzaltenango and Escuintla, some of the age by sex cells are so small that regroupings were required to permit useful statistical analyses.

B. Sex Characteristics of the Sample

The projected population statistics for Guatemala City and Quetzaltenango estimated the female portion at 51.9% and that for Escuintla at 52.1%. The sample distribution (Table II.1) was somewhat higher, 57.2% overall, just under that for Guatemala City, and higher for Quetzaltenango and Escuintla. Even though the samples were drawn randomly, the higher ratio of females favors their numbers (a compounding of the difference between males and females). These variations were corrected by reweighting the overall sample. Throughout the analysis, the weighted number is used when speaking of the total population.

As with the age group characteristic, some of the numbers for sex were small in Quetzaltenango and Escuintla, a function of the smaller size of the cities and their samples. They required some further regrouping when the substance response analyses showed important differences. Each of these regrouping arrangements are explained when the analysis is presented in later chapters.

Table II.1
Age and Sex Distributions of the Sample Population
by City and Total Sample

Age Groups by Sex	Quetzaltenango		Escuintla		Guatemala		Total	
	No.	%	No.	%	No.	%	No.	%
12-14 Both	19	11.0	13	13.7	201	13.1	233	12.9
Male	12	6.9	5	5.3	99	6.4	116	6.4
Female	7	4.0	8	8.4	102	6.6	117	6.5
15-19 Both	24	13.9	13	13.7	336	21.8	373	20.6
Male	14	8.1	6	6.3	172	11.2	192	10.6
Female	10	5.8	7	7.4	164	10.7	181	10.0
20-24 Both	26	15.0	18	18.9	248	16.1	292	16.2
Males	6	3.5	8	8.4	106	6.9	120	6.6
Female	20	11.6	10	10.5	142	9.2	172	9.5
25-29 Both	34	19.7	18	18.9	220	14.3	272	15.1
Male	11	6.4	7	7.4	78	5.1	96	5.3
Female	23	13.3	11	11.6	142	9.2	176	9.7
30-34 Both	24	13.9	11	11.6	177	11.5	212	11.7
Male	6	3.5	4	4.2	71	4.6	81	4.5
Female	18	10.4	7	7.4	106	6.9	122	6.8
35-39 Both	21	12.1	8	8.4	167	10.9	196	10.8
Male	6	3.5	5	5.3	63	4.1	74	4.1
Female	15	8.7	3	3.2	104	6.8	131	7.2
40-45 Both	25	14.5	14	14.7	190	12.3	229	12.7
Male	11	6.4	4	4.2	80	5.2	95	5.3
Female	14	8.1	10	10.5	110	7.1	134	7.4
Total Both	173	100.0	95	100.0	1539	100.0	1807	100.0
Male	66	38.2	39	41.1	669	43.5	774	42.8
Female	107	61.8	56	58.9	870	56.5	1033	57.2

NOTE: Because of computer rounding, small differences in some of the sums are evident. Percentage shown for city is the portion for that city; % of total is for the entire sample.

One measure to identify the indigenous in the sample was if the respondent spoke an indigenous language. That resulted in the distribution displayed in Table II.2. Six per cent of the total sample responded affirmatively. The highest proportion with this characteristic were located in Quetzaltenango and the smallest in Escuintla. The largest group among them was Queché speakers (65%), followed by Cakchiquel. Two spoke Mam.

The sex distribution for the indigenous language speakers did not follow the general sample pattern. Males predominated in Guatemala City and in Quetzaltenango, probably reflecting the large concentration of single working males present in those two cities. There were no known refusals among the indigenous in the sample. Some interviews could not have been completed, however, except for the Queché and Cakchiquel speaking interviewers.

Table II.2
Distribution of the Sample Population
that Reported Speaking an Indigenous
Language, by City and Sex

City	Male		Female		Total	
	No.	%	No.	%	No.	%
Quetzaltenango	8	4.6	7	4.0	15	8.7
Escuintla	1	1.1	3	3.2	4	4.2
Guatemala	55	3.6	35	2.3	90	5.8
Total	64	3.5	45	2.5	109	6.0

NOTE: Percentage shown for city indicates proportion for that city; % of total is for entire sample population.

C. Education Levels of the Sample

The distributions by educational level in the overall, Quetzaltenango, and Guatemala City samples were similar and approximated the general level of urban educational achievement in Guatemala. (Table II.3) A few had no schooling, a high proportion had some (but not complete) secondary schooling, and only a few had a university degree.

Table II.3
Distribution of the Educational Levels of the Sample
Population by City and Sex

Education Level Sex	Quetzaltenango		Escuintla		Guatemala		Total	
	No.	%	No.	%	No.	%	No.	%
No Schooling								
Both	2	1.2	8	.4	67	4.4	77	4.3
Male	0	0	1	1.1	9	0.6	10	0.6
Female	2	1.2	7	7.4	58	3.8	67	3.7
Some Primary								
Both	23	13.3	22	23.2	290	18.8	335	18.5
Male	10	5.8	7	7.4	115	7.5	132	7.3
Female	13	7.5	15	15.8	175	11.4	203	11.2
All Primary								
Both	24	13.9	15	15.8	245	15.9	284	15.7
Male	8	4.6	11	11.6	99	6.4	118	6.5
Female	16	9.2	4	4.2	146	9.5	166	9.2
Some Secondary								
Both	52	30.1	30	31.6	431	28.0	513	28.4
Male	27	15.6	10	10.5	209	13.6	246	13.6
Female	25	14.5	20	21.1	222	14.4	267	14.8
All Secondary								
Both	41	23.7	15	15.8	305	19.8	361	20.0
Male	8	4.6	7	7.4	117	7.6	132	7.3
Female	33	19.1	8	8.4	188	12.2	229	12.7
Some University								
Both	22	12.7	1	1.1	143	9.3	166	9.2
Male	8	4.6	0	0	81	5.3	89	4.9
Female	14	8.1	1	1.1	62	4.0	77	4.3
All University								
Both	9	5.2	4	4.2	58	3.8	71	3.9
Male	5	2.9	3	3.2	39	2.5	47	2.6
Female	4	2.3	1	1.1	19	1.2	24	1.3
Total	173	100.0	95	100.0	1539	100.0	1807	100.0

NOTE: Percentages by city indicate the proportion for that city; % total is for the entire sample population.

The Escuintla sample was the exception with higher percentages than the other cities in the categories of no schooling and incomplete primary. The Escuintla group also had fewer respondents with some university, perhaps because there was no local university.

Table II.4
Distributions of Educational Level of Speakers of an
Indigenous Language by City

Education Level	Quetzaltenango		Escuintla		Guatemala		Total	
	No.	%	No.	%	No.	%	No.	%
No Schooling	0	0	2	50.0	19	21.1	21	19.3
Some Primary	7	46.7	0	0	22	24.4	29	26.6
All Primary	2	13.3	1	25.0	10	11.1	13	11.9
Some Secondary	2	13.3	0	0	18	20.0	20	18.3
All Secondary	2	13.3	0	0	9	10.0	11	10.1
Some University	1	6.0	0	0	9	10.0	10	9.2
All University	1	6.7	1	25.0	3	3.3	5	4.6
Total	15	100.0	4	100.0	90	100.0	109	100.0

NOTE: Percentages of indigenous speakers by city indicate the proportions of them for that city; % of total is for the entire indigenous language group in the sample. The % of total is for all sample indigenous language speakers.

It had been postulated that respondents wearing traditional indigenous clothing would be "more conservative" as members of their groups than would those that only reported speaking an indigenous language. The 68 respondents (38.2% male and 61.8% female) that were observed wearing traditional clothing were a 61.8% subset of the speakers of an indigenous language. The substance responses were therefore analyzed by indigenous dress to determine whether important differences existed.

The educational level pattern of the indigenous speakers was quite different by city. Note that the distribution is fairly uniform among those from Guatemala City, including a sizable proportion that has had no schooling. The attraction of the capital appeared to be as strong for low educational achievement persons as for those in the middle ranges. The distribution of educational level was roughly proportional to their appearance in the city and total samples.

Wearing traditional Indian clothing was not a function of education when seen as a whole (omitting the one person in Escuintla). From the no schooling category to that of

completed secondary education, the traditional dress was about as likely at one level as another. No persons with a complete university education wore traditional dress. The number with a university degree was too small to allow for conclusions about that group.

D. Socioeconomic Level

It was anticipated that the proportion of middle level individuals would be higher in urban than in rural areas. The distribution for the study sample corroborated that supposition. For the entire 1,807, the middle level was 47.8% as compared to 46.2% for the lower level. (Table II.5) The 6.1% in the upper level about equalled the suggested national range for that category.

Table II.5
Distribution of Socioeconomic Levels by City and Sex

Socioeconomic Level by Sex	Quetzaltenango		Escuintla		Guatemala		Total	
	No.	%	No.	%	No.	%	No.	%
High								
Both	12	6.9	7	7.4	91	5.9	110	6.1
Male	1	0.6	6	6.3	41	2.7	48	2.7
Female	11	6.4	1	1.1	50	3.2	62	3.4
Middle								
Both	119	68.8	33	34.7	711	46.2	863	47.8
Male	35	20.2	10	10.5	279	18.1	324	17.9
Female	84	48.6	23	24.2	432	28.1	539	29.8
Low								
Both	42	24.3	55	67.9	737	47.9	834	46.2
Male	30	17.3	23	24.2	349	22.7	402	22.2
Female	12	6.9	32	33.7	388	25.2	432	23.9
Total	173	100.0	95	100.0	1539	100.0	1807	100.0

NOTE: Percentages indicated for the cities are the proportions of the item for that city; % total is for the entire sample population.

The distributions for middle and lower socioeconomic levels in Quetzaltenango and Escuintla did not follow the general pattern. (Table II.5) Far more middle than lower level respondents were sampled in Quetzaltenango. The Escuintla sample reversed the trend with nearly twice the proportion of lower level persons than middle. Since no

statistics were available on this characteristic, no judgments can be made on the proximity of the percentages to the real situation. It was reported that Escuintla had a weak economy, which may be reflected in the large lower level sample.

Table II.6
Distribution of Socioeconomic Levels for the
Indigenous Speakers in the Sample by City

Socio-economic Level	Quetzaltenango		Escuintla		Guatemala		Total	
	No.	%	No.	%	No.	%	No.	%
High	0	0	0	0	3	3.3	3	2.8
Middle	8	53.5	2	50.0	29	32.2	39	35.8
Low	7	46.7	2	50.0	58	64.4	67	61.5
Total	15	100.0	4	100.0	90	100.0	109	100.0

NOTE: Percentages indicated for the cities are the proportions of the item for that city; % total is for the entire sample population.

The indigenous speaking population (Table II.6) in the sample showed about the same distribution of socioeconomic levels, overall, as did the general population (Table II.5). The distribution by city was similar to that for the entire sample except that more of the speakers of an indigenous language were in the lower level (almost double the percentage in Guatemala City). This may reflect the relatively recent migration to the capital.

E. Occupations of the Study Respondents

The occupations for the sample and by city, by sex, are displayed in Table II.7. The categories utilized were those of the Guatemalan Census Office. In this classification, gardeners, for example, are included in agriculture; gravel and stone pit workers in mine worker; teachers are in professional. Police and armed forces personnel are classified according to their tasks; officers are in administrative but most of the lower level personnel are in office work, transport (traffic), or technical if their training indicates that level of preparation. Domestic services includes maids, butlers, waiters, and cooks. Artisan encompasses not only the usual cloth weaving, rug making, and jewelry making but also those who make and/or repair clothing, shoes, watches, and almost anything else so long as it is made by hand.

Table II.7
Distribution of Occupations of the Sample Population
by Sex and City

Occupation	Quetzaltenango		Escuintla		Guatemala		Total	
	No.	%	No.	%	No.	%	No.	%
Professional/Technical								
Both	29	16.8	11	11.6	130	8.4	170	9.4
Male	11	6.4	7	7.4	76	4.9	94	5.2
Female	18	10.4	4	4.2	54	3.5	76	4.2
Administrative/Management								
Both	0	0	2	2.1	26	1.7	28	1.5
Male	0	0	0	0	20	1.3	20	1.1
Female	0	0	2	2.1	6	0.4	8	0.4
Office Worker and Similar								
Both	6	3.5	4	4.2	126	8.2	136	7.5
Male	3	1.7	3	3.2	53	3.4	59	3.3
Female	3	1.7	1	1.1	73	4.7	77	4.3
Commerce and Sales								
Both	11	6.4	11	11.6	111	7.2	133	7.4
Male	6	3.5	4	4.2	71	4.6	81	4.5
Female	5	2.9	7	7.4	40	2.6	52	2.9
Agriculture/Lumber								
Both	2	1.2	3	3.2	19	1.2	24	1.3
Male	2	1.2	3	3.2	19	1.2	24	1.3
Female	0	0	0	0	0	0	0	0
Mine Worker								
Both	0	0	0	0	7	0.5	7	0.4
Male	0	0	0	0	7	0.5	7	0.4
Female	0	0	0	0	0	0	0	0
Transport Worker								
Both	1	0.6	2	2.1	27	1.8	30	1.7
Male	1	0.6	2	2.1	26	1.7	29	1.6
Female	0	0	0	0	1	0.1	1	0.1
Domestic Services								
Both	5	2.9	5	5.3	65	4.2	75	4.2
Male	0	0	0	0	6	0.4	6	0.3
Female	5	2.9	5	5.3	59	3.8	69	3.8
Artisan								
Both	21	12.1	6	6.3	95	5.5	112	6.2
Male	13	7.5	6	6.3	63	4.1	82	4.5
Female	8	4.6	0	0	22	1.4	30	1.7

Occupation	Quetzaltenango		Escuintla		Guatemala		Total	
	No.	%	No.	%	No.	%	No.	%
Construction Worker								
Both	3	1.7	4	4.2	54	3.5	61	3.4
Male	3	1.7	4	4.2	54	3.5	61	3.4
Female	0	0	0	0	0	0	0	0
Student								
Both	40	23.1	20	21.1	447	29.0	507	28.1
Male	23	13.3	9	9.5	243	15.8	275	15.2
Female	17	9.8	11	11.6	204	13.3	232	12.8
Housewife								
Both	42	28.3	24	25.3	395	25.7	468	25.9
Male	0	0	0	0	0	0	0	0
Female	49	28.3	24	25.3	395	25.7	468	25.9
Unemployed								
Both	5	2.9	3	3.2	45	2.9	53	2.9
Male	3	1.7	1	1.1	25	1.9	33	1.8
Female	2	1.2	2	2.1	16	1.0	20	1.1
Prostitute								
Both	1	0.6	0	0	2	0.1	3	0.2
Male	1	0.6	0	0	2	0.1	3	0.2
Female	0	0	0	0	0	0	0	0
Total	173	100.0	95	100.0	1539	100.0	1807	100.0

NOTE: Percentages by city indicate the proportions for that city; % total is for the entire sample population.

For the most part, the occupations are as would be expected from the distributions by education and socioeconomic level.

Respondents indicating use of indigenous language and clothing reflected their socioeconomic levels - there was a high proportion of wage workers.

F. Perceptions of Health

The self reported health status of the respondents was concentrated in the "good" and "fair" categories. (Table II.8) Few perceived their health condition to be either "excellent" or "bad." Most studies have found similar distributions from self reporting.

Table II.8
Reported Health Status by the
Sample Population

Status	Number	Percent
Excellent	87	4.8
Very Good	217	12.0
Good	753	41.7
Fair	676	37.4
Bad	74	4.1

The remaining indicators appeared to substantiate the self reported conditions. Just over 45% had consulted a doctor or had been to a clinic during the last twelve months. Only 9.1% had been hospitalized once or more during that same period (for all causes, including childbirth). No unusual health parameter was reported by the vast majority of the sample population. There were no important differences on the health indicators for the three cities nor for those who spoke an indigenous language.

G. Conclusion: Generalizing the Sample to the Appropriate Universe

As the proceeding description indicates, the sample included in this study was selected to represent the population of three cities in Guatemala, Guatemala City, Quezaltenango and Escuintala. These cities include approximately 53% of the total urban population of the country. Given that the sample used was a random sample, and given that adjustments made in the distribution of the sample by sex, the sample is representative of the population of these three cities. To the extent that the three cities have the same social characteristics as other cities in the country, an inference can be made that results in these three cities are likely to be replicated in other urban areas, although there is no way that the statistical confiability of such an inference can be tested. In other words, it is possible to general from the sample to the three cities of Guatemala, Quezaltenango and Escuintala can be within the limits of confidence discussed in Chapter III, but it is not possible to make a similar generalization with a similar ability to measure the probability of error regarding other cities in Guatemala. Thus, the results discussed in the following chapters are results referring to the three cities studied.

III. DRUG PREVALENCE IN GUATEMALAN CITIES

The purpose of this survey of three cities of Guatemala was to develop an understanding of the nature and extent of the drug problem in the urban areas of the country. As was indicated at the close of the previous chapter, the study's sample represented the population of the three cities and is therefore fully generalizable to those cities. To the extent that the three cities are similar in relevant characteristics to urban centers throughout the country, the study serves as an indicator of what may be happening in those other urban centers, although not with the same statistical probability that permits generalization regarding the three cities.

A. Lifetime Prevalence

The most elemental indicator of the nature and extent of drug abuse is what is known as lifetime prevalence. Lifetime prevalence measures whether a given individual or population has ever used a particular substance. It indicates whether a substance has been used over the life span of those interviewed in the survey. This in turn allows a controlled comparison between substances and across populations at the broadest possible level. Table III.1 describes the pattern of lifetime prevalence in the study population for the total universe surveyed and for each city. It should be noted that given the size of the sample, an overall confidence interval of approximately ± 3 per cent needs to be included in any estimate. In other words, it should be understood that the actual percentage of the population who have ever used a given substance may vary up to three per cent above or below the values stated in the table.¹ Bearing in mind the respective confidence interval, the data indicate that the highest levels of lifetime prevalence are for alcohol, analgesics, tobacco and sedatives. The lowest levels of prevalence are for cocaine/crack, opiates and hallucinogens. Marijuana, a traditional drug of choice in Central America is higher than other substances commonly categorized as "drugs" (which include opiates, cocaine and its derivatives as well as marijuana/hashish) although less than the around 33% observed in United States household surveys or the 8.3% observed in the national urban household survey in Peru in 1986.

Looking at the lifetime prevalence by cities and again taking into account confidence intervals, there are very few differences between the three urban centers examined. There is less tobacco, analgesic and alcohol use reported in Escuintala than in the other two cities, but slightly more cocaine/crack use (although this difference is a marginal one). Quezaltenango has the highest level of alcohol use while Guatemala City displays the highest level of marijuana use, both within the respective confidence intervals. Guatemala City also has the highest level of stimulant use.

¹ The three percent confidence interval would be for values around 50%. Smaller confidences intervals would be appropriate for higher and lower percentages. See appendix F for a table of such values.

There are greater differences in patterns of lifetime prevalence between the sexes than among cities. (See Table III.2) For all substances, with the exception of analgesics, men are more likely to have ever used the substance than women. Half the men, as opposed to around one-fifth of the women, have ever used tobacco. Six times more men than women have tried marijuana. A similar proportion of males versus females have tried inhalants. In fact only in the area of "medicines" such as hypnotics, sedatives, stimulants as well as analgesics have women in any way approached men in their use of the psychoactive substances studied. Again this prevalence pattern echoes that of Peru where men were more likely than women to use tobacco, alcohol, marijuana, coca paste and cocaine than women and where the reverse was true for medicines such as analgesics and sedatives.

Comparing the age of the respondents with their patterns of lifetime drug prevalence (Table III.3), older groups have higher levels of prevalence when compared with younger groups with three exceptions: levels of use of analgesics are relatively the same no matter the age cohort; sedative use is roughly the same for most cohorts with the exception of those who are 25-29 years of age and those who are 35-45 and most important of all, inhalants are more prevalent among those groups ages 12-19 than other age groups.

The differences in use patterns by socio-economic levels (Table III.4) that are statistically and programmatically significant are those for hallucinogens, inhalants, opiates, marijuana and cocaine/crack. With respect to marijuana, upper and lower class interviewees have higher prevalence rates than do middle class respondents. For inhalants, the same pattern holds true. For hallucinogens, opiates and cocaine/crack, upper class respondents have the highest prevalence rates of all socio-economic levels. Part of this may reflect the ability of upper class respondents to secure certain high priced substances or the likelihood that they may be more in touch with the international drug "scene" or that they are more likely to experiment with certain drugs. This study provides the basis for raising such questions but does not provide the answers. Such answers would depend on a more in-depth study of the causes of substance abuse in the Guatemalan context.

Overall the pattern of drug prevalence indicates that the drug users are more likely to be male than female, upper class than middle or lower class, and with the exception of inhalants, likely to be at least 20 years of age.

B. Current Use

While an examination of lifetime prevalence provides an overview of the extent of drug use among those studied, looking at the pattern of current use (use within the last thirty days, also referred to as 30 day prevalence) indicates the intensity of the problem in a given moment in time. Table III.5 displays the pattern of current use of the substances

that are under study. Table III.6 displays the pattern of current use as a percentage of those who have ever used a given substance. Taking the data in the two tables together, it is clear that a high proportion of the users admit to being current users. This includes around 60% of the marijuana users, roughly half of those who use alcohol and analgesics and around a third of those who are users of sedatives, stimulants, inhalants and opiates. Stated in other terms, there are large numbers of active drug users among the population admitting to having ever been involved in such use. Comparing these data with data from the 1986 Peru survey, as indicated in Table III.10, current users of marijuana as a percentage of those who have ever used the substance amount to 7% in Peru as compared with 60.7% in Guatemala, and for cocaine the respective percentages are 3.8% for Peru and 18.3 per cent for Guatemala. The situation is the same for other substances such as analgesics, sedatives, inhalants and hallucinogens. It is clear that the problem with respect to a variety of substances in Guatemala is far more acute than was the case in Peru.

The pattern of current use follows that of lifetime prevalence when controlling for the sex of users (Table III.7). With exception of analgesics, males are more likely to be current users of all substances than females. Current users of substances such as alcohol, marijuana and opiates are more likely to be older than 20 years (Table III.8). Current marijuana users, in fact, seem to be concentrated in the 25-39 age bracket. Current inhalant users are most likely to be younger than users of other substances, with considerable numbers in the age brackets 12-14 and 15-19.

Looking at socio-economic levels and current use patterns (Table III.9), there are some differences between lifetime prevalence(ever used) and current use patterns. While upper class Guatemalans are more likely to have tried marijuana, inhalants and cocaine than other social groups, they are far less likely to be current users. In the case of cocaine, 14% of those in the upper class who have tried cocaine are current users as compared to 21% of the lower class and around 43% of the middle class. For marijuana, the ratio is around 19% for upper class respondents, 35% for middle class and 45% for lower class. For inhalants, the ratio ranges from 13% for upper class respondents to 40% for lowers. With all three substances, there is a higher likelihood that upper class subjects will have tried a drug, but a far lower likelihood that they are present users.

C. Frequency of Substance Use

Frequency of use was dichotomized into two levels: 11 or more times in a lifetime (high use) versus 1 to 10 times in a lifetime (low use). The tables in this section show the association between frequencies of substance use and city, sex, socio-economic status, and age for the various categories of substance abuse. These data are for the persons who used a particular substance reported at least once and do not include non-users. The data are most reliable for the more commonly used substances (e.g., tobacco, alcohol, and

analgesics) and least reliable for the less commonly used substances (e.g., cocaine/crack, opiates, and inhalants).

Table III.2 shows the relationship between city and frequencies of substance use. Overall, Quetzaltenango had the lowest percentage of high frequency of use for all substances except hallucinogens. Guatemala City had the greatest percentage of high frequency of use for analgesics, hypnotics and opiates; while Escuinta had the greatest percentage of high frequency of use for marijuana, cocaine/crack, stimulants, sedatives and inhalants. Guatemala City and Escuinta were about the same in terms of the percentages of high frequency of use regarding tobacco and alcohol. These data suggest that in terms of the frequency of use index Escuinta currently may have the greatest substance use problem, followed closely by Guatemala City, while Quetzaltenango generally has the least substance use problem currently.

Table III.12 shows the relationship between sex (gender) and frequency of use. Males show greater percentages of high frequency users for tobacco, alcohol, marijuana, hypnotics, and hallucinogens. Females show greater percentages of high frequency users for cocaine/crack and opiates. Males and females show about equal percentages of high frequency users for analgesics, stimulants, sedatives and inhalants.

The relationship between socio-economic status (SES) and frequency of use of various substance is shown in Table III.13. The percentage of high frequency users of tobacco, marijuana, analgesics, and sedatives is about the same for all three levels of SES. Upper SES respondents show the greatest percentages of high frequency of use of alcohol, cocaine/crack, hypnotics, and stimulants and the least percentages of high frequency of use for opiates, hallucinogens, and inhalants. Middle SES respondents show the greatest percentages of high frequency of use of opiates and the least percentages of use of alcohol and stimulants. Lower SES respondents shows the greatest percentages of high frequency of use for hallucinogens and inhalants and the least percentages of high use for cocaine/crack and hallucinogens.

Data in Table III.14 show some interesting patterns regarding frequency of use across age which varies by substance. Although the percentages differ, the pattern for tobacco and alcohol is similar and show the lowest percentage of high frequency users in the 12-14 age group, a sharp increase in the 15-19 age group, and a fairly level percentage of high frequency users in the age groups thereafter.

The pattern of frequency of use for marijuana shows a different pattern. The highest frequency of use is in the 12-14 age group, followed by the 15-19, 20-24, and 25-29 age groups (all in the 32-35 percent range) and then dropping down further in the 30-34, 35-39, and 40-45 age groups (all in the 18-21 percent range). These data suggest that high

frequency marijuana use has been increasing over the last ten years compared with before then. The pattern for hallucinogens is similar to marijuana, but even more pronounced, suggesting that the use of hallucinogens has been undergoing an ever more recent and/or rapid growth in high frequency use than marijuana, especially among adolescents and youth.

Hypnotics, stimulants, and sedatives all show gradual rises in frequency of use with peaks in later age groups. These data suggest that the use of these substances gradually becomes established with increased age and/or that their high use may have been waning somewhat in recent years. An indication of which of these explanations is plausible (based on other data in the report) can suggest what prevention strategy may be most appropriate.

The pattern for analgesics is fairly flat across age groups, with not more than a gradual rise. This suggests that high analgesic users are established early (early to mid teens and before) and high use of this category of drug only gradually increases with age. Also the data suggest that analgesics use has been fairly stable over the last several decades.

Finally, it should be noted that the patterns for high frequency cocaine/crack use, opiate use, and inhalants use are quite erratic, so nothing definitive can be gleaned from these data. Quite likely the erratic nature of these data is due to the low Ns associated with the use of these substances, which make the data too unreliable to show clear patterns.

D. Perceived Risk of Using Substances

Table III.15 shows responses regarding perceived risk of using various substances. Very high percentages (90 percent or more) of respondents indicated that the use of any of the following six substances was risky: inhalants, tobacco, LSD, stimulants, marijuana, and alcohol. Perceived risk was fairly high for most of the rest of the substances listed in Table III.16 as well, although a sizeable minority (33 percent) did not perceive the use of hallucinogens to be risky. A sizeable minority of respondents also said they did not know if the use of cocaine, analgesics, and/or hypnotics was risky.

Table III.16 shows the relationship between lifetime prevalence (ever used) and perceived risk for the six substances most often perceived as risky. Except for analgesics and inhalants, lifetime prevalence does not seem related to perceived risk. For analgesics, lifetime prevalence is associated with a somewhat higher perception of risk, but for inhalants lifetime prevalence is associated with a lower percentage of perceived risk.

E. Age of First Use

The series of tables in this section report the percentage in each age category of first use for various substances, as well as the percentage who never used each of these substances.

Table III.17 reports the data regarding tobacco use. About 66 percent claim never to have used tobacco. Of those that have used tobacco, the highest percentage first used it between 15 and 19 years of age, with most doing so between 12 and 24 years of age. Few first used tobacco before 12 years of age and few first used it after 24 years of age.

Age of first use regarding alcohol is reported in Table III.18. About 43 percent claim never to have used alcohol. The pattern of first use is very similar to that for tobacco, with the highest percentage first using alcohol between 15 and 19 years of age, most doing so between 12 and 24 years of age, and relatively few doing so before age 12 or after age 24.

Table III.19 reports the age of first use of analgesics. About 48 percent claim never to have used analgesics. The data regarding those who have used analgesics is strikingly different from first use of tobacco or alcohol, in that virtually all who have used analgesics did so for the first time before age 12. Very likely this was under parental and/or doctor directions.

Age of first use of sedatives is shown in Table III.20. About 64 percent claim never to have used this category of substance. The pattern of first use for this category of substances is quite different than those presented so far. Although the largest percent of first users is in the 11 year old and younger age category, the distribution of first use is relatively flat across age.

Table III.21 shows the data for the first use of hypnotics. About 93 percent of respondents claim never to have used this category of substance, so only about 7 percent have done so. The pattern of first use is somewhat like tobacco and alcohol in that the greatest percentage of first use occurred between ages 15 and 19, but the distribution is a little more skewed toward the twenties. This suggests that hypnotics are generally tried for the first time somewhat later than tobacco or alcohol.

Age of first use of stimulants is shown in Table III.22. About 89 percent claim never to have used this category of substance. While the exact percentages are different, the pattern of first use of stimulants by age category is very similar to that for hypnotics reported above.

Table III.23 shows the age of first use of marijuana. Only about 7 percent of those sampled indicate they have used marijuana. The pattern of first use is quite similar to that for tobacco and alcohol, but much more clearly focused between 12 and 24 years of age and more strongly peaking in the years between 12 and 24.

The pattern of first use for hallucinogens (Table III.24) is different than any presented so far, although it should be pointed out that given the low percentage of users, (around 2%) the data is not as reliable. None of the respondents in this survey indicated first use of hallocinogens after age 24, virtually all of these first used hallocinogens before age 20, and more than half said they did so before age 12.

Table III.25 shows that data regarding the first use of inhalants. Again the low percentage (3%) of users make these data less reliable than for more commonly used substances. The greatest percentage did so between 12 and 14 years of age and most of the rest did so between 15 and 19 years of age. Age of primary onset, and hence the focus for primary prevention, of inhalant use seems to be the late pre-teens and early teens. Quite likely the relative inexpensiveness and availability of inhalants compared with other substances makes this category of substance attractive to a small minority of late pre-teens and teenagers.

First use of opium products is shown in Table III.26. About 98 percent of respondents claim never to have used opium products, so only about 2 percent have done so. While the data are less reliable than for more commonly used substances, the pattern of first use is fairly similar to hypnotics, as described above. First use occurs virtually always after age 14 and before age 30.

Finally, Table III.27 shows the data regarding first use of cocaine/crack. Lifetime prevalence is around 1%, the lowest percentage of admitted use for any category of substance reported in this section, so these also are the least reliable data in this section. Nevertheless, there appears to be a pattern of first use occurring predominantly in later teens and early twenties (15 to 24 years of age), with some starting in early teens (12 to 14 years of age).

F. Indigenous Drug Use

Respondents were categorized as to whether they were or were not indigenous in terms of two variables, use of an indigenous language and use of traditional dress. Dividing the population into three categories, those that both used an indigenous language and traditional dress (labelled high for this category), those that showed only one of these characteristics (either used traditional dress or used an indigenous language) (labelled low for this category) and those that displayed neither of these characteristics (i.e. the non-

indigenous population), Table III.28 examines the lifetime prevalence (having ever used) of the sample. The widest differences appear for alcohol, tobacco, marijuana, stimulants, hallucinogens, inhalants and cocaine/crack. Those high on the indigenous indicator are least likely to have ever used tobacco or marijuana, while those who are low on the indicator are most likely of the three groups to have used the three substances. The same is the case for cocaine/crack but in this case given the low number of cases this may not be a reliable estimate. For inhalants and hallucinogens as well, those in the low indigenous category have the highest lifetime prevalence of the three groups.

While this overall survey is suggestive of differences in patterns between the various groups, and particularly the more transitional "low indigenous" group, a more detailed study of indigenous behavior with regard to drug use would appear to be warranted given the relatively small size of indigenous individuals in the sample (52 in the high category and 94 in the low category, 2.6 and 4.8% of the total sample respectively).

G. Problems Caused by Drugs/Treatment

Around 11.7% of those sampled indicated that they had problems as a consequence of the use of any of the substances included in the study. Most frequently mentioned problems were health related (feeling nervous or having general health problems) followed by having been involved in fights either as aggressors or as victims. Only as very few (1.3%) however felt the necessity to seek treatment for their drug problems.

H. Conclusions

The Guatemalan cities studied face a drug problem that has several critical characteristics. While overall levels of drug prevalence in the population are not high, current use of drugs is, particularly when compared with drug use in another Latin American country, Peru. The data also indicate that with some drugs, including such gateway drugs as tobacco and alcohol as well as with marijuana, initiation in drug use takes place at an early age. The data also indicate that in most cases males rather than females are more likely to be drug users. Finally the data suggest as well that class is no barrier to drug use. Upper class as well as lower and middle class respondents were users, although it would appear that upper class males in particular are more likely to experiment with drugs such as marijuana, cocaine/crack and inhalants, while lower class males are more likely to be current users of such drugs.

The next chapter of this report will look at the institutional arrangements for engaging in the sort of awareness and education programs needed to deal with the drug problem in Guatemala. The final chapter will summarize the principal finding of the study and draw recommendations based on those findings.

Table III.1
Percentage of Sample That Ever Used the Substances
By City
Weighted N = 1987

Substances	Quetzaltenango	Escuintla	Guatemala City	Total Sample
Tobacco	33.9	26.3	34.4	33.9
Alcohol	63.2	52.7	56.3	56.7
Analgesics	49.6	42.5	53.2	52.3
Sedatives	36.1	39.1	36.7	36.8
Hypnotics	5.5	2.4	7.7	7.2
Stimulants	7.0	1.0	12.3	11.2
Marijuana	5.6	4.5	7.7	7.3
Hallucinogens	1.2	1.2	1.9	1.8
Inhalants	3.3	3.3	3.4	3.4
Opiates	0	1.2	1.9	1.7
Cocaine/Crack	0.7	2.4	1.4	1.4

Table III.2
 Percentages of Sample That Ever Used the Substances
 By Sex
 Weighted N = 1987

Substances	Male	Female	Total
Tobacco	50.1	19.0	33.9
Alcohol	65.9	48.3	56.7
Analgesics	46.4	57.7	52.3
Sedatives	39.9	33.9	36.8
Hypnotics	7.8	6.8	7.2
Stimulants	14.6	8.1	11.2
Marijuana	13.3	1.8	7.3
Hallucinogens	3.2	0.5	1.8
Inhalants	6.1	1.0	3.4
Opiates	2.6	0.9	1.7
Cocaine/Crack	2.2	0.6	1.4

Table III.3
Percentages of Sample that Ever Used the Substances
By Age of Respondent

Substances	12-14	15-19	20-24	25-29	30-34	35-39	40-45	Total
Tobacco	7.5	24.8	33.7	41.9	48.5	44.0	45.4	33.9
Alcohol	23.7	47.8	60.7	64.9	69.2	69.7	68.8	56.7
Analgesics	46.2	48.3	50.0	57.4	53.5	56.3	57.4	52.3
Sedatives	31.7	31.8	30.7	41.1	34.2	44.7	48.5	36.8
Hypnotics	3.4	7.1	6.2	7.7	9.3	8.8	9.0	7.2
Stimulants	7.0	10.8	12.9	14.3	12.8	9.4	10.8	11.2
Marijuana	1.7	6.3	7.6	7.6	12.0	10.9	7.1	7.3
Hallucinogens	0.9	2.1	0.8	1.6	4.0	2.3	1.5	1.8
Inhalants	5.3	5.3	1.9	3.5	2.1	2.8	1.9	3.4
Opiates	0	1.4	1.1	1.9	3.6	3.0	1.5	1.7
Cocaine/Crack	0.5	1.7	0.4	1.9	2.0	1.5	1.5	1.4

Table III.4
Percentages of Sample Respondents
Who Ever Used the Substances
By Socioeconomic Level
Weighted N = 1987

Substances	Upper	Middle	Lower	Sample
Tobacco	33.7	31.8	36.1	33.9
Alcohol	59.0	54.1	59.1	56.7
Analgesics	50.1	50.7	54.2	52.3
Sedatives	40.7	36.3	36.8	36.8
Hypnotics	10.0	5.5	8.6	7.2
Stimulants	13.3	9.9	12.3	11.2
Marijuana	10.8	5.1	9.2	7.3
Hallucinogens	6.9	0.6	2.4	1.8
Inhalants	7.9	1.6	4.7	3.4
Opiates	8.8	0.8	1.7	1.7
Cocaine/Crack	5.7	0.7	1.4	1.4

Table III.5
Current Users of Substances
(those reporting heavy used in the last 30 days)
by City
Weighted N = 1987
of Total Population

Substances	Percentage Using Substance in Last 30 Days			
	Quetzaltenango	Escuintla	Quatemala City	Total
Alcohol	27.2	31.4	26.7	27.0
Analgesics	24.3	18.2	26.3	25.7
Sedatives	9.1	16.0	12.5	12.4
Hypnotics	2.5	2.1	2.1	2.2
Stimulants	2.4	0	4.1	3.7
Marijuana	1.3	2.4	3.1	2.9
Hallucinogens	0	0	0.5	0.4
Inhalants	1.3	1.0	1.2	1.2
Cocaine/Crack	1.2	0	0.3	0.3
Opiates	0	0	0.9	0.7

Table III.6
Percentage of Those Who
Have Ever Used a Substance by Those Who Are Current Users
(Used in Last 30 Days)
Weighted N = 1987

Alcohol	47.4
Analgesics	48.8
Sedatives	33.5
Hypnotics	26.2
Stimulants	32.4
Marijuana	60.7
Hallucinogens	20.0
Inhalants	34.2
Opiates	39.8
Cocaine/Crack	18.3

Table III.7
Current Users of Substances
(those reporting heavy used in the last 30 days)
by Sex
Weighted N = 1987
of Total Population

Substances	Percentage Using Substance in Last 30 Days		
	Male	Female	Total
Alcohol	34.9	19.7	27.0
Analgesics	20.9	30.1	25.7
Sedatives	15.0	10.0	12.4
Hypnotics	2.3	2.0	2.2
Stimulants	4.8	2.7	3.7
Marijuana	5.4	0.5	2.9
Hallucinogens	0.9	0	0.4
Inhalants	1.9	0.6	1.2
Cocaine/Crack	0.4	0.3	0.3
Opiates	0.9	0.6	0.7

Table III.8
Current Users of Substances
(those reporting heavy used in the last 30 days)
by Age
Weighted N = 1987
of Total Population

Substances	Percentage Using Substance in Last 30 Days							
	12-14	15-19	20-24	25-29	30-34	35-39	40-45	Total
Alcohol	8.9	22.1	32.2	31.8	31.6	35.2	30.1	27.0
Analgesics	23.6	23.0	23.2	26.5	28.5	30.6	27.8	25.7
Sedatives	8.9	9.3	10.7	13.6	14.2	12.8	20.0	12.4
Hypnotics	2.5	1.8	1.4	2.3	2.4	2.1	3.2	2.2
Stimulants	2.7	3.1	4.3	5.5	3.5	2.7	4.0	3.71
Marijuana	1.2	2.0	2.7	4.5	3.6	4.6	2.0	2.9
Hallucinogens	0	0.9	0.4	0	0.5	1.2	0	0.4
Inhalants	2.3	1.5	0.4	1.4	1.1	1.0	0.9	1.2
Cocaine/Crack	0.5	0.3	0.3	0.3	0	0.5	0.5	0.3
Opiates	0	0.2	0.3	0.8	2.1	1.4	1.0	0.7

Table III.9
Current Users of Substances
(those reporting heavy used in the last 30 days)
by Socio-Economic Status
Weighted N = 1987
of Total Population

Substances	Percentage Using Substance in Last 30 Days			
	Upper	Middle	Lower	Total
Alcohol	26.2	25.8	28.2	27.0
Analgesics	21.8	24.7	27.2	25.7
Sedatives	9.4	11.5	13.7	12.4
Hypnotics	0.8	2.2	2.3	2.2
Stimulants	0.8	2.8	5.0	3.7
Marijuana	2.0	1.8	4.1	2.9
Hallucinogens	0	0.1	0.8	0.4
Inhalants	1.0	0.6	1.9	1.2
Cocaine/Crack	0.8	0.3	0.3	0.3
Opiates	0	0.7	0.9	0.7

Table III.10
Relationship Between Lifetime Prevalence
(Ever Used) and Currents Used
for Peru National Urban Drug Prevalence Study (1986)

Substances	Lifetime Prevalence (Percentage of Total population)	Current Use as a Percentage of Total Population	Current Use as a Percentage of Lifetime Prevalence
Marijuana	8.3	0.6	7.0
Cocaine/Crack	2.6	0.1	3.8
Analgesics	9.9	1.2	12.1
Sedatives	18.5	2.4	13.0
Inhalants	3.6	0.4	11.1
Hallucinogens	3.0	0.1	3.3

Table III.11
Frequency of Use by Substance and by City
(Total Times Used over Lifetime)
Weighted N = 1987

City	Quetzaltenango		Escuintla		Guatemala		Total	
	High	Low	High	Low	High	Low	High	Low
Tobacco	42.2	57.8	45.0	55.0	47.1	52.9	46.6	53.4
Alcohol	8.3	91.7	18.0	82.0	16.7	83.3	15.9	84.1
Marijuana	11.6	88.4	52.5	47.5	27.8	72.2	27.4	72.6
Cocaine/Crack	0	100.0	50.0	50.0	28.8	71.2	29.4	70.6
Analgesics	12.8	87.2	38.8	61.2	45.7	54.3	42.4	57.6
Hypnotics	0	100.0	0	100.0	33.8	66.2	30.8	69.2
Stimulants	17.0	83.0	100.0	0	48.8	51.2	47.2	52.8
Opiates	0	0	0	100.0	56.5	43.5	54.5	45.5
Sedatives	8.5	91.5	31.8	68.2	26.1	73.5	24.8	74.8
Hallucinogens	55.2	44.8	0	100.0	22.9	77.1	24.1	75.9
Inhalants	20.0	80.0	64.4	35.6	43.2	56.8	42.2	57.8

Table III.12
Frequency of Use by Substance and by Sex
(Total Times Used over Lifetime)
Weighted N = 1987

Sex	Male		Female		Total	
	High	Low	High	Low	High	Low
Tobacco	52.1	47.9	33.2	66.8	46.6	53.4
Alcohol	23.9	76.1	5.8	94.2	15.9	84.1
Marijuana	29.1	70.9	15.8	84.2	27.4	72.6
Cocaine/Crack	23.5	76.5	50.0	50.0	29.4	70.6
Analgesics	42.9	57.1	42.1	57.9	42.4	57.6
Hypnotics	38.3	61.7	22.9	77.1	30.8	69.2
Stimulants	46.9	53.1	47.6	52.4	47.2	52.8
Opiates	50.0	50.0	66.7	33.3	54.5	45.5
Sedatives	24.5	74.8	25.1	74.9	24.8	74.8
Hallucinogens	28.0	72.0	0	100.0	24.1	75.9
Inhalants	42.6	57.4	40.0	60.0	42.2	57.8

Table III.13
 Frequency of Use by Substance and by Socio-Economic Status
 (Total Times Used over Lifetime)
 Weighted N = 1987

Socioeconomic Status	Upper		Middle		Lower		Total	
	High	Low	High	Low	High	Low	High	Low
Tobacco	41.8	58.2	46.1	53.9	47.6	52.4	46.6	53.4
Alcohol	24.9	75.1	13.4	86.6	17.1	82.9	15.9	84.1
Marijuana	28.2	71.8	22.6	77.4	29.9	70.1	27.4	72.6
Cocaine/Crack	64.4	35.6	33.3	66.7	9.2	90.8	29.4	70.6
Analgesics	47.5	52.5	40.9	59.1	43.3	56.7	42.4	57.6
Hypnotics	46.8	53.2	37.4	62.6	24.1	75.9	30.8	69.2
Stimulants	63.2	36.8	39.5	60.5	51.1	48.9	47.2	52.8
Opiates	11.6	88.4	87.0	13.0	67.8	32.2	54.8	45.5
Sedatives	18.4	81.6	26.5	73.5	23.8	75.4	24.8	74.8
Hallucinogens	0	100.0	23.6	76.4	33.3	66.7	24.1	75.9
Inhalants	25.6	74.4	30.5	69.5	49.7	50.3	42.2	57.8

Table III.14
 Frequency of Use by Substance and by Age
 (Total Times Used over Lifetime)
 Weighted N = 1987

Age	12-14		15-19		20-24		25-29		30-34		35-39		40-45		Total	
	H	L	H	L	H	L	H	L	H	L	H	L	H	L	H	L
Tobacco	17.7	82.3	40.9	59.1	49.7	50.3	46.5	53.5	50.9	49.1	53.5	46.5	43.8	56.2	46.6	53.4
Alcohol	4.0	96.0	14.2	85.8	17.8	82.2	15.8	84.2	18.1	81.9	15.1	84.9	18.7	81.3	15.9	84.1
Marijuana	50.0	50.0	32.9	67.1	34.7	65.3	31.9	68.1	17.8	82.2	21.3	78.7	20.8	79.2	27.4	72.6
Cocaine/Crack	0	100	17.2	82.8	100	0	39.2	60.8	21.3	78.7	69.1	30.9	0	100	29.4	70.6
Analgesics	34.5	65.5	40.6	59.4	44.6	55.4	40.2	59.8	42.7	57.3	44.7	55.3	49.8	50.2	42.4	57.6
Hypnotics	11.2	88.8	24.1	75.9	26.3	73.7	35.0	65.0	42.8	57.2	35.5	64.5	31.8	68.2	30.8	69.2
Stimulants	42.5	57.5	38.5	61.5	41.3	58.7	44.7	55.3	58.0	42.0	50.6	49.4	63.3	36.7	47.2	52.8
Opiates	-	-	58.4	41.6	28.9	71.1	60.8	39.2	58.7	41.3	46.4	53.6	66.7	33.3	54.5	45.5
Sedatives	16.2	83.8	20.0	80.0	23.9	76.1	24.7	75.3	31.3	68.7	28.4	68.8	29.6	70.4	24.8	74.8
Hallucinogens	55.2	44.8	42.9	57.1	50.0	50.0	26.2	73.8	0	100	25.0	75.0	0	100	24.01	75.9
Inhalants	50.0	50.0	44.4	55.6	40.0	60.0	22.0	78.0	50.0	50.0	41.6	58.4	47.5	52.5	42.2	57.8

Table III.15
Perceived Risk of Using Substances
Weighted N = 1987

Substance/Perceived Risk	Yes	No	Do Not Know
Inhalants	92.3	5.8	1.9
Tobacco	96.2	1.6	2.3
Opium	73.9	15.0	11.0
Temgesic	75.6	10.9	13.5
Heroin	74.0	12.2	13.8
Cocaine	72.2	0.8	27.0
Analgesics	74.1	5.6	20.3
Hallucinogens	55.2	33.2	11.6
LSD	95.0	0.2	4.8
Stimulants	89.7	0.1	10.2
Hypnotics	63.5	1.6	34.9
Sedatives	81.6	0.4	17.9
Marijuana	93.4	5.0	1.6
Alcohol	95.2	1.0	3.8

Table III.16
Lifetime Prevalence (Ever Used) by
Perceived Risk of Selected Substances
Weighted N = 1987
(Percentage of those who have ever used
who consider use a risk)

Substances	Have Used	Have Not Used
Alcohol	95.3%	95.1%
Tobacco	95.9%	96.3%
Analgesics	76.0%	72.0%
Marijuana	92.4%	93.5%
Stimulants	88.9%	89.8%
Inhalants	85.5%	92.6%

Table III.17
Tobacco
Age of First Use
Weighted N = 1987

Age	Percent
0-11 Years Old	1.9
12-14 Years Old	9.3
15-19 Years Old	15.6
20-24 Years Old	4.7
25-29 Years Old	1.6
30-34 Years Old	0.5
35-39 Years Old	0.2
40-45 Years Old	0.2
Never Used	66.1
Total	100.0

Table III.18
Alcohol
Age of First Use
Weighted N = 1987

Age	Percent
0-11 Years Old	3.1
12-14 Years Old	9.5
15-19 Years Old	29.6
20-24 Years Old	10.2
25-29 Years Old	2.9
30-34 Years Old	0.9
35-39 Years Old	0.5
40-45 Years Old	0.1
Never Used	43.3
Total	100.0

Table III.19
Analgesics
Age of First Use
Weighted N = 1987

Age	Percent
0-11 Years Old	51.9
15-19 Years Old	0.1
20-24 Years Old	0.1
30-34 Years Old	0.1
35-39 Years Old	0.1
Never Used	47.7
Total	100.0

Table III.20
Sedatives
Age of First Use
Weighted N = 1987

Age	Percent
0-11 Years Old	9.3
12-14 Years Old	3.9
15-19 Years Old	6.5
20-24 Years Old	6.2
25-29 Years Old	4.2
30-34 Years Old	2.8
35-39 Years Old	2.4
40-45 Years Old	1.5
Never Used	63.2
Total	100.0

Table III.21
Hypnotics
Age of First Use
Weighted N = 1987

Age	Percent
0-11 Years Old	0.3
12-14 Years Old	0.8
15-19 Years Old	1.9
20-24 Years Old	1.5
25-29 Years Old	1.3
30-34 Years Old	0.6
35-39 Years Old	0.6
40-45 Years Old	0.2
Never Used	92.8
Total	100.0

Table III.22
Stimulants
Age of First Use
Weighted N = 1987

Age	Percent
0-11 Years Old	0.6
12-14 Years Old	1.2
15-19 Years Old	4.3
20-24 Years Old	2.2
25-29 Years Old	1.4
30-34 Years Old	0.8
35-39 Years Old	0.4
40-45 Years Old	0.3
Never Used	88.8
Total	100.0

Table III.23
Marijuana
Age of First Use
Weighted N = 1987

Age	Percent
0-11 Years Old	0.1
12-14 Years Old	1.4
15-19 Years Old	4.1
20-24 Years Old	1.4
25-29 Years Old	0.2
30-34 Years Old	0.1
35-39 Years Old	0.1
Never Used	92.7
Total	100.0

Table III.24
Hallucinogens
Age of First Use
Weighted N = 1987

Age	Percent
0-11 Years Old	1.1
12-14 Years Old	0.2
15-19 Years Old	0.4
20-24 Years Old	0.1
Never Used	98.2
Total	100.0

Table III.25
Inhalants
Age of First Use
Weighted N = 1987

Age	Percent
0-11 Years Old	0.4
12-14 Years Old	1.6
15-19 Years Old	1.0
20-24 Years Old	0.4
25-29 Years Old	0.1
Never Used	96.6
Total	100.0

Table III.26
Opium Products
Age of First Use
Weighted N = 1987

Age	Percent
12-14 Years Old	0.1
15-19 Years Old	0.5
20-24 Years Old	0.4
25-29 Years Old	0.5
30-34 Years Old	0.1
40-45 Years Old	0.1
Never Used	98.3
Total	100.0

Table III.27
Cocaine/Crack
Age of First Use
Weighted N = 1987

Age	Percent
12-14 Years Old	0.2
15-19 Years Old	0.4
20-24 Years Old	0.5
25-29 Years Old	0.1
30-34 Years Old	0.1
40-45 Years Old	0.1
Never Used	98.6
Total	100.0

Table III.28
Lifetime Prevalence
of Indigenous Respondents
(Weighted N = 1987)

Substances	High	Low	Non Indigenous	Total
Tobacco	18.6	54.0	33.3	33.9
Alcohol	47.0	68.5	56.4	56.7
Marijuana	2.4	9.1	7.4	7.3
Analgesics	46.3	47.4	52.7	52.3
Sedatives	31.3	40.8	36.7	36.8
Hypnotics	5.8	8.9	7.2	7.2
Stimulants	6.3	13.0	11.3	11.2
Hallucinogens	2.4	6.5	1.5	1.8
Inhalants	0	6.5	3.4	3.4
Opiates	1.9	2.6	1.6	1.7
Cocaine/Crack	0	3.9	1.3	1.4

IV. INSTITUTIONAL STUDY

As a part of the needs assessment and following guidelines developed jointly by USAID/Guatemala and Development Associates, representatives of Guatemalan institutions interested in drug prevention programs were interviewed in Quetzaltenango, Escuintla, and Guatemala City. Interviews took place in May 1990. Most of the institutions were identified from a list provided by the Office of Human Resource Development of USAID/Guatemala. Others were discovered during the conduct of the interviews in the three cities.

The interviews were carried out using a guide designed to collect basic information about the institutions and their programs related to the prevention of drug abuse. (The guide was presented in Report No. 2 of this series.) A second set of institutions with interest and/or activities in drug rehabilitation was visited in order to obtain information on that aspect of anti-drug activity. Visits were also made to private doctors, hospitals, and clinics to determine the status of their drug patient records and reporting.

A. Guatemala City

The following nine institutions interested in drug abuse prevention were visited in the capital:

- (1) Asesoramiento, Orientación y Prevención en Drogadicción (ASOPRED) - Advisory Services, Orientation, and Prevention of Drug Addiction
- (2) Asociación Nacional para la Prevención, Investigación y Tratamiento de las Adicciones (ANAFRE) - National Association for the Prevention, Research, and Treatment of Addictions
- (3) Cámara de Industria - Chamber of Industry
- (4) Consejo Nacional de Prevención del Alcoholismo y la Drogadicción - National Council for the Prevention of Alcoholism and Drug Addiction
- (5) Club de Leones - Lions Club
- (6) Departamento de Salud Mental, División de Atención a las Personas, Ministerio de Salud Pública - Mental Health Department, Personal Attention Division, Ministry of Public Health
- (7) Fundación Preventiva de la Drogadicción - Foundation for the Prevention of Drug Addiction

- (8) Juventud para Cristo - Youth for Christ
- (9) Sección de Menores, Policía Nacional - Minors Section, National Police

All nine of the institutions are presently conducting some type of drug abuse prevention activities. They are extremely interested, and dedicated to their work, and are getting some satisfaction from their initial activities. Using volunteers, a minimum of salaried personnel, and scarce financial resources, they are trying to do the best they can to obtain results with their programs.

Most of the organizations exert their major efforts on research and the training of volunteers so the programs can increase their outreach. As a group, the institutions cover a variety of activities in the drug field. Individually, in addition to financial resources, the institutions need organizational development assistance in formulation of specific, achievable program objectives. Definition of work strategies, information and its systematization, and internal organizational controls must be strengthened in most of them.

1. Coordination among Institutions

The organizations are becoming conscious of the need for the exchange of knowledge, experiences, and abilities. They would like to see the establishment of a solid interinstitutional network in the near future. One organization that appears capable of coordinating such a network is the National Council for the Prevention of Alcoholism and Drug Addiction. Although it is in its incipient stages it has achieved some success in bringing the various institutions together for mutual technical collaboration.

The administrators of all but one of the institutions surveyed expressed positive opinions on the technical coordination role of the National Council. They believe that financial coordination also should be sought but that role would be difficult via the National Council. Its present status as an organism of the government makes it suspect in the role of financial coordinator. Autonomous status was considered necessary if the Council is to achieve its role in drug addiction prevention.

2. Organizational Structures

Three of the institutions studied are from the public sector: the Department of Mental Health of the Ministry of Public Health, the Minors Section of the National Police, and the National Council for the Prevention of Alcoholism and

Drug Addiction. The last, even though created only in December of 1989, is the result of the efforts initiated beginning in 1985 by the National Commission for the Prevention of Abuse of Alcohol and Drug Addiction in cooperation with the Presidency of the Republic.

The personnel of the three programs are officials of the government organization to which they belong and are paid through the general budgets of their institutions. The National Council has a program coordinator and a secretary. The Program of Street Educators of the Minors Section within the National Police has a program chief, an assistant, an instructor to give talks in schools, and 40 street educators (police agents). The Department of Mental Health of the Ministry of Public Health has two persons that carry out the administrative functions and seven persons with professional duties related to the alcohol and drug field.

Of the six private institutions, three (Chamber of Industry, Lions Club, Youth for Christ) are primarily dedicated to other objectives: industry, recreation, and religion. Their substance abuse prevention programs are just one of several activities. Only three private institutions (Chamber of Industry, Lions Club, ANAFRE) have recognized legal status. All six organizations utilize volunteers in conducting their programs. Only two (Chamber of Industry, ANAFRE) of the six have salaried employees working in the substance abuse field. The small number of staff members, including both volunteers and salaried persons, is a significant limitation to their organizational development, planning, and specialization of personnel, as well as on their abilities to administer and control operational activities necessary to accomplish their program objectives. (See the directory in Appendix E for details.)

3. Technical Capacity

The majority of the personnel of the nine institutions has some technical preparation for the utilization of information and for teaching. The capability to offer training to other personnel is much better in the Department of Mental Health, the Foundation for the Prevention of Drug Addiction, and the National Association for Prevention, Research, and Treatment of Addictions. Despite this capability, the lack of financial resources has made it difficult for these organizations to design and publish formal educational materials in support of prevention activities.

So far, the Foundation for the Prevention of Drug Addiction is the one most interested in research. It has developed and pretested a special instrument for use in high schools. Its volunteer personnel have considerable technical ability in the research field.

Persons with substantial experience in the dissemination of information are found mostly in the Lions Club program and the Chamber of Industry. Again, the lack of funds has severely limited what they have been able to do in this field. The other institutions require a great deal of training in this subject.

In general, the nine organizations have some trained personnel to carry out their proposed functions. None has enough to conduct a large program. All of them need more personnel and intense, systematic training in several aspects of an educational campaign. Advanced training in most of the fields now covered in the programs will be required if their stated objectives are to be achieved.

4. Institutional Missions and Objectives

In summary, it is important to emphasize that there are institutions involved (partially or totally dedicated) in drug addiction prevention. This is a major step forward in any effort to inaugurate a solid campaign in Guatemala. Nine institutions is a useful base on which to build such an action campaign since it demonstrates a serious concern for the problem.

Among the six private organizations, three (ANAFRE, ASOPTRF, the Foundation) have missions and objectives totally dedicated to drug abuse prevention. The other three, even though their overall mission includes other objectives, carry out some important drug use prevention activities. Two of these institutions, the Chamber of Industry and the National Association for the Prevention of Addictions, have coordinated their capacities in education and research to provide a stronger attack on the problems.

Public sector concern is evident. The National Council's mission and objectives are dedicated to drug prevention through the coordination of efforts among the institutions, as well as carrying out some activities of its own. The National Police is well advanced in its prevention work; its drug prevention program is aimed primarily at a specific audience, street children. The objectives of the Department of Mental Health cover a wide range of activities but they include concrete efforts toward prevention of drug addiction. This is a favorable asset.

5. Audience Objectives

To date, the target populations of the nine institutions, collectively, are students, general youth, street children, parents, professionals, and teachers in public and private schools. Four organizations dedicate themselves mainly to work with primary and secondary school children, their parents, and their teachers. They also assist health professionals and those in related fields in the preparation and

delivery of educational materials. The National Police effort is dedicated primarily to work with street children. The Chamber of Industry works with factory and business employees and their families. In all of these programs, parents receive special emphasis as potential recipients of information that will help prevent drug abuse among their children.

While on the surface there appears to be some duplication in terms of target audiences among the nine programs, the total of their combined services is minimal compared to the need in Guatemala City alone. The demand for talks in schools, for example, far exceeds the capacity of the nine organizations to satisfy. Many community organizations also request assistance but personnel and financial resources severely limit what can be accomplished with them. Coordination among the institutions so each serves a different audience has helped expand their coverage.

6. Action Plans

All of the institutions reviewed have adequate short term action plans, considering their present resources. The plans primarily respond to requests for services.

The lack of sufficient permanent personnel and financial resources has influenced the degree of elaboration and extent of their action plans. The plans now being implemented are congruent with the resources of the programs. Each institution would like to reach out to additional audiences, provide greater coverage to those now being served, and begin new types of activities. They simply cannot. The action plans demonstrate, however, that with additional resources, the institutions could successfully initiate additional activities in the drug prevention field. In summary, the institutional action plans were found to be satisfactory within the possibilities of implementation at the present time. The actions carried out, however do not have an extensive outreach.

7. Expected and Obtained Results

Most of the interviewed institutional representatives expressed satisfaction with the results obtained so far when viewed in relation to their resources. They feel they have been able to disseminate some information on the topic of drug addiction. They also noted that they have been able to interest pertinent professionals in the Guatemalan drug problem. They believe that for the youth served so far, they have been able to convince most of them of the high risk of using drugs.

It must also be emphasized that the activities of most of the nine institutions were begun very recently. Their present flexible structures, diverse objectives and audiences, and resource limitations have made it difficult for the institutions to maintain adequate documentation of their activities that would permit verification of the results. Their incipient information systems have permitted only inexact data on even formative results (numbers of persons reached), much less an evaluation of the impact of their activities. Only the roughest approximations of results could be offered by the representatives of the programs. A formal capture system will need to be developed for each before concrete achievements can be documented.

B. Quetzaltenango

No information was available on the existence of any drug abuse prevention programs in the Quetzaltenango area so the personnel of the Guatemalan Association for Sexual Education office in that city and staff members of the faculty of Social Work of the Quetzaltenango campus of Rafael Landívar University were asked to help in the search of potential institutional efforts there.

Some educational institutions, mainly middle schools, and some religious groups that work with youth are concerned with drug problems. The teachers and group leaders give talks on drug risks and furnish some written information on the subject. They, themselves, reported difficulty in obtaining minimal information to prepare these offerings. The institutions also reported that they invite professionals and other knowledgeable people to present information to students and youth groups. All of the interviewed institutional representatives expressed great interest in learning about drug prevention and methods for disseminating information to their audiences. Training in the subject was requested by all of them.

The Guatemala City Chamber of Industry has offered conferences for youth and parents in the Quetzaltenango area. The Chamber of Commerce in Quetzaltenango currently has no program but is very interested in developing one. The program of the National Police in Guatemala City, now in an experimental stage, has not yet been extended outside the capital but the Quetzaltenango police commissioner expressed interest in joining the effort.

Two local institutions were identified as presently having some drug prevention activities in their programs.

- (1) Asociación para el Desarrollo del Potencial Humano (ADEPH) - Association for the Development of Human Potential
- (2) Fundación de Orientación Social (FUNORSO) - Foundation for Social Orientation

The two institutions are new. The ADEPH drug program was organized in 1989 with the assistance of the Quetzaltenango Lions Club. It has offered conferences for students, parents, and professionals that have included drug abuse topics. Because of last year's teacher strike, the activities were suspended and have not yet begun again.

ADEPH considers that a drug prevention campaign is required and that its focus must be integral, not just directed toward the symptoms of the problem. ADEPH's representative suggested that any worthwhile effort will require substantial planning for a solid dissemination program. The group believes that its own mission and actions must be clearly defined, coordinated with other efforts, and be realistic within the resources available.

FUNORSO, the other institution, works with groups that request their services. They use a forum approach with the help of lawyers, physicians, and an ex-addict instructor. This permits information on any of the major aspects of the substances and the problems associated with their abuse. In addition to its drug prevention program, the foundation also operates a treatment and rehabilitation center and a Protestant church.

Basically, the director of FUNORSO is the person in charge of all of the activities: promotion, conduct, and supervision of the activities. He demonstrated great interest in doing something about the problem but also expressed frustration over the difficulties of obtaining financial and material assistance so the program could reach a wider audience.

A third institution, the Quetzaltenango Episcopal Church, provides information through talks given to the street youth in a special program. The representatives noted that they, themselves, need training and more information before they can conduct a more solid program. They are sincerely interested in drug use prevention.

At the present time, there is no institution that could manage a large campaign in Quetzaltenango. The limited missions, structures, experience, capacity, and financial resources require considerable strengthening before any comprehensive tasks could be assigned to any Quetzaltenango institution. They do have, however, the potential for development.

C. Escuintla

Through Landívar University students working as interviewers in the drug awareness study, two doctors, and a representative of the National Police, a considerable search was made for drug abuse prevention programs in the vicinity of Escuintla. Only one was discovered:

Radio Ritmo FM - FM Rhythm Radio Station

The station has a special music program for youth on weekends and at night. Between selections, the station imparts information on drugs, the risks, and the consequences of their abuse. The station conducts this campaign purely because of the concerns of the personnel for the young people of the community. It has no special financial resources for its work. The station representative expressed a need for factual information on drugs and drug abuse; he noted that their greatest limitation is the lack of good material for the program. He also stated that the manager of the station would voluntarily organize a conference of young people, parents, teachers, and other community representatives if some institution would come to address them.

The telephone calls that the station receives give some notion of the results being obtained. The callers often congratulate the station on carrying out such a valuable community service, request more information, and ask that additional programming be dedicated to the topic. The disk jockey for the program stated that while no definitive study had been done, the station estimates that its audience for the program is about 25,000, mostly youth, a sizable group for this urban area with a population of some 75,000.

Escuintla appeared to have the least well organized effort on drug abuse prevention. It may be, however, that with the assistance of the radio station, the police, and other concerned organizations, a worthwhile campaign could be designed and carried out.

D. Treatment and Rehabilitation Programs

As a complement to the study of institutions in prevention, the research team studied the existence of quantitative and qualitative information available on the provision of services to drug addicts. Information on these types of services was found to be virtually non-existent in the three cities. Some general information was gleaned from conversations with doctors and hospital administrators in the capital and in Quetzaltenango. Similar informants in Escuintla could provide no useful data.

Treatment and rehabilitation methods utilized by the diverse professionals and the individual and institutional levels vary significantly in effectiveness and in the application of modern methods. Most use one drug to try to break the addiction to others. Withholding the drug is a common method used, usually under confinement. Palliatives are often offered as temporary measures. There is, however, a substantial interest on the part of private and institutional physicians in receiving training and advisory services regarding drug addiction and rehabilitation. They are concerned about the quality and effectiveness of the services they provide.

Among private organizations, Alcoholics Anonymous (AA) has been successful in the treatment and rehabilitation of alcoholics. Some AA groups have worked with drug addicts. These organizations use peer support through "confessions" and descriptions of

use and the problems associated with abuse. Ex-alcoholic participants in the program are a major force for success with others.

The Alcoholics Anonymous affiliate in Ciudad Vieja, not far from Guatemala City, has a good reputation for its services. It uses the same techniques with drug addicts in its Narcotics Anonymous program.

The few private centers that exist for the treatment of alcoholism sporadically receive applications for the treatment of drug addiction. Most of them limit their treatments to detoxification.

Three private centers were identified that provide treatment and rehabilitation services to drug addicts in Guatemala City.

- (1) Hospital los Pinos
- (2) Hospital San José las Rosas
- (3) Reto a la Juventud

A visit was made to a Reto a la Juventud institution for wayward youth: Casa Hogar Batallón Cristiano contra la Drogadicción y la Delincuencia. Its methods are quite violent and the institution has a low reputation with doctors. A second center with a greater capacity will soon be inaugurated.

In the City of Quetzaltenango, the only center found was Casa Getzemaní.

The City of Escuintla has no identifiable private services for the treatment or rehabilitation of drug addicts other than Alcoholics Anonymous. Public hospitals and health centers, because of the high demand for other services, are unable to offer specialized drug programs.

E. Addiction Treatment Records

The records that are maintained by health professionals, both private and public, consist basically of the usual medical cards and some information about the patient. Brief notations on services rendered are added. Because of the nature of the cases and the low priority assigned to them, no compilation of the information is done. At the ministerial level, no organized system of information collection or analysis exists on the incidence and nature of drug cases in the country. At various times, they have asked their central personnel to gather data but those efforts are sporadic and probably incomplete.

F. Conclusions

There are a sufficient number of organizations interested and involved in drug awareness and prevention activities to form the beginnings of a network to cover a major portion of the population of Guatemala. However, as evidenced by our review, they all lack the resources (skilled personnel and funds) and administrative and management capability to operate an effective drug awareness, education and prevention program. Availability of financial resources will certainly go far in enabling these organizations to expand their activities, but the lack of an appropriate infrastructure (to include legal status) and skilled personnel precludes their ability to effectively use additional funds.

None of the organizations surveyed, to include the government agencies, appear to have demonstrated the leadership (nor technical credibility) that would permit them to take the lead in development and implementation of a national drug awareness and prevention program. Additionally, several of the organizations surveyed have drug awareness activities as a secondary function, which would impact on their ability or willingness to take a leadership role in this area.

Based on the evidence available, and taking the above comments into consideration, it appears that the most likely organizations worthy of further exploration are The National Council for the Prevention of Alcoholism and Drug Addiction and the Foundation for the Prevention of Drug Addiction. The National Council, as a government agency has the potential for assuming the leadership necessary to coordinate and manage a national program. On the downside, a government agency will be subject to political whims and pressures and may get mired down in bureaucratic procedures that would impact negatively on any program. The Foundation for the Prevention of Drug Addiction, as a private agency would be more likely to be free of political pressures and may not be subject to bureaucratic processes. Additionally, it is in the possess of obtaining legal status; is interested and has conducted some research in addition to its curriculum development work.

V. CONCLUSIONS AND RECOMMENDATIONS

The purpose of this study was to provide the basis for assessing the need for future AID activity in the area of drug abuse awareness and education. Two components were included in that needs assessment, an examination of the nature and extent of drug use (levels of drug prevalence) in cities in Guatemala representing approximately half of the total urban population and an examination of existing institutional arrangements for the conduct of drug prevention (awareness and education) activities. This summarizes the conclusions of the needs assessment and draws out recommendations to USAID/Guatemala regarding the development of drug awareness and education activities.

A. Conclusions

Drug Prevalence in the cities sampled:

1. A variety of drugs are used by the population studied including tobacco, alcohol, marijuana, various categories of psychoactive medicines (analgesics, sedatives, stimulants, and cocaine/crack).
2. Overall lifetime prevalence of these drugs is not high, however, current use (use within the last thirty days) is high, particularly when compared with drug use in other Latin American contexts (e.g. Peru).
3. Initiation of use of some drugs, including such gateway drugs as tobacco and alcohol as well as marijuana, takes place at a relatively early age. There are, for example, instances of initiation of use of tobacco, alcohol and marijuana earlier than 12 years of age with the bulk of those using having tried initially between 12 and 20 years of age.
4. Males rather than females are more likely to be drug users.
5. Class is no barrier to drug use. There were users for all class levels, upper, middle and lower class. However, upper class males were more likely to experiment with drugs such as marijuana, cocaine/crack and inhalants, while lower class males were more likely to be current users of those drugs.

Institutional Basis for Drug Prevention

1. There are sufficient organizations interested in drug awareness and education to form the beginnings of a network to cover a major portion of Guatemala's population.

2. However, all those organizations lack basic human and financial resources, program expertise in drug abuse prevention and relevant administrative and management capabilities to operate effective drug awareness and education programs.
3. While all the organizations display weaknesses, it would appear that The National Council for the Prevention of Alcoholism and Drug Addiction, a public sector agency, and the Foundation for the Prevention of Drug Addiction, a private sector agency, are both worthy of further exploration as key players in a drug prevention effort.

B. Recommendations

If USAID/Guatemala wishes to develop a drug abuse awareness and education initiative, then it needs to take into account the following recommendations, based on the results of this needs assessment:

Regarding the institutional basis for drug abuse prevention activities:

Recommendation One: an in-depth analysis be made of the two organizations, "The National Council for the Prevention of Alcoholism and Drug Addiction" and the "Foundation for the Prevention of Drug Addiction" to determine their respective roles in providing leadership in a national drug awareness and education effort.

Recommendation Two: On the basis of the analysis in recommendation one, USAID provide the necessary support to ensure the success of the organizations in the role assigned to them. This support should include provision of the necessary training and technical assistance and information resources to place the agencies in the mainstream of prevention programming. This should also include assistance in the development of networking skills both within the country and outside the country among other agencies interested in and involved in drug abuse prevention.

Regarding the Design and Implementation of Drug Prevention Activities:

Recommendation Three: Based on the data generated in the survey, in the design of drug abuse prevention programs, emphasis needs to be placed on:

1. Targeting pre-teens and young teenagers with prevention messages regarding a wide range of substances including tobacco and alcohol.

2. Assuring that prevention messages are directed at such important secondary targets as parents and teachers as a means of reaching young potential users.
3. Placing immediate emphasis on efforts at reaching the relatively large numbers of current users of drugs in the population.
4. Placing special emphasis on prevention efforts directed at males who are such a high proportion of both current users and those who have ever used drugs.
5. Targeting all social classes, but differentiating where possible efforts to reflect the differences in drug prevalence patterns, e.g. the high level of current users among the lower class and the higher number of experimenters among the upper class.

Recommendation Four: In the implementation of drug prevention activities, resources be directed at continuing to monitor the nature and extent of drug abuse through epidemiological research and of attitudes toward the problem through appropriate attitudinal studies.

APPENDICES

APPENDIX A
STUDY QUESTIONNAIRE

INTRODUCCION

Buenos días (tardes). Por encargo de Asociados para el Desarrollo y la Fundación Preventiva de Drogadicción, estamos haciendo una encuesta sobre problemas de salud y el uso de ciertas sustancias en la población.

El estudio tiene por objeto conocer el problema y después preparar una campaña educativa. Su hogar ha sido seleccionado para participar en esta importante tarea. Necesitamos solo algunos minutos de su tiempo, que serán muy útiles para conocer mejor la situación en esta localidad.

Su nombre no aparecerá en este cuestionario. Sus respuestas no serán consideradas en forma individual.

Cuántas personas entre 12 y 45 años de edad viven en su casa, sin incluir el servicio doméstico?

Cuántos años tiene el mayor? y, el siguiente...?

	Edad	No.	
1	_____	_____	Cuál de estas personas cumplió años de último? No.____
2	_____	_____	
3	_____	_____	
4	_____	_____	Cuál de estas personas cumplió años antes de aquella? No.____
5	_____	_____	
6	_____	_____	
7	_____	_____	Está presente la persona que cumplió años de último? Sí_____ No.____
8	_____	_____	

No. de Encuesta: _____

No. de Mz. _____
 No. de Encuesta _____
 Entrevistador _____
 Ciudad: Quetzaltenango 1
 Escuintla 2
 Guatemala 3

Todos los días 1
 5 a 6 días por semana 2
 2 a 4 días por semana 3
 1 día por semana 4
 Menos de 1 día/semana 5
 Nada (anotar)

1. Durante los últimos doce meses, Ud. diría que su salud ha sido:

Excelente 1
 Muy buena 2
 Buena 3
 Regular 4
 Mala 5

2. Ha tenido que ver al médico o ir a un hospital o clínica en los últimos doce meses?

Sí 1
 No 2

3. Ha estado hospitalizado en los últimos 12 meses?

Sí 1
 No 2

I. TOBACO

4. Qué edad tenía Ud. la primera vez que fumó tobacco?

Edad ()
 Nunca probó tobacco 99

(E: Si es nunca, PASAR A P 8)

5. Más o menos, con qué frecuencia ha fumado en los últimos doce meses?

6. Ha funado Ud. diariamente alguna vez en su vida?

Sí 1
 No 2

7. Alguna vez ha tratado de dejar de fumar?

Sí 1
 No 2

II. ALCOHOL

8. Ha tomado bebidas alcohólicas alguna vez (vino, cerveza, ron, otras)?

Sí 1
 No 2

(E: Si no, PASAR A P. 14)

9. Qué edad tenía la primera vez que tomó una bebida alcohólica?

Edad ()

10. En los últimos 12 meses, cuántos días tomó 1 o más bebidas alcohólicas?

Todos los días 1
 5 a 6 días por semana 2
 2 a 4 días por semana 3
 1 día por semana 4
 Menos de 1 día/semana 5

11. Cuándo fue la última vez que tomó una bebida alcohólica o trago?

Hoy o ayer 1
 2 a 30 días 2
 Más de 1 a 6 meses 3

- Más de 6 a 12 meses 4
 Más de 1 a 3 años 5
12. Alguna vez en su vida Ud. consumió alcohol regularmente?

Sí 1
 No 2

13. Alguna vez ha tratado de dejar de tomar alcohol?

Sí 1
 No 2

(ENTREGAR TARJETA 1)

14. En esta tarjeta figuran algunos productos. Dígame si consumió alguno de ellos conjuntamente o luego de tomarse una bebida alcohólica?

Pastillas para dormir como Fenobarbital 02
 Estimulantes como Anfetaminas, Captagon u otros 03
 Píldoras para dolor como Baralgina 04
 Sedantes o relajantes como Darvon o Diazepan 05
 Marihuana o hachís 06
 Inhalantes: thiner, Flex, Tip Top u otros 07
 Alucinógenos como LSD, San Isidro o Floripondio 08
 Cocaína (harina blanca) o Crack 09
 Opios: en polvo, morfina, codeína u otros 10
 Ninguno 99

III. ANALGESICOS

(ENTREGAR TARJETA 2)

15. En esta lista aparecen algunos medicamentos para calmar el dolor. Cuáles de ellos ha tomado Ud. sin indicación médica?

Darvon 01
 Demerol 02
 Metadona 03
 Pentazocina 04
 Sosegon 05
 Baralgina 06
 Baralgina 06
 Laudano 07
 Lisalgil 08

Otros (especificar)

_____ ()
 Ninguno 99

(Si ninguno, PASAR A P. 21)

16. Qué edad tenía la primera vez que tomó uno de estos productos sin indicación médica?

Edad ()

17. Y, cuántas veces en su vida ha tomado esos sin indicación médica?

(E: LEER ALTERNATIVAS)

1 o 2 veces 1
 De 3 a 5 veces 2
 De 6 a 10 veces 3
 De 11 a 49 veces 4
 De 50 a 99 veces 5
 De 100 a 199 veces 6
 De 200 a más veces 7

18. Cuándo fue la última vez que usó un medicamento para calmar el dolor?

Hoy o ayer 1
 2 a 30 días 2
 Más de 1 a 6 meses 3

Más de 6 a 12 meses 4
 Más de 1 a 3 años 5

19. Alguna vez ha tratado de dejar de tomar estos medicamentos?

Sí 1
 No 2

20. Al usar algunos de estos medicamentos, consumió también al mismo tiempo o poco después algunos de los productos en esta lista?

(E: MOSTRAR TARJETA 1)

Alcohol 01
 Pastillas para dormir como Fenobarbital 02
 Estimulantes como Anfetaminas, Captagon u otros 03
 Sedantes o relajantes como Darvon o Diazepam 05
 Marihuana o hachís 06
 Inhalantes: thiner, Flex, Tip Top u otros 07
 Alucinógenos como LSD, San Isidro o Floripondio 08
 Cocaína (harina blanca) o Crack 09
 Opios: en polvo, morfina, codeína u otros 10
 Ninguno 99

IV. SEDANTES, RELAJANTES

21.Cuál de los medicamentos sedantes que aparecen en esta lista, que sirven para tranquilizar los nervios, ha consumido Ud. sin indicación médica?

(E: MOSTRAR TARJETA 3)

Ativan 01
 Meprogésico 02
 Librium 03
 Frisium 04
 Tensil 05
 Alivin 06
 Motival 07
 Mandrax 08
 Diazepam 09
 Quietarax 10
 Reposal 11
 Valium 12
 Luminai 13
 Jarabes para toz 14
 Otros (especificar) ()
 Ninguno 99

(E: Si es ninguno, PASAR A P. 27)

22. Qué edad tenía la primera vez que tomó sedantes?

Edad ()

23. Con qué frecuencia ha usado medicamentos para tranquilizar los nervios?

1 o 2 veces 1
 De 3 a 5 veces 2
 De 6 a 10 veces 3
 De 11 a 49 veces 4
 De 50 a 99 veces 5
 De 100 a 199 veces 6
 De 200 a más veces 7

24. Cuándo fue la última vez que tomó un sedante?

Hoy o ayer 1
 2 a 30 días 2
 Más de 1 a 6 meses 3
 Más de 6 a 12 meses 4
 Más de 1 a 3 años 5

25. Alguna vez ha tratado de dejar de usar sedantes?

Sí 1
No 2

Otros (especificar) ()
Ninguno 99

(E: Si es ninguno, PASAR A P. 33)

26. Al usar algunos de estos sedantes, consumió también algunos de los productos que aparecen en esta lista?

(E: MOSTRAR TARJETA 1)

Alcohol 01
Píldoras para dormir como Fenobarbital 02
Estimulantes como Anfetaminas o Captagon 03
Píldoras para dolor: Darvon o Diazepam 04
Marihuana o hachís 06
Inhalantes: thiner, Flex, Tip Top 07
Alucinógenos como LSD, San Isidro, Floripondio 08
Cocaína o Crack 09
Opios en polvo, heroína, codeína 10
Ninguno 99

V. HIPNOTICOS

27. Cuáles de las pastillas para dormir o hipnóticos que aparecen en esta lista ha tomado Ud. sin indicación médica?

(E: MOSTRAR TARJETA 4)

Franol 01
Fenobarbital 02
Seconal (Secobital) 03
Mogadon 04
Nembutal 05
Tedral 06
Rohypnol 07
Dalmadorm 08
Neurinase 09
Teofilina Efedrina 10

28. Qué edad tenía Ud. la primera vez que tomó píldoras para dormir?

Edad ()

29. En general, cuántas veces en su vida ha tomado algo para dormir?

1 o 2 veces 1
De 3 a 5 veces 2
De 6 a 10 veces 3
De 11 a 49 veces 4
De 50 a 99 veces 5
De 100 a 199 veces 6
De 200 a más veces 7

30. Cuándo fue la última vez que tomó algo para dormir?

Hoy o ayer 1
2 a 30 días 2
Más de 1 a 6 meses 3
Más de 6 a 12 meses 4
Más de 1 a 3 años 5

31. Alguna vez ha tratado de dejar de usar estos medicamentos?

Sí 1
No 2

32. Al usar algunos de los medicamentos para dormir, usó también algunos de los productos en esta lista?

(E: MOSTRAR TARJETA 1)

Alcohol 01
Estimulantes como Anfetaminas, Captagon u otros 03

Píldoras para dolor como Baralgina	04
Sedantes o relajantes como Darvon o Dia- zepam	05
Marihuana o hachís	06
Inhalantes: thiner, Flex, Tip Top u otros	07
Alucinógenos como LSD, San Isidro o Floripondio	08
Cocaína (harina blanca) o Crack	09
Opios: en polvo, morfina, codeína u otros	10
Ninguno	99

VI. ESTIMULANTES

33. En esta lista, figuran varios medicamentos utilizados para mantenerse despierto o para controlar el apetito, llamados estimulantes. Cuáles de ellos ha tomado Ud. sin indicación médica?

(E: MOSTRAR TARJETA 5)

Anfetamina	01
Captagon	02
Metacuolona	03
Lipenan	04
Metilfenidato	05
Obedrin	06
Pondinil	07
Tenuate Dospan	08
Ritalina	09
Pentabarbital	10
Secobarbital	11
Otros (especificar)	()
<u>Ninguno</u>	99

(E: Si es ninguno, PASAR
A P. 39)

34. Qué edad tenía la primera vez que tomó un estimulante?

Edad ()

35. Cuántas veces en su vida ha tomado un estimulante sin indicación médica?

1 o 2 veces	1
De 3 a 5 veces	2
De 6 a 10 veces	3
De 11 a 49 veces	4
De 50 a 99 veces	5
De 100 a 199 veces	6
De 200 a más veces	7

36. Cuándo fue la última vez que tomó un estimulante?

Hoy o ayer	1
2 a 30 días	2
Más de 1 a 6 meses	3
Más de 6 a 12 meses	4
Más de 1 a 3 años	5

37. Alguna vez ha tratado de dejar de usar los estimulantes?

Sí	1
No	2

38. Al usar uno de los estimulantes, tomó también al mismo tiempo o poco después algunos de los productos en esta lista?

Alcohol	02
Pastillas para dormir como Fenobarbital	02
Píldoras para dolor como Baralgina	04
Sedantes o relajantes como Darvon o Dia- zepam	05
Marihuana o hachís	06

Inhalantes: thiner,
Flex, Tip Top u
otros 07
Alucinógenos como
LSD, San Isidro
o Floripondio 08
Cocaína (harina
blanca) o Crack 09
Opios: en polvo,
morfina, codeína
u otros 10
Ninguno 99

VII. MARIHUANA

39. Qué edad tenía la primera vez que le ofrecieron o pudo probar marihuana o hachís?

Edad ()
Nunca los probó 99

(Si es nunca, PASAR A P.46)

40. Qué edad tenía la primera vez que usó marihuana o hachís?

Edad ()
Nunca los probó 99

41. En los últimos 12 meses con qué frecuencia usó marihuana o hachís?

Todos los días 1
5 a 6 días por semana 2
2 a 4 días por semana 3
1 día por semana 4
Menos de 1 día/semana 5

42. Cuándo fue la última vez que usó marihuana o hachís?

Hoy o ayer 1
2 a 30 días 2
Más de 1 a 6 meses 3
Más de 6 a 12 meses 4
Más de 1 a 3 años 5

43. Alguna vez en su vida ha usado regularmente marihuana o hachís?

Sí 1
No 2

44. Alguna vez ha tratado de dejar de usar marihuana o hachís?

Sí 1
No 2

45. Cuáles de los productos que figuran en esta lista ha usado al mismo tiempo o poco después de usar marihuana o hachís?

Alcohol 01
Pastillas para dormir
como Fenobarbital 02
Estimulantes como Anfetaminas, Captagon
u otros 03
Píldoras para dolor
como Baralgina 04
Sedantes o relajantes
como Darvon o Diazepam 05
Inhalantes: thiner,
Flex, Tip Top u
otros 07
Alucinógenos como
LSD, San Isidro
o Floripondio 08
Cocaína (harina
blanca) o Crack 09
Opios: en polvo,
morfina, codeína
u otros 10
Ninguno 99

VIII. ALUCINOGENOS

46. Qué edad tenía la primera vez que le ofrecieron o pudo probar algunos de las substancias en esta lista?

Edad ()
Nunca 99

(Si nunca, PASAR A P. 53)

47. Más o menos qué edad tenía cuando probó un inhalante por primera vez?

Edad ()
Nunca probó 99

(Si nunca probó, PASAR A P. 53)

48. Cuáles de las sustancias que figuran en esta lista utilizó alguna vez?

(E: MOSTRAR TARJETA 6)

LSD 01
Peyote 02
San Isidro 03
Floripondio (Florifundia) 04
Parturo 05
Belladona 06
Quiebra Cajete 07
Campana 08
Hoja de plátano 09
Otros (especificar) ()
Ninguno 99

49. En los últimos 12 meses, con qué frecuencia ha usado alucinógenos?

1 o 2 veces 1
De 3 a 5 veces 2
De 6 a 10 veces 3
De 11 a 49 veces 4
De 50 a 99 veces 5
De 100 a 199 veces 6
De 200 a más veces 7

50. Cuándo usó un alucinógeno la última vez?

Hoy o ayer 1
2 a 30 días 2
Más de 1 a 6 meses 3
Más de 6 a 12 meses 4
Más de 1 a 3 años 5

51. Alguna vez en su vida ha usado frecuentemente un alucinógeno?

Sí 1
No 2

52. Con cuál de los productos que figuran en esta tarjeta usó al mismo tiempo o poco después de usar un alucinógeno?

Alcohol 01
Pastillas para dormir como Fenobarbital 02
Estimulantes como Anfetaminas, Captagon u otros 03
Píldoras para dolor como Baralgina 04
Sedantes o relajantes como Darvon o Diazepan 05
Marihuana o hachís 06
Inhalantes: thiner, Flex, Tip Top u otros 07
Cocaína (harina blanca) o Crack 09
Opios: en polvo, morfina, codeína u otros 10
Ninguno 99

IX. INHALANTES

53. Cuál de las siguientes sustancias ha tenido la posibilidad de aspirar o inhalar para ponerse en onda?

(E: MOSTRAR TARJETA 7)

Gasolina o líquido para incendadores	01
Esmaltes u otra pintura	02
Atomizador o aerosol	03
Pegamento para zapatos o llantas como Flex o Tip Top	04
Lacas, disolventes de pintura, thinner	05
Nitrato de milo o "poppers"	06
Eter u otros anestésicos	07
Líquidos de limpieza	08
Otros (especificar)	()
Nunca usó un inhalante para volar	99

(Si nunca, PASAR A P. 59)

54. Qué edad tenía la primera vez que aspiró o inhaló algunas de esas sustancias que le he mostrado?

Edad	()
Nunca	99

(Si nunca, PASAR A P. 59)

55. En los últimos 12 meses, con qué frecuencia ha usado un inhalante para volar o ponerse en onda?

1 o 2 veces	1
De 3 a 5 veces	2
De 6 a 10 veces	3
De 11 a 49 veces	4
De 50 a 99 veces	5
De 100 a 199 veces	6
De 200 a más veces	7

56. Cuándo fue la última vez que aspiró o inhaló una de éstas?

Hoy o ayer	1
2 a 30 días	2
Más de 1 a 6 meses	3

Más de 6 a 12 meses	4
Más de 1 a 3 años	5

57. Alguna vez ha tratado de dejar de usar inhalantes?

Sí	1
No	2

58. Cuál de los productos que figuran en esta tarjeta ha tomado al mismo tiempo o poco después de usar un inhalante?

Alcohol	01
Pastillas para dormir como Fenobarbital	02
Estimulantes como Anfetaminas, Captagon u otros	03
Píldoras para dolor como Baralgina	04
Sedantes o relajantes como Darvon o Diazepan	05
Marihuana o hachís	06
Alucinógenos como LSD, San Isidro o Floripondio	08
Cocaína (harina blanca) o Crack	09
Opios: en polvo, morfina, codeína u otros	10
Ninguno	99

X. OPIO, HEROINA, TEMGESIC

59. Tuvo alguna vez la oportunidad de probar opio, heroína o temgesic aunque no haya probado? Qué edad tenía?

Edad	()
Nunca	99

(Si es nunca, PASAR A P. 68)

60. Probó alguna vez unos de estos productos?
- | | |
|----|---|
| Sí | 1 |
| No | 2 |
- Opio (pasta) 01
 Opio (polvo) 02
 Heroína 03
 Temgesic 04
 Codeína 05
 Codeína Clorohidrato 06
 Morfina Clorohidrato 07
 Morfina Sulfato 08
 Opic Elixir Benzoica 09
 Otros (especificar) ()
 Ninguno 99
- (Si es ninguno, PASAR A P68)
61. (Si es así:)
 Qué edad tenía?
- | | |
|-------|-----|
| Edad | () |
| Nunca | 99 |
- (Si es nunca, PASAR A P.68)
62. Cómo se usó?
- | | |
|--------------------------|-----|
| Fumándolo | 1 |
| Inhalándolo | 2 |
| Comiéndolo/Bebiéndolo | 3 |
| Inyectándose | 4 |
| Otra forma (especificar) | () |
63. Con qué frecuencia ha utilizado uno de estos productos durante los últimos 12 meses?
- | | |
|--------------------|---|
| 1 o 2 veces | 1 |
| De 3 a 5 veces | 2 |
| De 6 a 10 veces | 3 |
| De 11 a 49 veces | 4 |
| De 50 a 99 veces | 5 |
| De 100 a 199 veces | 6 |
| De 200 a más veces | 7 |
64. Alguna vez en su vida ha utilizado frecuentemente uno de estos productos?
65. Cuándo fue la última vez que usó uno de estos productos?
- | | |
|---------------------|---|
| Hoy o ayer | 1 |
| 2 a 30 días | 2 |
| Más de 1 a 6 meses | 3 |
| Más de 6 a 12 meses | 4 |
| Más de 1 a 3 años | 5 |
66. Alguna vez ha tratado de dejar de usar estos productos?
- | | |
|----|---|
| Sí | 1 |
| No | 2 |
67. Cuáles de los productos en esta tarjeta utilizó al mismo tiempo o poco después de usar opio, heroína, temgesic o algún otro de aquellos?
- | | |
|---|----|
| Alcohol | 01 |
| Pastillas para dormir como Fenobarbital | 02 |
| Estimulantes como Anfetaminas, Captagon u otros | 03 |
| Píldoras para dolor como Baraigina | 04 |
| Sedantes o relajantes como Darvon o Diazepam | 05 |
| Marihuana o hachís | 06 |
| Inhalantes: thiner, Flex, Tip Top u otros | 07 |
| Alucinógenos como LSD, San Isidro o Floripondio | 08 |
| Cocaína (harina blanca) o Crack | 09 |
| Ninguno | 99 |

XI. COCAINA

Más de 1 a 3 años 5

68. Alguna vez ha tenido la posibilidad de probar cocaína (harina blanca) o Crack aunque no lo ha probado? A qué edad?

Edad ()
Nunca 99

(Si nunca, PASAR A P. 77)

69. Probó alguna vez cocaína o Crack? A qué edad?

Edad ()
Nunca 99

(Si es nunca, PASAR A P. 77)

70. Con qué frecuencia ha usado cocaína o Crack?

Todos los días 1
5 a 6 días por semana 2
2 a 4 días por semana 3
1 día por semana 4
Menos de 1 día/semana 5

71. En qué forma utilizó uno de éstos?

Cocaína 1
Crack 2
Otro (especificar) ()

72. Alguna vez en su vida ha usado regularmente una de estas sustancias?

Sí 1
No 2

73. Cuándo fue la última vez que usó uno de éstos?

Hoy o ayer 1
2 a 30 días 2
Más de 1 a 6 meses 3
Más de 6 a 12 meses 4

74. Alguna vez ha tratado de dejar de usar cocaína o Crack?

Sí 1
No 2

75. Cuál de los productos que aparecen en esta lista usó al mismo tiempo o poco después de usar cocaína o Crack?

Alcohol 01
Pastillas para dormir como Fenobarbital 02
Estimulantes como Anfetaminas, Captagon u otros 03
Píldoras para dolor como Baralgina 04
Sedantes o relajantes como Darvon o Diazepan 05
Marihuana o hachís 06
Inhalantes: thiner, Flex, Tip Top u otros 07
Alucinógenos como LSD, San Isidro o Floripondio 08
Opios: en polvo, morfina, codeína u otros 10
Ninguno 99

XII. RIESGO DE DROGAS

77. De las siguientes sustancias, por favor indicarme las que considera las que son arriesgadas.

(LEER LAS ALTERNATIVAS Y ANOTAR LAS RESPUESTAS)

<u>Substancia</u>	<u>Sí</u>	<u>No</u>	<u>NS</u>
Bebida alcohólica	1	2	3
Marihuana	1	2	3
Sedantes	1	2	3
Hipnóticos	1	2	3
Estimulantes	1	2	3
LSD	1	2	3
Alucinógenos en general	1	2	3
Analgésicos en general	1	2	3
Cocaína	1	2	3
Heroína	1	2	3
Temgesic	1	2	3
Opio	1	2	3
Cigarros	1	2	3
Inhalantes	1	2	3

XIII. PROBLEMAS DE DROGAS

78. En los últimos 12 meses, ha tenido los siguientes problemas como consecuencia de consumir alguna de las sustancias mencionadas?

(E: LEER UNA POR UNA LAS ALTERNATIVAS Y ANOTAR LAS RESPUESTAS)

Tuvo discusiones o peleas con su familia	01
Tuvo discusiones o peleas con sus amigos	02
Tuvo problemas en el colegio, universidad, o en el trabajo	03
Se sintió muy nervioso o ansioso	04
Tuvo problemas de salud	05
Tuvo problemas con la policía	06
Solicitó ayuda médica	07
Ha sufrido accidentes	08
Ha sido víctima de asaltos o robos	09
Ha golpeado a otros	10
Ninguno	99

XIV. SOBRE TRATAMIENTO

79. Alguna vez ha estado en tratamiento por usar drogas?

Sí 1
No 2

(Si no, PASAR A P. 81)

80. Favor indicarme cuál de los siguientes lugares recibió tratamiento por usar drogas.

Hospital general (sin internarse)	1
Clínica (sin internarse)	2
Hospital (internado)	3
Hospital psiquiátrico	4
Centro de tratamiento y rehabilitación	5
Otro (especificar)	()

XV. DEMOGRAFICOS

81. Edad del entrevistado (de la primera página) ()

82. Sexo (Anotar)

Masculino 1
Femenino 2

83. Cuál es el último año o nivel de estudios que aprobó?

Ningún nivel (no fue a la escuela)	1
Algo de primaria (sin terminar)	2
Primaria completa	3
Algo de secundaria	4
Secundaria completa	5
Algo de universidad	6
Universidad completa	7

84. Cuál es su principal ocupación?

Profesional o técnico	01
Administrador, gerente o directivo	02
Oficinista, telefonista o similar	03
Comerciante o vendedor	04
Agricultor o maderero	05
Trabajador en minas	06
Trabajador en transporte	07
Oficios domésticos	08
Artesano	09
Trabajador en construcción	10
Estudiante	11
Ama de casa	12
Sin empleo	13
Prostitución (agregado)	14

85. Habla Ud. un idioma
indígena?

Sí	1
No	2

**MUCHAS GRACIAS POR SU TIEMPO Y
SU COOPERACION!**

86. Anotar entrevistador
(Lleva ropa indígena?)

Sí	1
No	2

87. Clasificación por el
supervisor (nivel
socioeconómico):

Alto	1
Mediano	2
Bajo	3
Vive en la calle	4

88. Fue necesario hacer una
segunda entrevista total
o parcialmente?

Sí	1
No	2

APPENDIX B

CLASSIFICATION OF LOCAL SUBSTANCES

Anacate	Mushroom (not hallucinogenic) <u>Canthar ellus cibarius</u>
Belladona	Leaves, roots, and fruit utilized. <u>Alropa belladonna</u>
Campana	Flowers. <u>Datura arborea</u>
Floripondio	(also Floripón and Florifún). Flowers. <u>Datura candido</u>
Parturo	(also known as Vuelve Loco) Leaves. <u>Datura stramenum</u>
Peyote	Dried buds. <u>Tophophora williamsii</u>
Pito	(often confused with marihuana, closely related) Leaves. <u>Erythema americana</u>
Plátano	(plantain) Dried leaves. <u>Musa paradisiore</u>
Quiebra cajete	Seeds. <u>Ipomosa SP</u>
San Isidro	Mushroom. <u>P.Siloqbe cubensii, S. mexicana</u>

APPENDIX C

ADDITIONAL NAMED SUBSTANCES FROM THE STUDY

Classified by Content and Strength

Mild Analgesics

Absorbine	Certal	Panadol
Acción	Desenfriol/Bisulfin	Serchin
Acetominafen	Dolofenil Panadol	Sukrol
Alka Seltzer	Focus	Tiamina 500
Anacin	Mejoral	Tylonol
Ascriptin	Nervesa	Unspecified/Analgesics
Aspirin	Nervitamina	Unspecified/Cough Symp.
Cetafen 500	Nerviton	Winsorb

Medium Strength Analgesics

(mostly for anti-rheumatism and anti-spasms)

Antagon	Ganol	Postavit
Clinoril	Lomotil	Silomat/Redotex
Conmel	Motrin	Sintavenn/Cinta Berin
Espasmo Cibalgina	Neomelubrina	Tabcin
Focal		

Strong Analgesics

(capable of producing addiction; also used as hypnotics)

Alegril/Alegrin	Dormicum/Dorminol	Dolosed
	Tranquilan	

Sedatives/Relaxants

(capable of producing addiction)

Bisulfin	Minipres	Pasiflora
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Hypnotics

(capable of producing addiction)

Lexotan

Nutritional Supplements

Essential Gripon C	Nutrison Treson	Iloban Ferrum Vital Fuerte
	Meditonic	Vitamins

Antibiotics

Pentomicina	Tetraclina	Yodoclorina
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Stimulants

Apetinorex B-Alert Brondocon	Cheraccl Fux/Fuxol Medox	Nervon Neurobion Sinsueno Touadal
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Stimulants

(generally prescribed for weight loss and wakefulness;
capable of producing addiction)

Apettinorex B-Alert Brondocon Cheracol Fuxol	Gripon C Nervon Nervotiamina Neurobion Redotex	Sinsueño Sukrol Tiamina Tofranol Tonodal
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Nutritional Supplements

(named as stimulants)

Iloban Ferrum Meditonic	Tresol Vital Fuerte	Unsp. vitamins Vigoron
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APPENDIX D
EXAMPLES OF SAMPLE CONTROLS

BICACION DE ENCUESTAS SOBRE LAS DROGAS

MUESTRA ESCUINTA

SECTOR	CASAS SECTOR	MANZANAS EN SECTOR	NUMERO MZ	DESCRIPCION DE LA MANZANA	CASAS EN MANZANA	MULTI-FAMILIAR	MUESTRA
4	100	6	30	"Carlos Hernandez" con ferrocarril	12		4
7	200	20	31	11 Av., 12 Av., 7a. calle "B" 5a. calle "A"	12		4
			032	12 Av., 11 av. A, 4a. calle A, 5a. calle A	6		13
10	150	5	033	1a. Av. 5a. calle, 6a. calle, calle hacia puente	43		14
11	150	0	034	MZ triangular, entrada lado no. frente vivienda multifamiliar	6		2
			035	7a. calle, frente a una iglesia.	21		7
15	100	1	036	Colonia San Pedro, Este una pila publica			
				Oeste 2a. calle, puente sobre no. 2 pilas	44		15
17	200	9	037	2a. calle, 3a. calle, 4a. av. y 6a. av.	30		10
			038	2a. Av., 3a. Av., "N. Mazariegos".	13		4
			039	3a. calle, frente a una iglesia.	21		7
23	150	10	040	1a. calle, 2a., calle, 3a. avenida callejoncito	10		6
			041	2a. av., 2a. calle, Av. Centro America, frente a una iglesia.	12		4
35/38	100	4	042	Frente a ferrocarril, otro lado de la calle hacia un puente, contiene fabrica	22		7
37/38	150	14	043	Colonia Palmeras del Sur, 1a. Av. Av. del ferrocarril, 2a. calle, y callejoncito	10		3
			044	2a. calle, 1a. Av., y 2a. Av.		2	7
	1440	85			288	2	98

CONTROL DE ENCUESTAS

Escuintla

<u>No. OO</u>	<u>No. Mz.</u>	<u>Encuestador</u>	<u>Supervisor</u>	<u>Entrada</u>
0174	<u>038</u>	<u>CAL</u>	<u>SZ</u>	<u>LM</u>
0175	<u>037</u>	<u>VJLC</u>	<u>SZ</u>	<u>JOHNNY</u>
0176	<u>039</u>	<u>EIRG</u>	<u>SZ</u>	<u>JOHNNY</u>
0177	<u>037</u>	<u>EGR</u>	<u>SZ</u>	<u>JOHNNY</u>
0178	<u>039</u>	<u>EGR</u>	<u>SZ</u>	<u>LM</u>
0179	<u>037</u>	<u>EGR</u>	<u>SZ</u>	<u>LM</u>
0180	<u>038</u>	<u>JETCh</u>	<u>SZ</u>	<u>LM</u>
0181	<u>040</u>	<u>JETCh</u>	<u>SZ</u>	<u>JOHNNY</u>
0182	<u>038</u>	<u>VJLC</u>	<u>SZ</u>	<u>JOHNNY</u>
0183	<u>038</u>	<u>VJLC</u>	<u>SZ</u>	<u>JOHNNY</u>
0184	<u>038</u>	<u>VTC</u>	<u>MP</u>	<u>LM</u>
0185	<u>040</u>	<u>VTC</u>	<u>MP</u>	<u>LM</u>
0186	<u>037</u>	<u>VJLC</u>	<u>SZ</u>	<u>LM</u>
0187	<u>041</u>	<u>EIRG</u>	<u>SZ</u>	<u>LM</u>
0188	<u>031</u>	<u>EIRG</u>	<u>SZ</u>	<u>LM</u>
0189	<u>041</u>	<u>VTC</u>	<u>SZ</u>	<u>LM</u>
0190	<u>037</u>	<u>CAL</u>	<u>SZ</u>	<u>JOHNNY</u>
0191	<u>032</u>	<u>JETCh</u>	<u>SZ</u>	<u>JOHNNY</u>
0192	<u>032</u>	<u>EIGR</u>	<u>MP</u>	<u>JOHNNY</u>
0193	<u>032</u>	<u>EIGR</u>	<u>MP</u>	<u>JOHNNY</u>
0194	<u>033</u>	<u>EIGR</u>	<u>MP</u>	<u>JOHNNY</u>
0195	<u>041</u>	<u>VTC</u>	<u>SZ</u>	<u>JOHNNY</u>
0196	<u>035</u>	<u>EIGR</u>	<u>SZ</u>	<u>JOHNNY</u>
0197	<u>040</u>	<u>VJLC</u>	<u>SZ</u>	<u>LM</u>
0198	<u>032</u>	<u>VJLC</u>	<u>SZ</u>	<u>LM</u>
0199	<u>033</u>	<u>EIGR</u>	<u>MP</u>	<u>LM</u>
0200	<u>030</u>	<u>EIGR</u>	<u>MP</u>	<u>JOHNNY</u>
0201	<u>033</u>	<u>VJLC</u>	<u>SZ</u>	<u>JOHNNY</u>
0202	<u>033</u>	<u>VJLC</u>	<u>SZ</u>	<u>LM</u>
0203	<u>030</u>	<u>CAL</u>	<u>SZ</u>	<u>JOHNNY</u>
0204	<u>033</u>	<u>CAL</u>	<u>SZ</u>	<u>LM</u>
0205	<u>030</u>	<u>CAL</u>	<u>MP</u>	<u>LM</u>
0206	<u>033</u>	<u>JETCh</u>	<u>SZ</u>	<u>JOHNNY</u>
0207	<u>030</u>	<u>JETCh</u>	<u>MP</u>	<u>JOHNNY</u>
0208	<u>034</u>	<u>JETCh</u>	<u>SZ</u>	<u>JOHNNY</u>
0209	<u>030</u>	<u>VTC</u>	<u>SZ</u>	<u>LM</u>
0210	<u>033</u>	<u>VTC</u>	<u>SZ</u>	<u>LM</u>
0211	<u>033</u>	<u>VTC</u>	<u>SZ</u>	<u>LM</u>
0212	<u>034</u>	<u>CAL</u>	<u>SZ</u>	<u>LM</u>
0213	<u>036</u>	<u>CAL</u>	<u>SZ</u>	<u>JOHNNY</u>
0214	<u>036</u>	<u>CAL</u>	<u>MP</u>	<u>LM</u>

ETC. to 0268...

APPENDIX E

DIRECTORY OF PREVENTION INSTITUTIONS

As a potential aid to future efforts to begin and/or expand educational services with institutions that might collaborate in a campaign against drug abuse, a preliminary directory of the studied institutions is presented herein. While some of the information may change over time, it should provide useful contacts for any future actions.

Asesoramiento, Orientación y Prevención de Drogadicción
(ASORPRED)

NAME: Counselling, Orientation, and
Prevention in Drug Addiction

CONTACT: Lic. Edgar Palala

ADDRESS: 1a. calle 6-26, zona 1

TELEPHONE: 20221

FORMATION DATE: 1985

History: Lic. Palala, after working in two other drug prevention programs, decided to form a special organization dedicated to the prevention of drug abuse and the treatment of addicts. In addition to its recruitment of church members, the association provides individual and group orientation to youths and parents. A number of other persons work as volunteers in the program.

General Characteristics: Legal status application in process. Has a board of directors, one salaried person, and 15 volunteers.

Educational Materials: The design is being initiated.

Finance: Individual and church donations.

Type of Services: Dissemination of church information, education and information on the danger of drugs, professional orientation to youth and adults.

Projects: Clamor Juvenil: youth sports activities; spiritual retreats and meetings for national schools. Juventud sin Drogas: talks on risks of drug use in 4 national schools; counseling for children, youth, and adults.

Future Projects: broaden present projects; found a rehabilitation center; create other affiliates in Central America; construct an educational complex.

* * *

Asociación Nacional para la Prevención, Investigación
y el Tratamiento de las Adicciones
(ANAPRE)

NAME: National Association for the Prevention, Research, and Treatment of Addictions

CONTACT: Lic. Mariano Codoñer

ADDRESS: 12 Calle "A" 15-25, zona 1

DEPARTMENT: Guatemala

TELEPHONE: 25011

FORMATION DATE: 1989

History: Professionals from different disciplines with interest and experience in drug use prevention decided to form a group to collaborate in the solution of problems such as drug consumption.

General Characteristics: Legal status in process. There are 8 associates and a board of directors.

Educational Materials: Pamphlets designed but not yet published.

Type of Services: Technical advice on the development of educational materials; training for professionals; seminars for university students.

Finance: Has no outside funding; associates support the institution through contributions.

Projects: Organize seminars with professionals; continue support of the Chamber of Industry; give advice on the design and content of pamphlets directed to adolescents and parents.

Future Projects: Medium term realization of epidemiological research; long term: develop programs for addicts.

* * *

Asociación para el Desarrollo del Potencial Humano
(ADEPH)

NAME: Association for the Development
of the Human Potential

CONTACT: Lic. Anibal Velásquez

ADDRESS: 4a. Calle 16-10, zona 3

DEPARTMENT: Quetzaltenango

FORMATION DATE: 1989

History: Because of interest among the members of the Lions Club of Quetzaltenango, the Association initiated informational activities on substance abuse.

General Characteristics: Legal status possessed. Principal development of the project was carried by the micro enterprise group and implementation of activities was spurred by the directives from the International Lions Club.

Educational Materials: Pamphlets and flyers developed with the assistance of the Foundation for the Prevention of Drug Addiction of Guatemala City.

Type of Services: Psychological, informational, and educational.

Finance: Quotas paid by the micro enterprise beneficiaries when they receive services.

Projects: Psychological and personnel development for micro entrepreneurs; individual and group orientation; talks, seminars, and conferences for students, parents, teachers, and professionals on drug abuse prevention in 1989.

Future Projects: Reactivate the activities on drug consumption prevention that were suspended due to the lack of time and financial resources.

* * *

Cámara de Industria de Guatemala
Programa de Prevención de Consumo de Drogas

NAME: Chamber of Industry of Guatemala
Program for the Prevention of
Drug Consumption

CONTACT: Dr. Luis Eduardo Morales
 ADDRESS: Ruta 6, 9-21 zona 4
 Edificio Cámara de Industria
 Nivel 12.
 DEPARTMENT: Guatemala
 TELEPHONE: 340849 al 56
 FORMATION DATE: 1988

History: Conscious of national problems, the Chamber of Industry of Guatemala decided to contribute to education, family development, and specifically to the prevention of drug consumption.

General Characteristics: Legal status possessed. Salaried staff includes professionals and one for administrative support for the drug program.

Educational Materials: Pamphlets and flyers to support the educational workshops offered; a video to promote the program.

Type of Services: Information and education for children, youth, and parents in educational institutions and in business establishments; information and training for teachers and other professionals.

Finance: Support from the Chamber of Industry of Guatemala, individual businesses, and membership dues.

Projects: Educational workshops in schools that request them; educational workshops for businesses; seminars for educators and other professionals.

Future Projects: Broaden the coverage of the present activities; develop more educational materials.

* * *

Club de Leones de Guatemala

NAME: Lions Club of Guatemala
 CONTACT: Carlos Guzmán
 ADDRESS: 13 Av. 20-40, zona 1
 DEPARTMENT: Guatemala
 TELEPHONE: 81931

FORMATION DATE: 1989

History: The International Lions Club is concerned with the problems of youth and decided to begin a campaign called "No to Drugs" through its member clubs of young Lions. This initiative was joined with great enthusiasm by the clubs in Guatemala.

General Characteristics: It possesses its legal status in Guatemala. It has one professional and the youth members develop the program for the prevention of drug use.

Educational Materials: T-shirts, caps, and cassettes with the messages on prevention of the consumption of drugs.

Types of Services: National dissemination on raising the consciousness of the drug problems; talks at schools.

Finance: Proceeds from the sale of the dissemination campaign articles and from other club activities.

Projects: National campaign "No a las Drogas" in 1989; a national contest for students with songs, speeches, and special drug prevention subjects in 1989; talks by members and the coordinator to school audiences.

Future Projects: Continue organizing dissemination projects on information about drugs.

* * *

Consejo Nacional de Prevención del Alcoholismo
y la Drogadicción

NAME: National Council for the Prevention
of Alcoholism and Drug Addiction

CONTACT: Carlos Arenas

ADDRESS: 7a. Av. 1-17, zona 4
Edificio INGUAT, 10 nivel

DEPARTMENT: Guatemala

TELEPHONE: 311333 EXT. 244

FORMATION DATE: 1989

History: The National Council was created as a dependency of the Presidency by Government Decree No. 950-89. Previously, the National Commission for the Prevention of Alcohol and Drug

Addiction functioned in this field; it provided the basis for the present council.

Type of Services: Coordination of public and private institutions concerned with the problem of drugs. The coordination is realized via advisory meetings, seminars, and workshops.

Type of Organization: The Council is presently composed of 9 representatives of government organisms and from 17 private institutions. The Council has a coordinator and a secretary.

Finance: Government support for administrative costs.

Projects: Integration of the Council with all of the institutions working in the field.

Future Projects: Disseminate the Council activities. Collect information; unify communications and information criteria to help standardize dissemination messages; promote the development of accurate statistics.

* * *

Fundación de Orientación Social
(FUNORSO)

NAME: Foundation for Social Orientation
CONTACT: Manfredo Jacobs
ADDRESS: Diagonal 3, 3-23, zona 8
DEPARTMENT: Quetzaltenango
FORMATION DATE: 1986

History: As a result of personal experiences, Mr. Jacobs brought together professionals in order to provide orientation to the youth of Quetzaltenango and thereby avoid the consumption of drugs.

General Characteristics: Legal status in process. The Foundation has a small group of volunteer professionals that carry out all of the activities.

Educational Materials: Flyers and pamphlets.

Type of Services: Evangelical orientation; drug addiction prevention orientation; information for school age youth; treatment and rehabilitation of addicts.

Finance: Has no finance. Supports the activities through individual donations.

Projects: Forums and talks in schools and for other groups that request them; treatment and rehabilitation of addicts; talks and orientation for the church members; orientation for individuals and groups in homes.

Future Projects: Continue with the present projects if finance is obtained.

* * *

Fundación Preventiva de la Drogadicción

NAME: Foundation for the Prevention of Drug Addiction

CONTACT: Raymond J. Wennier

ADDRESS: 10 Av. 10-50, zona 14

TELEPHONE: 37045/371931

DEPARTMENT: Guatemala

FORMATION DATE: 1989

History: A group of professionals with individual experience in the different areas of drug addiction prevention, treatment, and rehabilitation decided to create the Foundation in order to coordinate efforts.

General Characteristics: The Foundation possesses its legal status. It has 20 associates organized in a board of financial and program collaborators.

Educational Materials: Curriculum for training teachers and parents; not yet published.

Type of Services: Seminars for professionals, teachers, community leaders, and parents; design the curriculum for training teachers and parents.

Finance: Individual contributions by the associates; because of insufficient finances it has not been able to develop its activities and materials.

Projects: Survey of opinions of drug use in Guatemala City in 1985; pilot study in educational centers in the capital in order to plan a national epidemiological study; pilot research Study.

Future Projects: Carry out the national epidemiological study; obtain an office where information can be transmitted by telephone and via courses on drug subjects; publish a curriculum for training teachers and parents on prevention; design, adapt, and publish materials; offer technical advisory services to other institutions; obtain funding for these projects.

* * *

Juventud para Cristo

NAME: Youth for Christ
 CONTACT: Uriel García
 ADDRESS: Av. Reforma 8-95, zona 10
 Condominio Avenida
 DEPARTMENT: Guatemala
 TELEPHONE: 320134
 FORMATION DATE: 1984

History: The organization is an affiliate of the international Evangelical movement that operates in 100 countries. For the last three years, the local organization has directed and provided its own support for the Guatemalan program.

General Characteristics: Legal status in process. It has a consulting committee, two salaried positions, and 36 young volunteers.

Educational Materials: Some are in the design stage.

Type of Services: Disseminate Evangelical doctrine to youth; provide educational information to youth and church members; orientation for gang members (mara) and in correctional centers for young offenders.

Finance: Donations from church members.

Projects: Youth Clubs for Christ in 13 educational establishments to spread the Evangelical doctrine; give talks on diverse themes of youth interest; emphasize avoiding drug consumption; camps for organizational, religious, recreational, and educational activities for youth; support the church through talks at meetings of youth in the capital; orientation and information for gang members and youth in correctional institutions.

Future Projects: Continue the development of the present projects if financial assistance is obtained.

* * *

Ministerio de Salud Pública,
División de Atención a las Personas,
Departamento de Salud Mental

NAME: Ministry of Public Health, Personal
Attention Division, Mental Health
Department

CONTACT: Licda. Dina Valle

ADDRESS: 9a. Av. 14-65, zona 1

DEPARTMENT: Guatemala

TELEPHONE: 21801/536071/712280

FORMATION DATE: 1984

History: Through the initiative of the Department personnel and in reply to identified needs within the population served by the health posts of the Ministry, a component of drug use prevention was added to the regular programs.

General Characteristics: The program has 7 members, 2 of which have administrative duties and 5 who are professionals (psychologists, psychiatrists, and social workers). They work in the capital and in other areas of the country.

Type of Services: Training courses for medical and paramedical personnel; advisory services to government and private institutions.

Finance: Government support for administrative costs.

Projects: Training for medical and paramedical personnel in all the health centers and posts in the nation; collaborate with the National Council on the preparation of curricula for students in conjunction with the Ministry of Education.

Future Projects: Train the health monitors on the prevention of drug abuse, as well as teachers, community leaders, and the health orientation and provision personnel in health; plan specific work tasks; train National Police monitors and Youth Patrols.

* * *

Policia Nacional, Sección de Menores

NAME: National Police, Minors Section
 CONTACT: Oficial Roberto Marroquín Urbina
 ADDRESS: Sub-Dirección General de Policía
 Nacional 6a. Av. y 13 calle zona 1
 DEPARTMENT: Guatemala
 TELEPHONE: 20221
 FORMATION DATE: 1989

History: The National Police initiated this program for the prevention of drug addiction among children and teenage youth who have access to drugs and for delinquent groups of youths.

General Characteristics: The program has 3 administrators and 37 street educators; all of the staff members are salaried.

Educational Materials: Matchbook cover messages, pamphlets, and flyers.

Type of Services: Dissemination, information, and education for school children, working children, teachers, and parents.

Finance: Government support for administrative costs and donations from the private sector.

Projects: Street Education Program, school programs, programs in the interior of the country, and a dissemination campaign.

Future Projects: Expand the services to the entire nation.

* * *

Radio Ritmo FM

NAME: Radio Rhythm FM
 CONTACT: Luis Enrique Varillas
 ADDRESS: 6a. Av. 3-45, zona 1
 TELEPHONE: 381-801
 DEPARTMENT: Escuintla
 FORMATION DATE: 1990

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History: Conscious of the problems related to drugs that confront youth, and because the youth of the population are the primary audience of its weekend programming, the station decided to initiate the transmission of educational messages on this theme.

General Characteristics: As a part of the regular programming of the station, the messages about drug addiction were developed and broadcast within the main youth attraction programs, those of popular music. The messages are aired at night and on weekends.

Educational Materials: None.

Type of Services: Messages on musical programs for all audiences but especially directed toward youth.

Finance: Resources of the radio station.

Projects: Disseminate information on drug abuse prevention.

Future Projects: Acquire educational materials to enrich the content of the messages; train the station personnel so they can broaden their message broadcasts; help organize a community conference on drug abuse if an organization can provide the professional personnel.

APPENDIX F

Differences Required for Significance at the .05 Level

Size of Samples Compared	Approximate Size of Both Estimates						
	10% or 90%	20% or 80%	25% or 75%	30% or 70%	35% or 65%	40% or 60%	50%
2000 and 2000	2.3%	3.1%	3.4%	3.6%	3.7%	3.8%	3.9%
1800	2.4%	3.2%	3.4%	3.6%	3.8%	3.9%	4.0%
1600	2.5%	3.3%	3.6%	3.8%	3.9%	4.0%	4.1%
1500	2.5%	3.3%	3.6%	3.8%	4.0%	4.1%	4.8
1400	2.6%	3.4%	3.7%	3.9%	4.1%	4.2%	4.3%
1300	2.6%	3.5%	3.8%	4.0%	4.2%	4.3%	4.4%
1200	2.7%	3.6%	3.9%	4.1%	4.3%	4.4%	4.5%
1100	2.8%	3.7%	4.0%	4.2%	4.4%	4.5%	4.6%
1000	2.8%	3.8%	4.1%	4.3%	4.5%	4.6%	4.7%
900	3.0%	3.9%	4.3%	4.5%	4.7%	4.8%	4.9%
800	3.1%	4.1%	4.4%	4.7%	4.9%	5.0%	5.1%
700	3.2%	4.3%	4.7%	4.9%	5.1%	5.3%	5.4%
600	3.4%	4.6%	4.9%	5.2%	5.4%	5.6%	5.7%
500	3.7%	4.9%	5.3%	5.6%	5.8%	6.0%	6.1%
450	3.8%	5.1%	5.5%	5.9%	6.1%	6.3%	6.4%
400	4.0%	5.4%	5.8%	6.1%	6.4%	6.6%	6.7%
350	4.3%	5.7%	6.1%	6.5%	6.8%	7.0%	7.1%
300	4.6%	6.1%	6.6%	7.0%	7.2%	7.4%	7.6%
250	4.9%	6.6%	7.1%	7.5%	7.8%	8.1%	8.2%
200	5.5%	7.3%	7.9%	8.3%	8.7%	8.9%	9.1%

APPENDIX G**REFERENCE DOCUMENTS**

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APPENDIX H
SUPPLEMENTARY TABLES

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Legend for Tables H.1, H.2, H.3, H.4

(Legend: 1=mild analgesics; 2=medium strength analgesics; 3=strong analgesics; 4=antibiotics; 5=nutritional supplements; 6=stimulants; 7=sedatives 8=hypnotics. See Appendix C for classified lists.)

**Table H.1
Distribution of All Substances Named by Respondents as Analgesics**

<u>Substance</u>	<u>#</u>	<u>%</u>	<u>Substance</u>	<u>#</u>	<u>%</u>
Nervesa (1)	4	.2	Focus (1)	62	3.4
Ascriptin (1)	3	.2	Alka Seltzer (1)	13	.7
Neomelobrina (2)	8	.4	Ganol (2)	7	.4
Focal (2)	1	.1	Accion (1)	7	.4
Cetafen 500 (1)	5	.3	Nervitamina (1)	1	.1
Tranquilan (3)	1	.1	Dolofenil (1)	6	.3
Nerviton (1)	1	.1	Silomat (2)	1	.1
Tiamina (1)	1	.1	Aspirin (1)	220	12.2
Panadol (1)	36	2.0	Neurobion (6)	4	.2
Tylenol (1)	8	.4	Pasiflora (7)	1	.1
Absorbine (1)	1	.1	Winasorb (1)	29	1.6
Fux (6)	1	.1	Cinta Berin (2)	1	.1
Conmel (2)	10	.6	Tabcin (2)	17	.9
Yodoclorina (4)	3	.2	Certal (1)	3	.2
Motrin (2)	9	.5	Tetraciclina (4)	4	.2
Tonadal (6)	1	.1	Calmante (1)	4	.2
Espasmo			Clinoril (2)	1	.1
Cibalgina (2)	26	1.4	Lomotil (2)	1	.1
Anacin (1)	5	.3	Mejoral (1)	7	.4
Asetaminofen (1)	11	.6	Vitamins (5)	3	.2

Table H.2
Distribution of All Substances Named by Respondents as Sedatives

<u>Substance</u>	<u>#</u>	<u>%</u>	<u>Substance</u>	<u>#</u>	<u>%</u>
Nervesa (1)	23	1.3	Focus (1)	4	.2
Dormicum (3)	1	.1	Medox (6)	2	.1
Nervitamina (1)	7	.4	Tranquilan (3)	16	.9
Dolosed (3)	1	.1	Dolofenil (1)	1	.1
Nerviton (1)	5	.3	Silomat (2)	1	.1
Baralgin (2)	1	.1	Tiamina 300 (1)	5	.3
Aspirin (1)	1	.1	Panadol (1)	1	.1
Neurobion (6)	14	.8	Pasiflora (7)	2	.1
Motrin (2)	1	.1	Tetraciclina (4)	1	.1
Calmante (1)	5	.3	Espasmo		
Lomotil (2)	1	.1	Cibalgina (2)	1	.1
Asetaminofen (1)	1	.1	Vitamins (5)	2	.1
Sukrol (1)	3	.2	Nervon (6)	2	.1
Postavit (2)	2	.1	Brondocon (6)	2	.1
Cheracol (6)	2	.1	Gripon C (5)	1	.1
Diazepan (7)	1	.1	Bisulfin (7)	1	.1
Essential (5)	2	.1	Minipres (7)	1	.1

Table H.3
Distribution of All Substances Named by Respondents as Hypnotics

<u>Substance</u>	<u>#</u>	<u>%</u>	<u>Substance</u>	<u>#</u>	<u>%</u>
Nervesa (1)	49	2.7	Focus (1)	1	.1
Nervitamina (1)	5	.3	Tranquilan (3)	3	.2
Frisium (7)	2	.1	Tiamina 300 (1)	2	.1
Panadol (1)	1	.1	Pasiflora (7)	1	.1
Sinsueño (6)	1	.1	Espasmo		
Sukrol (1)	1	.1	Cibalgina (2)	1	.1
Diazepan (7)	5	.3	Alegrin (3)	2	.1
Essential (8)	1	.1	Lexotan (8)	1	.1

APPENDIX I**RESEARCH STAFF**Central Office

Lissette G. de Mancilla, Secretary
 Miguel Pellecer Barrios, Driver
 Miguel Pellecer Cruz, Driver
 Marco Tulio Herrera, Driver and Data Controller
 Johnny Barricos, Data Entry Specialist
 Ing. Byron Ponce, Programmer

Supervisors

Lic. Carlos Maldonado, Landívar University, Quetzaltenango
 Lic. Julio César Arriola, Landívar University, Guatemala
 Lic. Arlina V. de Sánchez, Landívar University, Guatemala
 Sergio Zamora, Consultores Agroindustriales
 José Enrique Peralta, Consultores Agroindustriales
 Manuel Bernardo Valdez, Consultores Agroindustriales

Interviewers

Marta E. Estrada, Landívar University, Guatemala
 Josefina T. de Figueroa, Consultores Agroindustriales
 C. Antonieta López, Landívar University, Guatemala
 Hector Gutiérrez, Consultores Agroindustriales
 Vilma Janeth Contreras, Landívar University, Guatemala
 Werner Estuardo Muñiz, Consultores Agroindustriales
 Diliam C. Gómez, Landívar University, Quetzaltenango
 Fabian Tubac Larios, San Carlos University
 M. Lisseth P. de Palacios, Consultores Agroindustriales
 Lesvia Sánchez, Landívar University, Guatemala
 Mario R. Porras, Consultores Agroindustriales
 Juan E. Tzuc C., Landívar University, Quetzaltenango
 Francisco Sáenz, Consultores Agroindustriales
 Victor E. Tzul C., Landívar University, Quetzaltenango
 Hugo R. Palacios, Guatemalan Association for Sexual Education
 Carlos E. Gómez R., Landívar University, Quetzaltenango
 Juan Patricio Trujillo, Landívar University, Guatemala
 Edna Z. Rivera G., Landívar University, Guatemala
 Clara L. de López, Landívar University, Guatemala
 Lic. M. Oralia R. de Rufz, Landívar University, Quetzaltenango

Table H.4
Distribution of All Substances Named by Respondents as Stimulants

<u>Substance</u>	<u>#</u>	<u>%</u>	<u>Substance</u>	<u>#</u>	<u>%</u>
Nervesa (1)	4	.2	Focus (1)	1	.1
Alka Seltzer (1)	1	.1	Tofranol (5)	1	.1
Nervitamina (2)	1	.1	Apetinorex (6)	2	.1
Redotex (1)	1	.1	Vital Fuerte (5)	6	.3
Tiamina 300 (1)	26	1.4	Neurobion (6)	1	.1
Sinsueño (6)	10	.6	Tresol (5)	2	.1
Serchin (1)	1	.1	Winasorb (1)	1	.1
Tetraciclina (4)	1	.1	Calmante (1)	1	.1
Vitamins (5)	28	1.5	Sukrol (1)	5	.3