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NARCOTICS AWARENESS AND
EDUCATION PROJECT

SURVEY ON DRUG PREVALENCE AND ATTITUDES IN THE DOMINICAN REPUBLIC

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The Narcotics Awareness and Education (NAE) Project is designed to strengthen the capabilities of LDC institutions to design, implement and evaluate effective drug awareness and prevention programs. The project focuses on drug demand reduction through public awareness and education. Key to the overall project strategy are activities that: generate an understanding of the nature and extent of drug abuse in a given country; develop public awareness of the problem among government policy makers, opinion leaders and the general public and of the importance of implementing comprehensive prevention programs before the drug problem gets out of hand; and assist in obtaining the support of key national leaders and institutions to develop and effectively implement national prevention strategies. Among the technical support services involved in the project strategies are research, information dissemination, and policy dialogue.

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EXECUTIVE SUMMARY

The purpose of this study is to lay the foundation for future interventions to prevent use, that would be appropriate to the Dominican context. The study consists of two separate research efforts: a national survey and a focus group study. The survey covers the full range of psychoactive substances from alcohol and tobacco to cocaine hydrochloride and "crack" considered to be available in the Dominican Republic. The survey is based on a probability sample of the country's urban population (municipalities over 20,000). The study took place from October, 1991 to April, 1992.

Main Findings

Regarding Prevalence

- Illicit drug use in urban areas of the Dominican Republic is considerably lower than in urban areas of other Latin American and Caribbean countries (e.g., Panama, Peru, Guatemala, Haiti).

- Alcohol and tobacco have the highest prevalence of all psychoactive substances.

- Comparing urban areas, Santo Domingo has the highest lifetime and current use (last 30 days) of alcohol and marijuana, and the highest current use of cocaine, while mid-sized cities have the highest lifetime and current use of inhalants and small-sized cities have the highest lifetime use of crack.

- Men are more likely than women to be current and lifetime users of illicit drugs, while women are more likely than men to have used pharmaceuticals.

- Lifetime and current use of inhalants are greatest among the youngest age groups (12-24).

- Persons ages 20-29 are more likely than persons in other age groups to have tried marijuana and cocaine.

- More than half of first use of inhalants occurred before age 15. Most of first use of marijuana and cocaine occurred between ages 15-24, whereas all crack use started between ages 15-19.

- Lifetime and current use of marijuana are similar across social classes.

- Measures of frequency of illicit drug use indicate that marijuana, cocaine and crack have a greater intensity of use than inhalants.

Regarding Awareness

- The majority of urban Dominicans considered both drug consumption and drug trafficking as serious problems.

- The majority have seen or heard a message concerning drug issues in the month prior to being interviewed.

- Television was the most common source of information.

- Dominicans who are in the oldest age group studied (35-45), who live in Santo Domingo, or who belong to the upper class are most likely to have received a drug-related message via any source of information.

Regarding Attitudes/From Focus Groups

- This study suggests that dramatic content and realism are key elements of effective messages, particularly for adolescents of lower and middle class origin.

- The study indicated the importance of tailoring messages to the cultural values and norms of Dominicans, to their approach to inculcating norms regarding behavior, and to their perceptions of reality.

Regarding Attitudes/From the Survey

Alcohol and Tobacco

- The levels of intention to quit tobacco and reduce consumption of alcohol are both high. This means that there are favorable conditions for the reduction of both activities.

- Heavy alcohol users demonstrate the highest level of intention to use other substances and perceive that other substances have more positive effects and sense more social pressure to use those substances.

Crack and Inhalants

- People are not in general, motivated to try marijuana, cocaine and crack.

- Comparing marijuana to the other substances, we note a smaller proportion of subjects who consider that its use will produce negative effects, as well as less of a sense of normative coercion.

- The group that expressed positive intentions towards the use of these substance are young males between the ages of 15 and 29 principally belonging to the "lower" economic stratum.

Populations at Risk for Drug Use

Based on the findings from this study, the principal populations at risk for drug use in the Dominican Republic can be defined as follows:

- **Alcohol and Tobacco** -- Young men ages 12-19 in Santo Domingo and mid-sized cities.

- **Pharmaceuticals** -- Young women ages 15-29.

- **Marijuana, Cocaine and Crack** -- Blue collar or unemployed young men ages 15-24 in Santo Domingo who have less than secondary education.

- **Inhalants** -- Students ages 12-19.

Summary

This study indicates that a major illicit drug use problem does not exist in municipalities of the Dominican Republic at this time. However, because there is a high level of illicit drug use among the younger population, and because the use of marijuana and cocaine among that portion of the population reporting use is quite frequent and apparently increasing, there is a great potential for a rapid expansion of the use of marijuana and cocaine. The use of inhalants among the youngest age groups also is apparently increasing. The study suggests that current efforts at primary prevention of drug use are weak. Those who are at greatest risk (i.e., younger persons) are least likely to be aware of the problem. Moreover, the study underscores the need for messages directed to audiences in terms that are culturally appropriate and properly targeted by age and class background.

Recommendations

Given that the use of illicit substances such as marijuana, cocaine and crack, is not widespread at present, efforts need to focus on primary prevention: action that is directed at preventing the onset of large scale drug use. This requires a clear definition of target audiences, the formulation of specific, measurable, attainable, realistic and time-bound objectives, the development of appropriate messages that educate, motivate and persuade the target audience, the identification of appropriate channels to transmit the messages and the evaluation of the results to provide feedback for future efforts. The study described in this report provides the necessary basis to define many of these key elements. Thus, we make the following recommendations:

Regarding Target Groups

- Primary prevention programs need to be strengthened and directed at future high risk target groups, e.g., males under the age of twelve.

- Primary prevention needs to be undertaken in a national context and not just in the largest urban centers.

- Primary prevention needs to focus on all social classes, although with different types of messages.

- Target populations should be segmented, placing emphasis on the groups that show the highest levels of positive intentions toward consumption.

Regarding Messages

- Primary prevention messages need to be subject to research procedures (e.g. use of focus groups) to pretest message content for cultural appropriateness and relevance to the target audience, as well as to post-test message impact on those audience.

- Awareness and education efforts need to build on the existing minimal understanding of the dangers of drug trafficking and use, by amplifying the sort of information provided and more carefully targeting high risk groups.

Regarding Media

- Use of the family as an integral part of prevention efforts would strengthen those efforts.

- Television needs to be an important channel for primary prevention efforts. Efforts should include use of regular programming as well as advertising.

Regarding Additional Requirements for Formative Research

- Given the low levels of prevalence, a follow-up prevalence study need not be undertaken for at least two years.

- Prevalence research in the general population needs to be supplemented by prevalence research in high-risk populations, through schools, street ethnography, case histories and other studies of special universes.

- Prevalence research needs to be conducted with careful attention to scientifically tested and accepted standards of definition of variables and field procedures.

Regarding Campaign Objectives

Given the current low levels of prevalence, specific campaign objectives need to focus on primary prevention. Campaigns need to be directed at preserving the high numbers of non-users, and at doing nothing to unintentionally provoke expanded interest in drug use. Measurable objectives need to focus on fortifying the intentions of users to reduce alcohol use, eliminate smoking and avoiding the use (not trying) of marijuana, cocaine, crack and inhalants. Specific objectives need to be defined in terms of the resources available for campaigns.

Current low levels of prevalence provide the necessary breathing space for action, but the relationship of high levels of alcohol use and the intention to use other substances suggest that a failure to engage in primary prevention as soon as possible may lead to ever increasing levels of use.

CHAPTER I

THE SCOPE OF THE STUDY

A. Introduction

A first step in dealing with a problem is to understand its dimensions. In the case of drug use in the Dominican Republic, there has not been to date any comprehensive study that examined drug use or prevalence at a national level in the broadest possible context. The study presented here seeks to take such a comprehensive approach by looking at both the extent of drug use among the population in urban areas, and the attitudes of Dominicans toward approaches that can be taken to prevent use. The purpose of this study is to lay the foundation for future interventions to prevent use, that would be appropriate to the Dominican context.

The study described here consists of two separate research efforts: a national survey and a focus group study. The survey provides a description and analysis of the prevalence of drug use at the national level, as a first step in a systematic approach to dealing with drug abuse in the Dominican Republic. Because it is an initial view of the situation, it is as comprehensive as possible within the scope of available resources and information regarding the context of the problem. It covers the full range of psychoactive substances from alcohol and tobacco to prescription drugs to the derivatives of the coca plant--cocaine hydrochloride and "crack" considered to be available in the Dominican Republic according to local experts. To assure complete coverage of all substances, a set of questions was included regarding "other substances" that the respondent might have used which were not specifically included in the questionnaire.[1] The survey is based on a probability sample of the country's urban population (municipalities over 20,000), and draws on over 20 years of international experience in the design of epidemiological studies of the phenomena of drug use and abuse. The details of the survey design and methods are explained in Chapter II. The balance of this chapter explores the context of drug abuse in the Dominican Republic.

B. Background

Although there are isolated references to drug use of some type or other dating back to the days of Columbus, there is no historical evidence prior to recent decades of serious drug consumption in the Dominican Republic. In 1967 a shipment of cocaine was intercepted on its way to international markets. This was the beginning of a series of interdictions that indicated that the

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1 Only 0.3% of the respondents mentioned another substance, too small a number to consider of any significance.

Dominican Republic was fast becoming a transit country between the producing countries and the United States and Europe. With U. S. support, GODR officials increased their efforts to interdict in-transit shipments. Publicity of these interdiction efforts, coupled with an increase in the number of arrests for drug possession or use, have resulted in declarations by the news media and claims by interested individuals that drug use is increasing in the Dominican Republic.

Opinions on the drug problem in the Dominican Republic range from "slight" to "very serious." GODR agencies perceive that there is a problem and are working to address it. Some official agencies and their representatives claim that consumption is not a problem. Private sector individuals working in the poorest sections of Santo Domingo, however, claim that the problem is serious. They argue that government enforcement agencies fail to acknowledge and address blatant examples of drug trafficking and consumption. Regardless of the range of opinions, it is clear that some elements within the government and in the private sector do recognize that there is a problem which needs to be addressed.

While there is no question that drug use is increasing as is evident by treatment statistics,[2] claims that drug use has reached specific levels (numbers of addicts or drug users) are not based on valid research studies. Nonetheless, media reports of growing drug trafficking and local consumption have served to increase the level of awareness among certain elements of the population that drug use is a growing problem. As a consequence, they have taken actions to counteract that problem.

CASA ABIERTA, a church-supported prevention and treatment organization, was established in 1974 by a group of Dominican priests to address what they perceived as an incipient drug problem. Sponsored and financed by the Fundación Pablo Sexto it was formed as an intervention facility to address the needs of drug users. CASA ABIERTA has since changed its focus to place more emphasis on prevention and awareness. Although it still maintains a walk-in clinic that offers counseling and referral, CASA ABIERTA has added a communications component, documentation center, and community action component.

In February 1975, a concerned parent led a movement to establish an organization known as Hogares Crea, to deal with the perceived problem of drug use, utilizing the concept of the therapeutic community to treat drug addicts. Based on reports by the news media, and in part on the number of people that avail themselves of their services, the Hogares Crea staff have reported on the extent of the drug problem, especially in the capital, Santo Domingo. For example, in October 1977, Hogares Crea announced that " drug consumption is very high with 150 youth in treatment in Hogares Crea." A November 9, 1977 article in **Ultima Hora** reports that "a study (unnamed) determined that drug addiction is taking on alarming proportions".

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2 See for example reports by Luis Elipidio Féliz Féliz in **Revista Cientifica Hogar Crea Dominicano,** vol 1. no. 1, 1992 and by Ana Marina Ménendez Gómez, **op. cit.**

These types of claims are made periodically, as for example the claim in April 1991 stating that "studies show that drug use is up 400 percent."

Part of the drug problem is blamed on the influence of what are called the "Dominican-Yorks", i.e., Dominicans who migrate to New York, become involved in the drug trade, and then voluntarily or involuntarily end up back in the Dominican Republic. When they return, these migrants continue to ply their trade, contributing to the local trafficking problem as well as fostering drug use among Dominicans. Claims such as these and intense lobbying by drug abuse professionals has led the GODR to modify its anti-drug legislation and create a national structure for addressing the various aspects of the drug problem.

Enactment of Law 50-88 on Drugs and Controlled Substances in the Dominican Republic, in May 1988, is the latest evidence of GODR interest in addressing what is perceived as a growing drug problem. Recent involvement by the United Nations Drug Control Program (UNDCP), and the long standing involvement of several NGOs in drug abuse prevention and education, further attests to the fact that there is sufficient concern among the population to do something about drug use, distribution, and trafficking.

The enactment of Drug Law 50-88, centralizes responsibility for drug-related matters (control, interdiction, treatment, and prevention) in a new organization called the Dirección Nacional de Control de Drogas (DNCD). The DNCD is a military-type organization with representatives from the military and the police. The DNCD does not have any reliable information on the extent of drug consumption. Any estimates they have are based on drug arrests. According to DNCD staff the most commonly used drugs include marijuana, crack, cocaine, inhalants, and medications without prescription. Cocaine is allegedly consumed at all levels of Dominican society. Crack is reported to be primarily used by the lower middle class, inhalants by the lowest class, and marijuana and medications by all social classes.

The DNCD is currently implementing a three-year prevention program funded by the United Nations Drug Control Program (UNDCP). Under this pilot program the DNCD is in the process of developing an instrument to carry out a study of drug use, knowledge, attitudes, and practices in 240 schools in the city of Santo Domingo. The DNCD is also working closely with the Secretariat for Education, Arts, and Culture to establish and maintain a counseling and orientation program in the nation's schools on drug use, trafficking, and distribution.

In addition to the GODR agencies, there are several non-governmental organizations and international agencies involved in drug abuse awareness, prevention, and treatment; some are more active than others. **Hogar Crea** of Santo Domingo and **Hogar Crea International** are two well-known treatment programs that work closely with families of the drug/alcohol abuser. **Reto a la Juventud** and **Grupo Barahona** are two church-sponsored treatment and prevention programs. UNICEF is working with "street children", both those abandoned and those working to help their families. According to the Director of the UNICEF program children that do not work tend to abuse inhalants.

The lack of viable data, other than arrest records and treatment statistics, casts doubt as to whether the drug problem, especially drug consumption among the Dominican population, is sufficiently serious to warrant the expenditure of scarce resources. Some attempts at determining the extent of drug use among school students have been made, but without reference to internationally accepted methodologies for such measurement. As indicated above, the study reported in this document is the first comprehensive national study undertaken in an attempt to establish a realistic baseline for drug use, a baseline that will serve to help focus effective drug prevention activities.

This study represents the combined efforts of several institutions. The study was made possible by financing from the US Agency for International Development's Mission to the Dominican Republic. Overall design and supervision of the study was undertaken by the staff of the Narcotics Awareness and Education (NAE) Project of the Agency for International Development's Bureau for Research and Development, Office of Education. Fieldwork for the survey was conducted by Asesorias e Investigaciones S.A. (ASISA), as was analysis of the variables dealing with attitudes. Orientación Mercadologica, S. A. (OMSA) conducted the focus groups. Hogares Crea provided background information on drug use. The Universidad Autonoma de Santo Domingo sponsored the survey, providing the necessary credentials for those conducting field work. Without this process of collaboration, the study would not have been possible.

The next chapter (Chapter II) will describe the survey methods. The following chapter (Chapter III) presents a description of the respondents in the sample. Chapter IV describes the patterns of prevalence that were encountered, while Chapter V presents the results of the focus group study. Chapter VI presents the data on attitudes toward use. Chapter VII presents conclusions as well as recommendations.

CHAPTER II

SURVEY METHODS

In this chapter, we will present the methods employed in the conduct of the national survey. These methods were based on previous surveys undertaken or designed by Development Associates in Peru, Guatemala, Haiti and Panama as well as South and Southeast Asia in the past several years. Those surveys, in turn, used as references national surveys conducted in the United States, which represent over twenty years of experience in drug prevalence research. Survey instruments were adapted to the customs and context of the Dominican Republic.

The study took place from October, 1991 to April, 1992. Data collection was conducted from January 13, 1992 to February 21, 1992.

A. Questionnaire

1. Preparation

The instrument employed was developed from instruments that had been employed most recently in surveys in Guatemala and Haiti. In addition, variables were included as part of a cross-national study of the relationship of attitudes and beliefs to the design of drug prevention interventions. The initial instrument was reviewed jointly by a Narcotics Awareness and Education Project team and the staff of the Dominican Research firm, ASISA, that undertook the field research. It was also reviewed by several Dominican drug abuse and medical specialists to assure that the substances studied were available in the Dominican Republic and that the terminology used corresponded to local practice.

2. Pilot Test

A pilot test of the instrument was conducted in four cities in different regions of the country: the Federal District (Santo Domingo), Santiago, San Pedro de Macoris and Barahona. The latter two cities are reported to have high levels of drug use, because their populations are reputed to be heavily involved in drug trafficking. It was decided in designing the pilot study to pay particular attention to Barahona, a city that was not selected for inclusion in the national survey (see below the discussion of the sample selection process). Thus, an expanded sample was drawn in Barahona. After a review of the results of the pilot test certain minor adjustments were made in the presentation of the questions, but no major changes were required.

The results of the pilot study show that drug use in Barahona did not greatly differ from other cities included in the pilot survey. As Table 2.1 indicates, prevalence levels of drug use in Barahona, are extremely low, lower even than the average level of use in all cities included in

the pilot study. While 2.7% of the population surveyed in all four cities included in the pilot study reported having ever used marijuana and 1.1% reported having ever used cocaine, no one in Barahona reported use of either drug. With respect to inhalants, use in Barahona was approximately the same as the average of all cities. Only with respect to one set of substances, analgesics, was prevalence in Barahona higher (bearing in mind appropriate confidence intervals) than the average of all the four cities included in the pilot test.

Table 2.1
Prevalence of Drug Use in Barahona vs. Four Cities Included in the Pilot Study

Substance	Barahona*	Four Cities**
Cocaine	0.0%	1.1%
Marijuana	0.0%	2.7%
Inhalants	3.0%	3.7%
Analgesics	7.1%	5.3%
Sedatives	8.1%	11.1%
Hypnotics	1.0%	0.5%
Stimulants	1.0%	2.1%

*These results are not valid for the Dominican Republic as a whole, but are indicative of Barahona

**Barahona, Santo Domingo, Santiago, and San Pedro de Macoris. The results are indicative of the four cities but are not representative of the total population of these cities. Santo Domingo and Santiago will be included in the national sample.

3. Final Questionnaire

The final instrument used in the national survey consisted of 427 items. All items were closed except for a final question that requested respondents to describe the best way to avoid the expansion of drug use in the Dominican Republic. Prevalence items covered all substances reputed to be available in the Dominican Republic. The variables included in the instrument were:

- respondent's state of health and use of health facilities;
- age of initiation of drug use;
- lifetime prevalence (having ever used a substance);
- twelve month prevalence (use in the last twelve months);

- 30 day prevalence (use in the last 30 days);
- frequency of use;
- poly-drug use (use of one substance in conjunction with other substances);
- mode of administration (where applicable);
- attempts to end use;
- attempts to seek medical treatment;
- problems associated with use;
- attitudes and beliefs regarding ending tobacco use, reducing alcohol use and initiating marijuana, cocaine, crack and inhalant use. These attitudes and beliefs referred to intentions, social norms and beliefs that serve to influence respondents in the respective behaviors;
- opinions regarding whether drug use and trafficking are problems in the Dominican Republic;
- sources of information regarding the drug problem;
- interest in and awareness of the drug problem;
- opinions regarding the best approach to drug prevention.

Psychoactive substances covered by the instrument consisted of marijuana, cocaine, crack, inhalants, stimulants, analgesics, sedatives, hypnotics, alcohol, tobacco and others.

B. Sample

1. The Range of the Study

This study focuses on drug prevalence in urban areas above 20,000 in population of the Dominican Republic, because drug problems are most likely to occur in urban settings. The sample for the study consisted of persons ages 12 to 45 who, according to similar studies in Latin America, are most likely to be subjected to drug use; it was assumed that children under 12 years old could not answer this questionnaire appropriately. Municipalities are used as the unit of urban locality because they are the only urban measure with clearly defined borders and population data. The urban areas of the Dominican Republic were included in the study classified into three strata based on the population size of municipalities: (1) large cities -- municipalities with populations over 500,000, (2) mid-sized cities -- municipalities with populations under

with populations over 500,000, (2) mid-sized cities -- municipalities with populations under 500,000 and over 100,000 and (3) small-sized cities -- municipalities with populations under 100,000 and over 20,000. One thousand cases are selected from each stratum to capture sufficient information from each stratum.

Santo Domingo is categorized separately because it is the only municipality with a population of more than one half million. Santo Domingo represents 38% of the total urban population of the Dominican Republic.[3] One thousand cases were selected from Santo Domingo.

Mid-sized cities contain 27% of the total urban population. **Santiago** has been selected as a mid-sized city for inclusion in this study because it is the second largest city in the Dominican Republic, with nearly two and a half times the population of the next largest municipality. Besides Santiago, three other municipalities -- **La Vega, Bani** and **San Pedro de Macoris** -- have been selected as mid-sized cities. Two hundred and fifty cases were selected from each of these four municipalities. (See the map in the next page.)

Small-sized cities contain 35% of the total urban population. Five municipalities -- **Gaspar Hernandez, Nagua, Esperanza, Bayaguana** and **Miches** -- are selected from this stratum and 200 cases are selected from each municipality. (See map in the next page.)

2. Sample Design

The most recent census data available for the Dominican Republic are from 1981. The projected 1990 population figures used in this report are therefore subject to some error. This is due to the fact that there has been considerable rural-to-urban migration within the country and emigration to the United States in the 1980s. In addition, actual fertility and mortality trends in the 1980s may have differed from those assumed in our projection.

In Santo Domingo, updated maps -- **Boletín Geoestadistico de la ONE** by GAAR and Associates in 1991 -- were used to select the sample. Individual maps of the selected neighborhoods, which contain elaborate diagrams of the selected blocks of houses, were drawn later from the respective municipal map. For other municipalities, work-zone maps were used. These work-zone maps were made for vaccination campaigns by public health workers, and are updated periodically to carry out health program activities.

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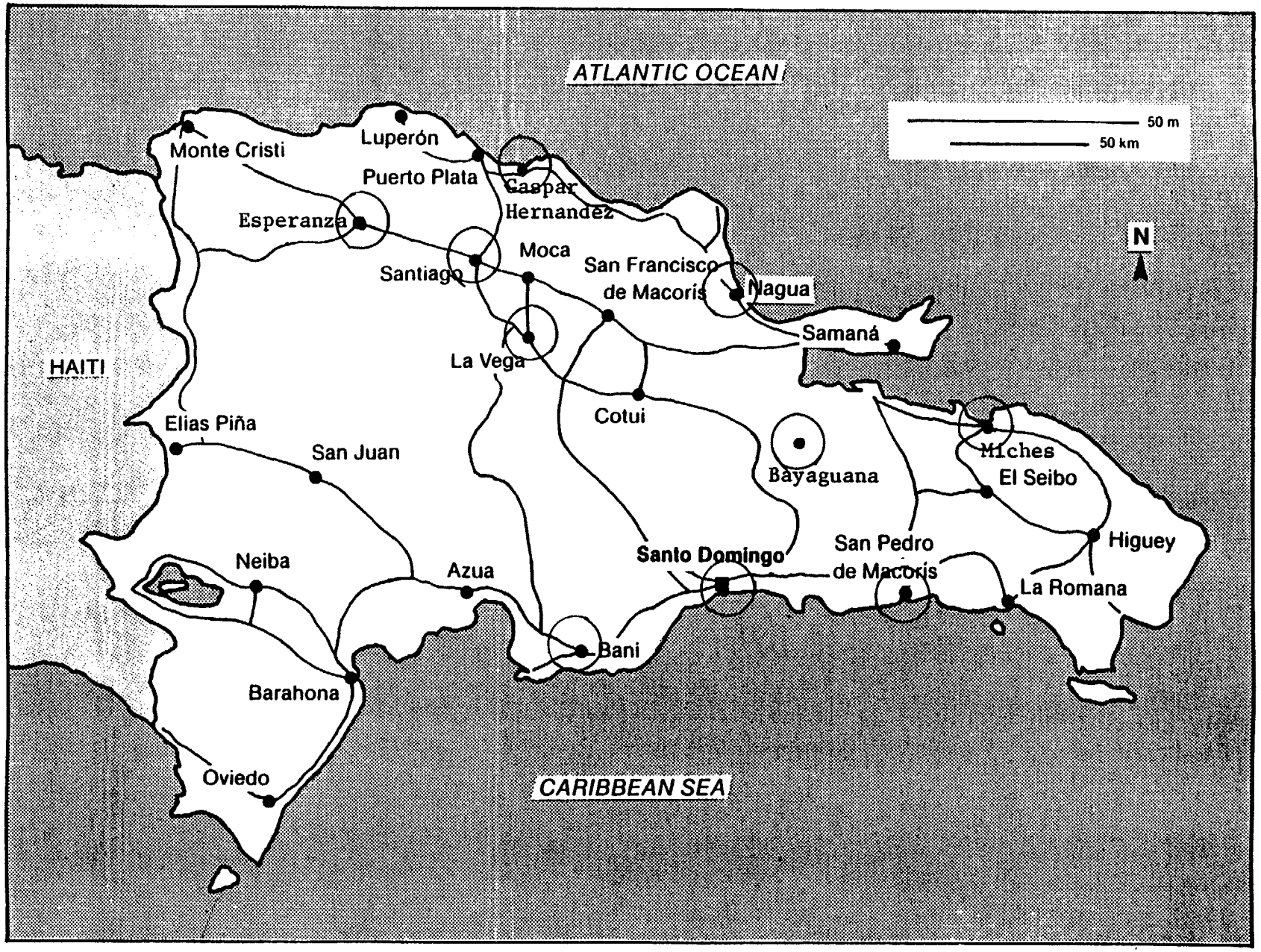
3 These estimates are based on the projections for 1990 reported in REPUBLICA DOMINICANA EN CIFRAS. The projections are drawn from the 1981 national census.

CITIES INCLUDED IN THE SAMPLE

DOMINICAN REPUBLIC



CITIES CIRCLED WERE INCLUDED

3. Sample Selection

(a) Selection of Municipalities

Municipalities were selected from the strata of mid-sized and small-sized cities using a systematic sampling method that produced a probability of selection proportional to population size.

(b) Selection within Municipalities

In all municipalities, every household was given an equal probability of being selected within the municipality. In the case of Santo Domingo, this process was slightly different than in the other municipalities because a great deal of work was put into mapping city blocks in order to avoid over-representation of neighborhoods (barrios) with fewer blocks. This risk of over-sampling was avoided by choosing fewer houses from the over-represented neighborhoods in Santo Domingo.

In Santo Domingo, four steps were employed to select the sample:

(1) Fifty-five neighborhoods (barrios) and rural zones were randomly selected from a total of 112 neighborhoods and rural zones.

(2) Six blocks were randomly chosen from each of the 55 neighborhoods.[4] These blocks were mapped in order to have a complete listing of households for the following procedure.

(3) Households were chosen from the selected blocks. Every household in San to Domingo had an equal probability of being selected: The probability of selection of the blocks within a neighborhood times the probability of selection of the household from within the block was constant for all of the neighborhoods.

(4) Individuals were selected from the residents of the selected households who were between 12 and 45 years of age. This selection was done using the Kish chart selection process. In this procedure the eligible individuals are listed in random order and given a number from 1 to n, where n is the number of eligible individuals in the household. The last digit (d) in the number of the

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4 This is the step that caused over-representation of neighborhoods with fewer blocks (barrios), since six blocks were chosen from each neighborhood regardless of the number of blocks that were in the neighborhood; for example, a block in a neighborhood with 10 blocks was five times more likely to be selected than a block in a neighborhood with 50 blocks.

questionnaire is then used as a key to the table. The interviewer then goes to row n and column d of the Kish chart and selects the person who corresponds to that number.

For other municipalities, three selection steps were taken:

(1) Work-zones (arbitrarily determined portions of the municipality consisting of similar numbers of houses) were randomly selected from each municipality.

(2) Households were selected proportional to the total number of households in each selected work-zone. For example, twice as many households were selected from a work-zone with 500 households than from a work-zone with 250 households.

(3) Individuals were selected from each selected household using the samemethod as in Santo Domingo (Step 4).

C. Field Work

1. Interviewer Training

The first part of the training was carried out with a group of supervisors before the pre-test of the questionnaire by two teams of investigators. These trained supervisors conducted the pre-test. The second part consisted of two days of training for interviewers in most locations. In Santiago and La Vega, training was extended to four days due to high drop-out rates among interviewers. Training workshops included:

- presentation of general information to the interviewers on drugs and drug use;
- familiarization of the interviewers with general aspects of survey research, and the importance of precision in collecting data;
- instruction on the technique for the selection of households and individuals to be interviewed;
- instruction on the design of the questionnaire and the relevant skip patterns within it.

A manual was put together during the training workshops as a reference document for the interviewers.

Interviewers were instructed to visit a selected household no more than three times, when they could not interview the selected person in the household during their first visit. Supervisors and

interviewers were mostly from the selected localities. All were high school graduates, and the majority were university students.

2. Data Collection and Analysis

Primary data collection was carried out from January 13 to February 14, 1992. Re-interviews were conducted until February 21, 1992. Each location had a work group with one supervisor and a number of interviewers proportional to the number of interviews to be done. The administration of the questionnaire was completed as planned, by transferring experienced interviewers to cooperate with local work groups. The data collection process was successful and mapping of the selected city blocks considerably reduced the number of substitutes for selected households due to the absence of eligible respondents.

There was a total of 3015 interviews completed. The response rate of households was 98%. The majority of the interviews were done at the first visit; only 20% were done at the second or third visit. Men were less available than women for interviews, representing 70.4% of non-responses (42 cases). Upper class persons were also more difficult to locate than middle or lower class persons. The average age of persons who did not respond was greater than the average age of persons interviewed (29 compared to 25.7). These sampling selection biases, however, were adjusted by applying a series of weights.

Data entry was carried out by ASISA and final cleaning of the data was done by the Narcotics Awareness and Education Project. Data processing took place both in the offices of ASISA and the Narcotics Awareness and Education Project. Both SPSS and SAS statistical packages were used in the data analysis.

D. Reliability and Validity of the Data

A concern with all self-reported data is its reliability and validity. Reliability refers to the internal consistency of the data. Validity refers to the accuracy of the data in reporting actual behavior. The data in this survey were checked for reliability by looking at the consistency of responses to such questions as use of substances in different time frames and poly-drug abuse (use of one or more substances at the same time). Overall, the data proved to be highly consistent.

Validity is a more complex subject. It is clear that a central concern in establishing the validity of self-reported data on drug use is to minimize denial of use among those actually using a given substance. Various studies have been undertaken in different cultural contexts to explore the level of such denials (the existence of "false negatives"). Analyses of the problem point to a need for careful control of the administration of field work and for care in the setting of the interview

to avoid situations which would tend to limit the likelihood of truthful answers (e.g. presence of other family members).[5] Careful control over field work was part of the training and supervision undertaken by ASISA in carrying out the survey. Another indicator of the validity of the data is the degree to which respondents willingly participated in the study. As the response rate indicates, there was virtually universal acceptance of the survey, given that the non-response rate was only 2%. This suggests again that there was little pressure to respond or to supply a set of "expected" answers.

Finally, studies of self-reported data have indicated that over time there is a certain consistency of response among samples. Trend data, the result of repeated surveys, reflect the general direction of the drug problem, even if a single survey may be a conservative estimate of the problem (actual prevalence may be higher than reported prevalence). For example, in the United States both household and high school surveys have reported the same general trends of use for almost two decades, trends supported by other indicators as well.

The next chapter describes the characteristics of the respondents.

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5 For a discussion of these issues see Beatrice A. Rouse, Nicholas J. Kozel and Louis G. Richards ed., **Self Report Methods of Estimating Drug Use: Meeting Current Challenges to Validity,** NIDA Research Monograph 57, 1985. See also Ole-Jorgen Skog, "The Validity of Self-Reported Use, **British Journal of Addiction,** 1992, 87, 539-548.

CHAPTER III

RESPONDENT CHARACTERISTICS

As was indicated in the previous chapter, the sample for this study was drawn from residents between ages 12 and 45 in municipalities of 20,000 or more in population of the Dominican Republic.

A. Demographic Characteristics

Table 3.1 shows the percentage distribution of the unweighted sample by urban locality, age and gender. The sample is predominantly women (58%). This is attributable to sampling error and the high probability that missing cases are male -- i.e., a high proportion of males among those individuals who should have been interviewed according to the sampling design but were not interviewed. Since the unit of sampling was the household, women were more likely to be at home at the time of the interview. This over-sampling of women has been adjusted here based on size of municipality, household where an individual is selected, and sex ratio in the household. More specifically, the sample has been weighted to represent the urban population of the Dominican Republic based on the following four probabilities: (1) an individual municipality is selected within a given stratum, (2) an individual household is selected within a given municipality, (3) an individual is selected within a given household, and (4) a man or a woman is selected within a given household. The total weight, therefore, is equal to the product of all four probabilities. Hence, the discussion will hereafter refer to the weighted sample, i.e., the sample adjusted by the total weight.

Table 3.2 presents the percentage distribution of the weighted sample by urban locality, age and gender. The proportion of women is now reduced from 58% to 52%, and the sex ratio for the weighted sample as a whole is 92. Very low sex ratios among persons ages 25-34 reflect emigration of men to work abroad. With regard to age composition, decreasing proportions as age increases between 15 and 34 suggests a reasonable representation of the urban population of the Dominican Republic, where the population age structure is relatively young due to continued moderately high levels of fertility and mortality (e.g., in 1991, the total fertility rate was 3.6 and the infant mortality rate was 60). Since no statistics are available on these characteristics, no judgements can be made on the proximity of these percentages to the real situation. Furthermore, the size of the 12-14 age group cannot be compared to other age groups, because this age interval is smaller than the others.

As Table 3.3 indicates, more than one-third of respondents were selected from both Santo Domingo and small-sized cities (20-100 thousand population), whereas 27.1% were from mid-sized cities (100 - 500 thousand population).

Table 3.1
Percentage Distribution of the Unweighted Sample by Urban Locality, Age and Gender in the Dominican Republic
(N = 3015)

DEMOGRAPHIC CHARACTERISTICS	AGE							Total
	12-14	15-19	20-24	25-29	30-34	35-39	40-45	
TOTAL	10.4	20.9	19.6	15.5	12.7	10.0	11.0	100.0
SEX								
Men	11.2	22.9	19.5	12.6	11.6	10.8	11.4	41.6
Women	9.8	19.4	19.7	17.5	13.5	9.4	10.7	58.4
SEX RATIO (Men/Women*100)	81	84	70	51	61	82	75	71
URBAN LOCALITY								
Santo Domingo	8.9	19.7	19.5	17.9	13.2	9.8	11.2	100.0
Men	11.9	22.0	21.3	14.1	10.9	8.5	12.2	45.9
Women	7.0	17.7	17.9	21.0	15.1	10.9	10.3	54.1
Mid-sized cities	10.1	21.3	19.1	15.6	12.2	11.3	10.4	100.0
Men	10.2	24.4	18.3	12.6	10.8	12.9	10.8	44.3
Women	10.1	18.9	19.7	17.9	13.3	10.1	10.1	55.7
Small-sized cities	12.0	21.6	20.3	12.9	12.8	8.8	11.5	100.0
Men	12.5	22.2	18.8	10.5	13.7	11.1	11.1	34.7
Women	11.8	21.3	21.2	14.2	12.4	7.6	11.6	65.3

Table 3.2
Percentage Distribution of the Weighted Sample by Urban Locality, Age and Gender in the Dominican Republic
(Weighted N = 6,411)

DEMOGRAPHIC CHARACTERISTICS	AGE							Total
	12-14	15-19	20-24	25-29	30-34	35-39	40-45	
TOTAL	10.8	24.3	20.3	13.8	10.6	9.0	11.1	100.0
SEX								
Men	11.1	26.8	20.6	11.6	9.6	9.1	11.2	47.8
Women	10.7	22.0	19.9	15.8	11.6	8.9	11.1	52.2
SEX RATIO (Men/Women*100)	95	112	95	67	76	93	93	92
URBAN LOCALITY								
Santo Domingo	9.9	23.3	20.4	17.0	10.6	8.2	10.6	100.0
Men	11.6	26.5	21.8	13.9	8.7	7.1	10.5	47.8
Women	8.3	20.3	19.1	19.8	12.5	9.3	10.7	52.2
Mid-sized cities	10.8	25.1	19.1	13.7	10.2	9.8	11.3	100.0
Men	10.4	29.3	18.8	10.6	8.7	10.3	11.9	48.2
Women	11.3	21.1	19.4	16.5	11.6	9.3	10.8	51.8
Small-sized cities	11.9	24.9	21.0	10.5	11.0	9.2	11.6	100.0
Men	11.0	25.2	20.8	9.9	11.4	10.3	11.5	47.6
Women	12.7	24.5	21.2	11.1	10.6	8.3	11.8	52.4

Table 3.4 shows the marital status of the respondents. More than half of the respondents were single, 23% were married and 16% were living together. The high proportion of singles can be explained by the relatively young age distribution of the sample.

Table 3.3
Percentage Distribution of the Weighted Sample
by Urban Locality in the Dominican Republic
(Weighted N = 6,411)

Santo Domingo	37.6
Mid-sized cities (100,000 - 500,000)	27.1
Small-sized cities (20,000 - 100,000)	35.3
TOTAL	100.0

Table 3.4
Percentage Distribution of the Weighted Sample
by Marital Status in the Dominican Republic
(Weighted N = 6,411)

Marital Status\Gender	Men	Women	Total
Married	19.5	25.8	22.8
Living together	12.8	19.6	16.3
Widow	0.3	1.3	0.8
Separated/Divorced	2.9	5.4	4.2
Single	64.6	48.0	55.9
TOTAL	100.0	100.0	100.0

About 45% of respondents had not worked in the last 6 months, but 80% of those who had not worked reported themselves as housewives or students. As Table 3.5 indicates, about 15% of respondents are white collar workers (i.e., professionals, administrative staff, officers), and 21% were blue collar workers (i.e., construction workers, artisans, domestic workers). Given the urban sample, there were few farmers (3.4%), while only 6% of the respondents reported themselves as unemployed.

Table 3.6 shows the educational level of respondents by gender. A majority of respondents (70%) have not completed secondary school, whereas 13% have completed secondary school and 17% have attended or completed university. A noteworthy differential in education between men and women is that more women respondents than men have finished university. This runs counter to the pattern observed in almost all other developing societies. (See Table 3.7)

B. Socio-Economic Status

Socio-economic status is an important variable in any drug prevalence study, because patterns of drug use are known to differ according to social class. As an indicator of socio-economic status, we use the interviewer's subjective rating of social class of respondents, because objective measures such as income, house materials (i.e., materials of walls, roofs, and floors) and household amenities (i.e., electricity, plumbing) are not available. Table 3.7 shows the socio-economic status of respondents. About 6% of persons were from the upper class, as compared to 35% from the middle class and 59% from the lower class.

Further investigation of relationships between this subjective measure of socio-economic status and educational level and occupation supports the reliability of this measure of socio-economic status. As Table 3.8 indicates, those who attained a higher educational level are more likely than those with lower education to be from the upper class. For example, those who have attended or completed university are more likely than others to belong to the upper class, while those who have not finished primary school are more likely than others to belong to the lower class. This suggests the validity, or at least the internal consistency, of the measure being used.

Table 3.9 shows the relationship between socio-economic status and occupation of respondents. White collars workers were more likely than others to be rated as upper class, whereas blue collar workers and farmers were more likely than others to be rated as lower class. The reliability of the socio-economic status measure is also indicated by the distribution of socio-economic status among students: Students are more likely to be rated as upper class than middle or lower class. This obviously reflects their parents' socio-economic status and suggests that parents in the upper class are more likely than those in the middle or lower class to support their children's study.

Table 3.5
Percentage Distribution of the Weighted Sample
by Occupation in the Dominican Republic
(Weighted N = 6,411)

OCCUPATION		
White Collar	15.8	
Professionals		8.6
Administrative		2.4
Office workers		4.7
Merchants/Drivers	7.9	
Merchants		5.5
Drivers		2.4
Blue Collar	12.1	
Construction workers		5.7
Artisans		1.4
Day laborers		2.5
Domestic workers		2.5
Farmers	3.7	
Housewives	21.9	
Students	27.9	
Unemployed	7.0	
Others	3.9	
Army or police personnel		0.5
Retired		0.2
Landlord		0.8
Unidentifiable		2.4
TOTAL	100.0	

Table 3.6
Percentage Distribution of the Weighted Sample by Education
and Gender in the Dominican Republic
(Weighted N=6,411)

Education\Gender	Men	Women	Total
Less than 2nd grade in primary school	5.3	5.4	5.3
Primary incomplete	27.8	27.9	27.9
Primary complete	13.7	12.0	12.8
Secondary incomplete	23.8	24.1	24.0
Secondary complete	12.2	13.8	13.0
University incomplete	8.5	7.4	7.9
University complete	8.8	9.4	9.0
TOTAL	100.0	100.0	100.0

Table 3.7
Percentage Distribution of the Weighted Sample
by Socio-economic Status and Gender in the Dominican Republic
(Weighted N=6,411)

SES\Gender	Men	Women	Total
Upper class	4.9	7.2	6.1
Middle class	35.1	35.5	35.3
Lower class	60.0	57.3	58.6
TOTAL	100.0	100.0	100.0

C. Health Status

With respect to health status, respondents were asked three general questions. A majority of respondents (73%) reported that their health had been 'average' or 'good' in the last 12 months and 21% reported their health as 'very good' or 'excellent.' Only 5% of respondents considered their health as 'bad.' (See Table 3.10) About 46% of respondents had consulted a doctor or had been to a clinic during the last 12 months, while only 11% had been hospitalized once or more during that time period (for any causes, including childbirth).

Table 3.8
Percentage Distribution of the Weighted Sample
by Socio-economic Status and Education in the Dominican Republic
(Weighted N=6,411)

SES\Education	Less than Primary	Primary	Secondary	University
Upper class	2.8	4.8	9.1	16.9
Middle class	28.0	34.2	45.5	43.2
Lower class	69.2	61.1	45.4	39.9
TOTAL	100.0	100.0	100.0	100.0

Table 3.9
Percentage Distribution of the Weighted Sample
by Socio-economic Status and Occupation in the Dominican Republic
(Weighted N = 6,411)

SES\Occupation	White collar	Merchants /Drivers	Blue collar	Farmers	Housewives	Students	Unemployed	Others
Upper class	10.3	4.5	3.7	0.5	4.4	7.2	1.9	13.5
Middle class	48.4	36.5	29.2	23.3	30.2	38.0	31.9	26.9
Lower class	41.3	59.2	67.1	76.2	65.4	54.8	66.2	59.6
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Table 3.10
Percentage Distribution of the Weighted Sample
by Self-reported Health Status in the last 12 months and Gender
in the Dominican Republic
(Weighted N = 6,411)

Health\Gender	Men	Women	Total
Excellent1	12.5	8.5	10.4
Very good	13.4	9.0	11.1
Good	38.2	32.8	35.4
Average	32.4	42.8	37.8
Poor	3.5	7.0	5.3
TOTAL	100.0	100.0	100.0

In the next chapter, we present the patterns of drug prevalence found in the sample surveyed.

CHAPTER IV

DRUG PREVALENCE IN THE DOMINICAN REPUBLIC

This chapter studies the patterns of drug prevalence among persons ages 12 to 45 years in municipalities of the Dominican Republic with a population of 20,000 or greater. Prevalence of drug use is indicated by three basic measures: Lifetime prevalence -- the proportion of the sample population who have ever used a given substance at least once in their life; 12 month prevalence -- the proportion who have used a given substance in the last year; and current or 30 day prevalence -- the proportion who have used a given substance in the last month. Lifetime, 12 month and 30 day prevalence are essential indicators of the nature and extent of drug abuse, which allow controlled comparisons between substances and across national populations at the broadest level. Current prevalence also indicates the intensity of the drug problem at a given time. Comparison of these three measures indicates trends in drug use.

The following section examines overall patterns of lifetime, 12 month, and current drug prevalence. This is followed by an investigation of differentials in drug use by major demographic factors (i.e., urban locality, gender, age, age at first use) and socio-economic characteristics (i.e., socio-economic status, occupation, education); an investigation of frequency of illicit drug use and relationships between illicit drugs, alcohol and tobacco; and a discussion of problems due to drug use and perception of drug problems.

A. General Pattern of Prevalence

Table 4.1 presents lifetime, 12 month and current prevalence levels of drug use. Alcohol was by far the most commonly used substance, with a lifetime prevalence level of 67%. Lifetime prevalence was 21% for tobacco, and 4.5 to 7% for major pharmaceuticals. Lifetime use of illicit drugs -- marijuana, cocaine, crack, and inhalants -- was less than 3% for each substance (See Graph 4.1). These figures for illicit drug use in the Dominican Republic are considerably lower than in other Latin American countries (i.e., Panama, Peru, Guatemala, Haiti).

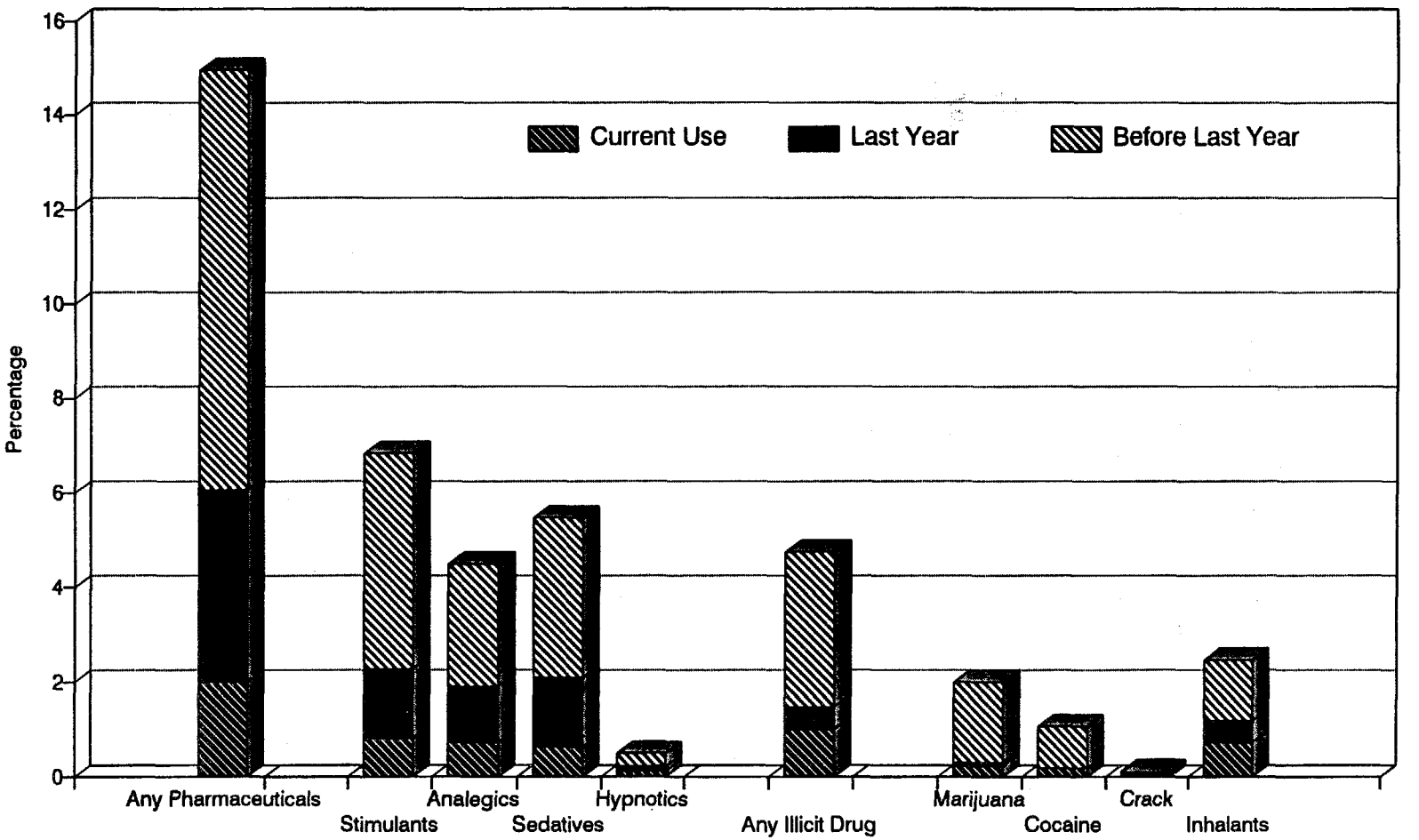
With respect to current drug use (use in the last 30 days), alcohol shows the highest prevalence at 40%, followed by tobacco at 15%. Current prevalence of major pharmaceuticals and inhalants is less than 0.8%, while current use of marijuana, cocaine and crack is negligible, at less than 0.2% of the sample for each substance. This compares dramatically, for instance, to Panama, where current prevalence of cocaine and marijuana was approximately 2% each or roughly 10 times higher than in the Dominican Republic.

Use of marijuana, cocaine and crack, as measured by the ratio of 30 day to lifetime prevalence (next to last column of Table 4.1), is much lower than in the case of tobacco and alcohol use. However, the low number of survey respondents reporting use of the psychoactive substances

Table 4.1
Percentage of Drug Users of Alcohol, Tobacco, and Selected Drugs in the Dominican Republic: Lifetime, Last Year, and Current Prevalences
(Weighted N = 6,411)

	Lifetime	Last Year	Current	Current/ Lifetime	Current/ Last Year
ANY ILLICIT DRUG USE	4.8	1.5	1.0	20.8	66.7
Marijuana	2.0	0.3	0.2	10.0	66.7
Cocaine	1.1	0.2	0.2	18.2	100.0
Crack	0.1	0.1	0.0	0.0	0.0
Inhalants	2.5	1.2	0.7	28.0	58.3
NONMEDICAL USE OF ANY PHARMA-CEUTICALS	15.0	6.1	2.0	13.3	32.8
Stimulants	6.9	2.3	0.8	11.6	34.8
Analgesics	4.5	1.9	0.7	15.6	36.8
Sedatives	5.5	2.1	0.6	10.9	28.6
Hypnotics	0.5	0.2	0.1	20.0	50.0
ALCOHOL	66.5	55.0	39.9	60.0	72.5
TOBACCO	21.2	16.6	15.4	72.6	92.8
OTHERS	0.3	0.0	0.0	0.0	0.0

Graph 4.1
Drug Prevalence in the Dominican Republic



makes this generalization somewhat unreliable.

No heroin use was reported by those surveyed.

B. Differentials by Demographic Factors

1. Urban Localities

As Table 4.2 indicates, lifetime prevalence of inhalants was considerably higher in mid-sized cities (i.e., cities of 100,000 to 500,000 population) than in other municipalities, while alcohol and sedative use was moderately higher in Santo Domingo than elsewhere. Lifetime prevalence of marijuana and cocaine was similar in Santo Domingo and small-sized cities (ranging from 2.2% to 2.5% for marijuana and 1.0% to 1.4% for cocaine), and was very low in mid-sized cities (0.8% for both marijuana and cocaine). No prevalence of crack use was reported in Santo Domingo and mid-sized cities. Lifetime prevalence of tobacco and stimulants was similar in Santo Domingo and mid-sized cities and was lower in small-sized cities than in other urban localities, while lifetime prevalence of analgesics was lower in Santo Domingo than in other urban localities.

Current prevalence of marijuana is very low (0.1%-0.4%) across urban localities, and is slightly higher in Santa Domingo and small-sized cities than mid-sized cities. Current use of cocaine, on the other hand, was slightly higher in Santo Domingo and mid-sized cities (0.3%, 0.2%) than in small cities, where no use was reported.

Overall, then, Santo Domingo has the highest lifetime and current use of alcohol and marijuana, and the highest current prevalence of cocaine. Mid-sized cities have the highest lifetime and current prevalence of inhalants and hypnotics. Small-sized cities have the highest lifetime prevalence of crack. Nevertheless, one should keep in mind that differentials in illicit drug use across Dominican municipalities are very small, since overall prevalence is relatively low.

2. Gender

Table 4.3 shows that, as in Guatemala and Panama, men in the Dominican Republic are more likely than women to be current and lifetime users of tobacco, alcohol, inhalants, marijuana, cocaine, crack, and other drugs, while women are more likely than men to have used pharmaceuticals. The size of the differentials between men and women are striking. Men are more than seven times as likely as women to have tried marijuana and three times as likely to be currently using marijuana. Men are the exclusive current users of cocaine, and roughly twenty times as likely as women to have used cocaine in their lifetime. On the other hand, women are 12 times as likely as men to be currently using analgesics, and more than twice as likely to be using sedatives.

Table 4.2
Percentage of Drug Users of Alcohol, Tobacco, and Selected Drugs by Urban Locality in the Dominican Republic: Lifetime and Current Prevalences
(Weighted N = 6,411)

	SANTO DOMINGO			MID-SIZED CITIES			SMALL-SIZED CITIES		
	Lifetime	Last Year	Current	Lifetime	Last Year	Current	Lifetime	Last Year	Current
ANY ILLICIT DRUG USE	4.8	1.2	0.7	5.7	2.5	1.6	3.9	1.1	0.8
Marijuana	2.5	0.7	0.4	0.8	0.1	0.1	2.2	0.2	0.2
Cocaine	1.0	0.3	0.3	0.8	0.2	0.2	1.4	0.2	0.0
Crack	0.0	0.0	0.0	0.0	0.0	0.0	0.3	0.0	0.0
Inhalants	2.3	0.8	0.3	4.4	2.2	1.4	1.3	0.9	0.6
NONMEDICAL USE OF ANY PHARMA-CEUTICALS	17.1	6.7	1.9	17.2	6.0	1.9	11.2	5.4	2.1
Stimulants	8.6	2.6	0.7	8.3	2.4	0.8	4.0	1.8	0.9
Analgesics	3.8	1.9	0.6	5.3	1.4	0.5	4.8	2.2	0.8
Sedatives	6.6	2.3	0.6	5.8	2.2	0.5	4.1	1.8	0.6
Hypnotics	0.5	0.2	0.0	0.8	0.5	0.2	0.2	0.0	0.0
ALCOHOL	80.3	67.7	48.6	64.5	51.5	37.7	53.3	35.3	32.3
TOBACCO	23.5	16.2	14.6	23.3	20.9	19.3	16.9	13.7	13.1
OTHERS	0.2	0.0	0.0	0.4	0.0	0.0	0.4	0.0	0.0

Table 4.3
Percentage of Drug Users of Alcohol, Tobacco, and Selected Drugs by Gender in the Dominican Republic: Lifetime, Last Year, and Current Prevalences
(Weighted N = 6,411)

	Men			Women		
	Lifetime	Last Year	Current	Lifetime	Last Year	Current
ANY ILLICIT DRUG USE	7.0	1.8	1.1	2.7	1.3	0.8
Marijuana	3.6	0.6	0.4	0.5	0.1	0.1
Cocaine	2.2	0.5	0.3	0.1	0.0	0.0
Crack	0.2	0.1	0.0	0.0	0.0	0.0
Inhalants	2.9	1.3	0.6	2.2	1.2	0.7
NONMEDICAL USE OF ANY PHARMA-CEUTICALS	13.1	4.7	1.1	16.8	7.3	2.7
Stimulants	5.8	2.1	0.7	7.8	2.4	0.9
Analgesics	3.6	1.0	0.1	5.4	2.7	1.2
Sedatives	4.9	1.5	0.3	6.0	2.6	0.8
Hypnotics	0.5	0.2	0.1	0.5	0.2	0.0
ALCOHOL	74.6	64.8	49.9	59.0	46.0	30.7
TOBACCO	24.2	20.1	18.8	18.4	13.3	12.2
OTHERS	0.6	0.0	0.0	0.0	0.0	0.0

Table 4.4
Percentage of Drug Users of Alcohol, Tobacco, and Selected Drugs by Age in the Dominican Republic: Lifetime and Current Prevalences
(Weighted N = 6,411)

LIFETIME PREVALENCE

	AGE						
	12-14	15-19	20-24	25-29	30-34	35-39	40-45
ANY ILLICIT DRUG USE	5.8	4.4	6.5	5.8	2.8	3.1	3.5
Marijuana	0.6	0.7	3.5	3.2	1.2	2.3	2.0
Cocaine	0.2	0.6	2.3	2.4	0.0	0.7	0.4
Crack	0.0	0.3	0.2	0.0	0.0	0.0	0.0
Inhalants	5.5	3.2	3.1	1.8	1.3	0.2	1.1
NONMEDICAL USE OF ANY PHARMA-CEUTICALS	10.8	13.2	17.7	16.0	11.8	16.8	18.8
Stimulants	4.1	6.6	10.6	7.6	5.1	3.9	6.3
Analgesics	4.0	3.8	4.0	3.4	3.5	7.2	7.7
Sedatives	2.8	5.0	5.3	6.3	3.7	7.9	8.3
Hypnotics	0.2	0.9	0.2	0.7	0.6	0.3	0.2
ALCOHOL	43.3	66.3	69.5	74.3	73.3	67.8	66.5
TOBACCO	2.8	8.3	20.0	25.6	29.9	36.2	43.0
OTHERS	0.0	1.1	0.0	0.2	0.2	0.3	0.0

(Table 4.4 continues on the next page)

(Table 4.4 Continues)

CURRENT PREVALENCE

	AGE						
	12-14	15-19	20-24	25-29	30-34	35-39	40-45
ANY ILLICIT DRUG USE	2.0	1.1	1.1	0.7	0.5	0.2	0.9
Marijuana	0.2	0.4	0.3	0.3	0.0	0.0	0.0
Cocaine	0.0	0.3	0.3	0.3	0.0	0.0	0.0
Crack	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Inhalants	1.7	0.5	0.7	0.4	0.5	0.2	0.9
NONMEDICAL USE OF ANY PHARMA-CEUTICALS	0.8	1.9	1.8	2.1	1.6	2.5	3.2
Stimulants	0.0	0.9	1.2	1.0	0.8	0.2	0.6
Analgesics	0.6	0.7	0.4	0.7	0.9	0.5	1.0
Sedatives	0.0	0.5	0.2	0.4	0.0	1.8	1.6
Hypnotics	0.2	0.0	0.0	0.0	0.0	0.0	0.2
ALCOHOL	19.5	37.8	46.6	46.0	46.3	40.9	37.8
TOBACCO	2.0	5.2	15.4	20.0	23.0	25.7	29.0
OTHERS	0.0	0.0	0.0	0.0	0.0	0.0	0.0

3. Age

Table 4.4 presents drug prevalence among various age groups. It shows that the likelihood of lifetime use of tobacco and sedatives increases with age. This probably reflects the long history of cigarette availability and use in the Dominican Republic, and the limited access to and appeal of sedatives among younger persons. With regard to alcohol, lifetime and current prevalence is highest among persons ages 20-34. However, except for the youngest age group, 12-14, differentials by age groups are not substantial, suggesting that alcohol has been tried and is used by all age groups except the very young. Inhalants are more likely to have been ever used or currently used by the youngest age groups, 12-24, reflecting in part easy access to the substance and its affordability. This also suggests a recent upswing in trying inhalants, indicating problems for the future.

Persons ages 20-29 are more likely than persons in other age groups to have ever tried marijuana, cocaine, and stimulants, while current use of these substances by persons over age 30 was negligible. Hence, to the extent that an illicit drug problem exists in urban areas of the Dominican Republic, it is mainly a problem among young males. Current use of marijuana and cocaine was also mostly concentrated among age groups 15-29, with very small variation between these age groups (0.3%-0.4%). Again, as with inhalants this suggests a recent increase in onset of use in the younger age cohorts. In contrast, current use of sedatives is mostly concentrated among persons ages 35 to 45. Among the age group 12-14, no current use of cocaine, compared to some marijuana use (0.2%), may reflect the greater affordability of marijuana than cocaine and the role of marijuana as a precursor. Hence, primary prevention needs to be focused on the age group younger than 12.

4. Age at First Use

As an important variable in designing a drug prevention strategy, age at first use of a given substance defines the youngest population at risk of use, and provides insight into the sequence in which initiation into use of various substances takes place. As Table 4.5 indicates, among those Dominicans who have tried inhalants, 60% did so before their fifteenth birthday, compared to 39% of alcohol users and 35% of tobacco and analgesic users. However, more than three-fourths of Dominicans who have tried tobacco or alcohol initiated use as teenagers (78% of tobacco users and 88% of alcohol users). With regard to marijuana and cocaine, 87% of first use occurred between ages 15-24, whereas all crack use started at ages 15-19. On the other hand, more than two-fifths of first use of pharmaceuticals occurred after age 20.

A comparison of lifetime prevalence by age (Table 4.4) and age at first use (Table 4.5) reveals some interesting patterns of drug prevalence in the Dominican Republic. Although, lifetime tobacco use steadily increases with age, almost all tobacco users started use before age 25, suggesting that cigarette has become less popular among youth in the Dominican Republic than it used to be among the older age groups. However, alcohol use by youth has remained stable over the years, as indicated by the fairly even lifetime prevalence levels and concentrated early

Table 4.5
Percentage of Lifetime Users of Alcohol, Tobacco, and Selected Drugs by Age at First Use in the Dominican Republic
(Weighted N = 6,411)

	AGE AT FIRST USE								
	11 or less	12-14	15-19	20-24	25-29	30-34	35-39	40-45	Total
ANY ILLICIT DRUG USE	4.5	34.3	27.2	23.4	6.2	1.5	1.6	1.4	100.0
Marijuana	0.0	15.2	33.2	38.6	6.7	2.4	4.0	0.0	100.0
Cocaine	2.1	10.3	25.8	48.4	13.4	0.0	0.0	0.0	100.0
Crack	0.0	0.0	100.0	0.0	0.0	0.0	0.0	0.0	100.0
Inhalants	8.3	51.8	25.7	9.0	2.7	0.0	0.0	2.6	100.0
NONMEDICAL USE OF ANY PHARMA-CEUTICALS	7.9	13.6	31.1	20.1	10.8	7.2	6.7	2.7	100.0
Stimulants	3.8	10.5	42.0	21.0	9.5	6.7	4.6	2.0	100.0
Analgesics	15.9	18.6	22.7	19.3	7.6	8.7	6.5	0.7	100.0
Sedatives	4.2	12.1	25.1	20.7	13.8	7.1	12.5	4.4	100.0
Hypnotics	0.0	4.9	50.6	2.4	33.7	4.9	0.0	3.4	100.0
ALCOHOL	11.1	27.5	49.1	9.6	1.6	0.7	0.3	0.1	100.0
TOBACCO	10.9	24.0	42.7	15.9	4.2	1.7	0.3	0.4	100.0

first use. Late age of first use of pharmaceuticals, and high lifetime prevalence among older age groups, indicates that pharmaceuticals were introduced to somewhat older Dominicans for the first time in recent years and have become increasingly popular among older persons.

Furthermore, a closer investigation of age and year of first use -- calculated by age, age at first use and the date of the survey -- of illicit drugs is presented in the series of Graph 4.2. They reveal that inhalants have been increasingly popular among the very young (12-19) since the late 1980s. Patterns of marijuana and cocaine use are similar to each other, and suggest that introduction to marijuana and cocaine occurs later (i.e., ages 20-29) than in the case of inhalants. Moreover, marijuana had gained popularity among young adults (20-29) earlier (from the early 1980s) than cocaine (from the late 1980s) again suggesting marijuana's potential as a precursor.

C. Socio-Economic Characteristics

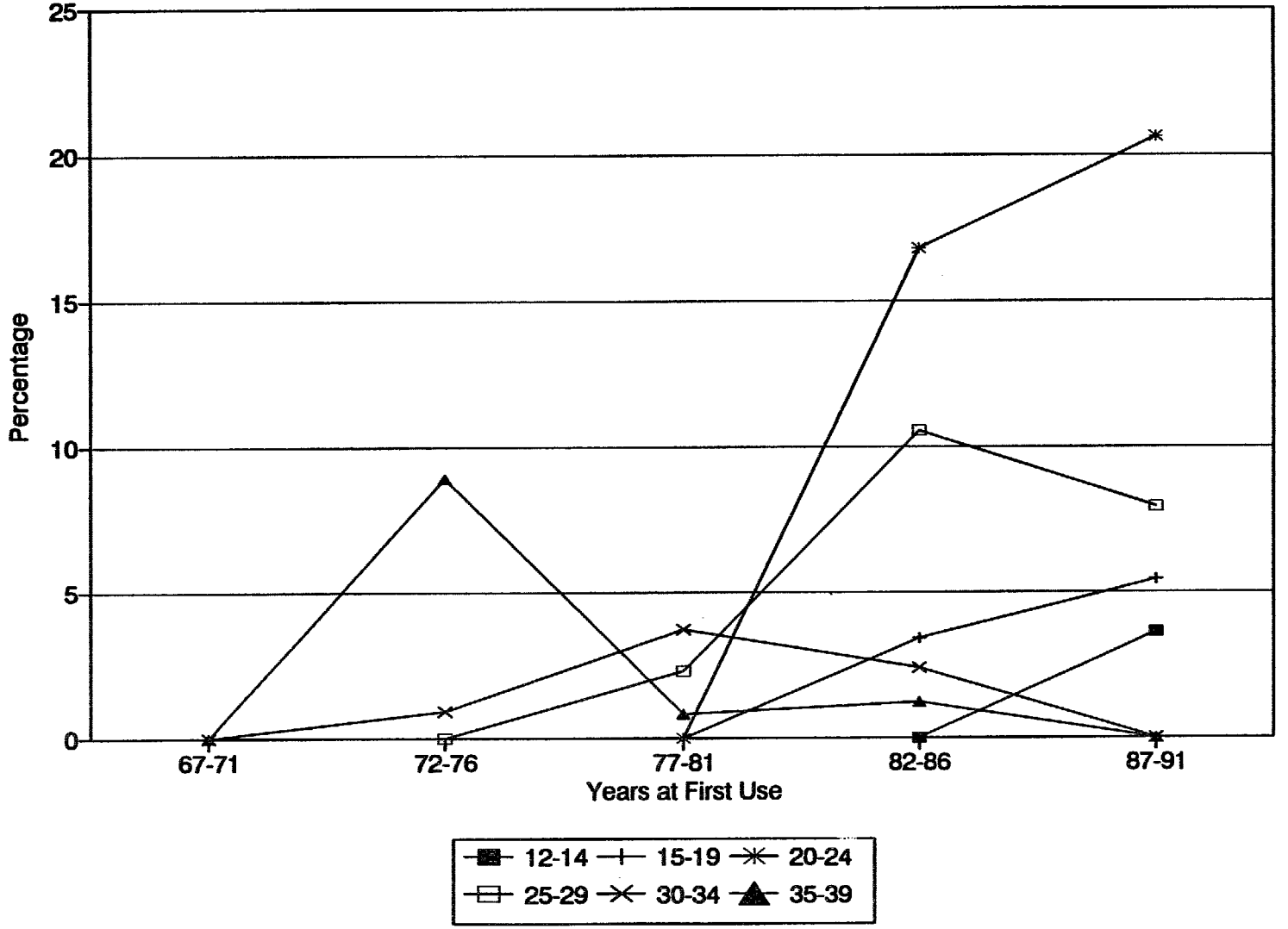
As discussed in the previous chapter, socio-economic status is measured by the interviewer's subjective rating of social class of respondents. Further analyses of the relationship between this subjective measure of socio-economic status and education and occupation of respondents shows the validity of this variable (consult the previous chapter for details).

Table 4.6 shows drug prevalence by socio-economic status. Alcohol and sedatives have been, and are currently more likely to be used by persons in the upper class than those in the middle or lower class, while inhalants and analgesics are more likely to be used in the lower class than in the upper or middle class. There are no distinct differentials in tobacco use among social classes. With regard to illicit drug use, lifetime and current prevalence of marijuana use is similar across social classes. Upper and middle class persons were more likely to have used cocaine sometime in their life, but current use of cocaine is more common in the lower class.

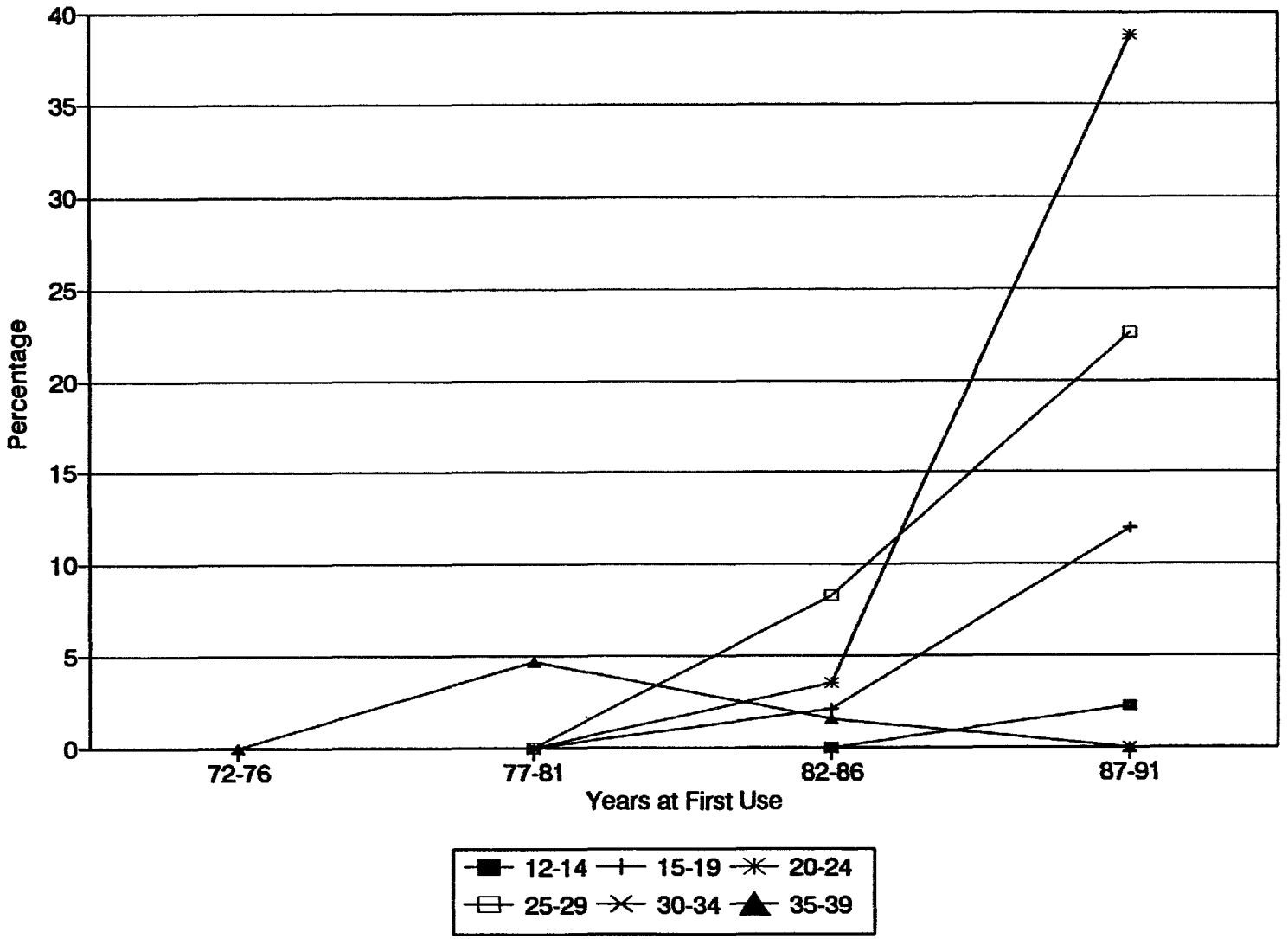
Investigation of prevalence of illicit drugs by occupation (Table 4.7) and education (Table 4.8) reveals that marijuana and cocaine are most likely to be currently used by blue collar workers (i.e., manual workers, artisans) and students, and inhalants are most likely to be currently used by students and farmers. Although college graduates were as likely as others to have tried marijuana and cocaine, no prevalence of current illicit drug use was found among college graduates. This may reflect an increasing awareness among more educated persons of the hazards of cocaine use, or alternatively, the decreasing popularity of these drugs among older adults. Marijuana is most likely to be currently used by Dominicans with primary education or less, cocaine by persons with primary and secondary education, and inhalants by persons with no education or those who are still in primary.

In sum, illicit drug use in the Dominican Republic is greater among young adults, men, persons who have not reached or completed secondary school, blue collar workers and students, and residents of Santo Domingo and mid-sized cities.

Graph 4.2a Lifetime Marijuana Users
by Calendar Years at First Use



Graph 4.2b Lifetime Cocaine Users
by Calendar Years at First Use



Graph 4.2c Lifetime Inhalant Users
by Calendar Years at First Use

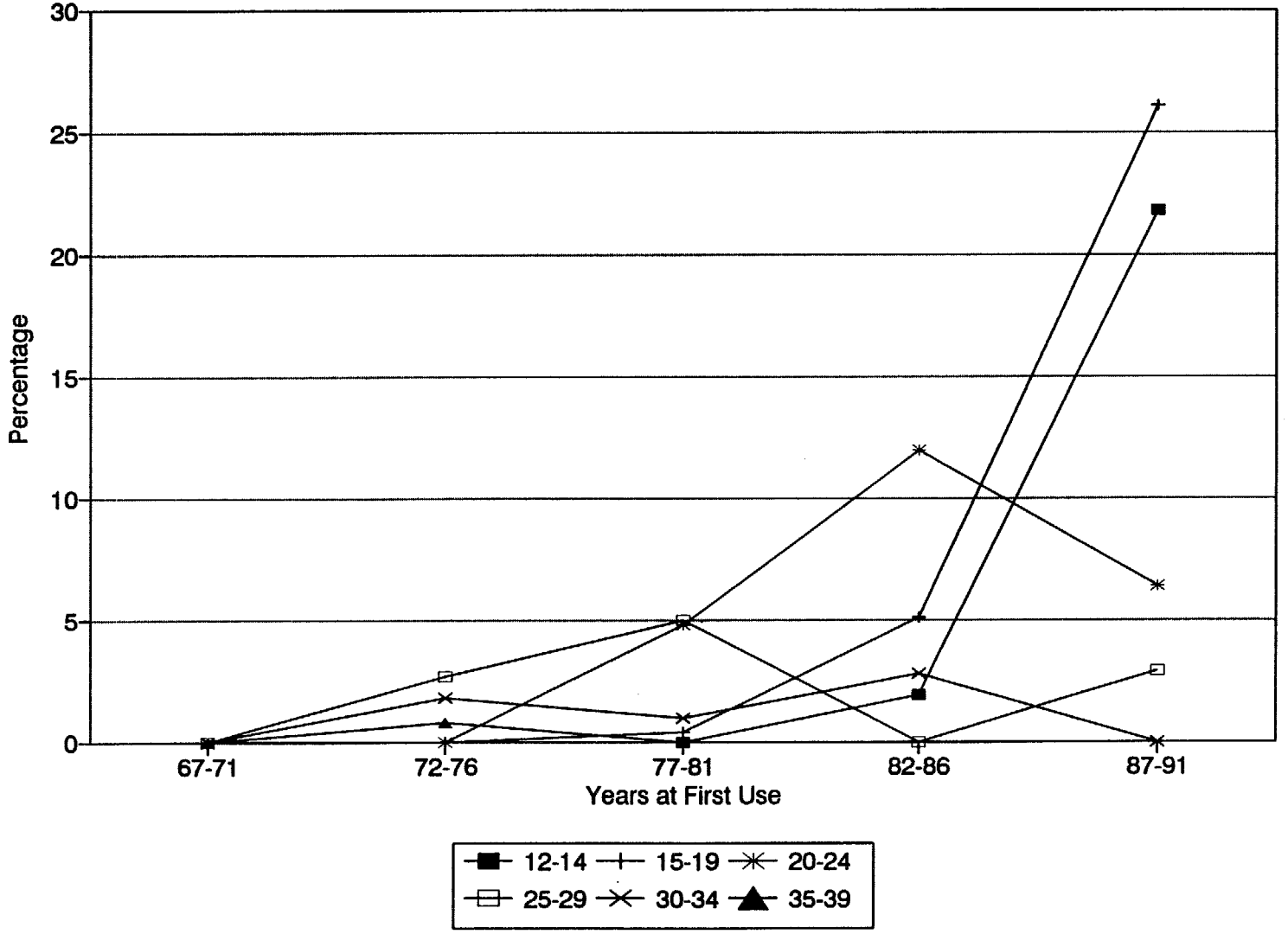


Table 4.6
Percentage of Drug Users of Alcohol, Tobacco, and Selected Drugs by Socio-economic Status in the Dominican Republic: Lifetime and Current Prevalences
(Weighted N = 6,411)

	LIFETIME			CURRENT		
	Upper	Middle	Lower	Upper	Middle	Lower
ANY ILLICIT DRUG USE	5.0	5.0	4.6	0.8	0.7	1.1
Marijuana	1.9	2.2	1.9	0.2	0.3	0.2
Cocaine	1.5	1.5	0.8	0.0	0.1	0.2
Crack	0.0	0.2	0.1	0.0	0.0	0.0
Inhalants	1.0	2.1	2.9	0.6	0.3	1.0
NONMEDICAL USE OF ANY PHARMA-CEUTICALS	16.3	14.6	15.1	1.8	2.2	1.8
Stimulants	6.1	7.0	6.9	0.9	0.9	0.7
Analgesics	2.9	3.8	5.2	0.0	0.6	0.8
Sedatives	8.1	5.1	5.5	1.0	0.7	0.4
Hypnotics	0.2	0.7	0.4	0.0	0.1	0.1
ALCOHOL	75.7	69.8	63.5	44.0	41.6	38.4
TOBACCO	23.1	18.2	22.7	15.1	11.3	17.8
OTHERS	1.3	0.3	0.2	0.0	0.0	0.0

Table 4.7
Percentage of Illicit Drug Users by Occupation in the Dominican Republic: Lifetime and Current Prevalences
(Weighted N = 6,411)

	OCCUPATION							
	White Collar	Merchants /Drivers	Blue Collar	Farmers	House-wives	Student	Unemployed	Others
	LIFETIME							
ANY ILLICIT DRUG USE	5.4	3.0	6.7	10.0	1.9	4.8	7.7	2.6
Marijuana	4.3	1.4	3.3	3.8	0.5	1.0	3.0	0.6
Cocaine	2.4	0.7	2.7	0.9	0.0	0.7	1.2	0.0
Crack	0.0	0.6	0.5	0.0	0.0	0.0	0.0	0.0
Inhalants	0.4	0.6	3.7	6.2	1.4	3.8	4.1	2.0
	CURRENT							
ANY ILLICIT DRUG USE	0.1	0.5	1.2	3.5	0.5	1.5	1.1	0.0
Marijuana	0.1	0.0	1.0	0.0	0.0	0.2	0.1	0.0
Cocaine	0.0	0.0	0.5	0.0	0.0	0.2	0.0	0.0
Crack	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Inhalants	0.0	0.5	0.2	3.5	0.5	1.1	0.5	0.0

Table 4.8
Percentage of Illicit Drug Users by Level of Education in the Dominican Republic: Lifetime and Current Prevalences
(Weighted N = 6,411)

	LIFETIME				CURRENT			
	Less than Primary	Primary	Secondary	University	Less than Primary	Primary	Secondary	University
ANY ILLICIT DRUG USE	4.3	5.6	4.4	3.1	1.5	0.7	1.1	0.0
Marijuana	1.2	2.6	1.7	2.4	0.3	0.4	0.1	0.0
Cocaine	0.3	1.5	1.4	1.6	0.0	0.3	0.2	0.0
Crack	0.2	0.1	0.0	0.0	0.0	0.0	0.0	0.0
Inhalants	2.8	0.3	1.9	0.3	1.2	0.3	0.8	0.0

D. Frequency of Illicit Drug Use

As an alternative to the prevalence measures we used earlier, examining individual frequency of illicit drug use in a given time period indicates the intensity of drug use. We focus on frequency of illicit drug use during a respondent's lifetime here, since 12 month and current prevalence of these drugs are very low in the Dominican Republic.

Graph 4.3 presents the percentage distribution of lifetime illicit drug users according to their frequency of use of these drugs. It shows that heavy lifetime users (i.e., those who have used more than 40 times) represent 12% of marijuana users, 10% of cocaine users, and 9% of inhalant users. Lifetime users who have used more than 10 but less than 39 times are 9.9% of marijuana users, 19.8% of cocaine users, and 6.6% of inhalant users. Over two-fifths of lifetime marijuana, cocaine and inhalant users have tried the drug just once or twice, and another one-fifth tried it three to five times. These results suggest that, although prevalence of marijuana, cocaine and crack is lower than prevalence of inhalants, these drugs are used more intensively than inhalants among those who have ever used.

Further study of differentials in frequency of lifetime illicit drug use across gender, urban localities and socioeconomic status presents similar results to the general patterns of prevalence. For example, frequent users of marijuana and cocaine are most likely to be lower class young men, ages 18-25.

E. Relationships between Illicit Drugs, Alcohol and Tobacco

It is known that psychoactive drug users commonly combine two or more substances to extend or alter their "highs" and "lows". Table 4.9 indicates that one-half of lifetime cocaine users, about one-third of marijuana users, and less than one-tenth of inhalant users also used another drug on the same occasion. In each case, the illicit drug was more often combined with alcohol than with another illicit drug, although the data indicate that marijuana and cocaine are often used concurrently.

The correlations in Table 4.10 show a strong positive relationship (.43) between marijuana and cocaine use. Low correlations (below .10) between alcohol and tobacco use and illicit drug use are not surprising, as they merely indicate that most of the many persons who consume alcohol and cigarettes do not use illicit drugs. An implication of the high correlation between marijuana and cocaine use is that, to a large extent, educational or prevention programs aimed at either marijuana or cocaine users are in fact addressing the same target population (i.e., persons using both drugs).

Graph 4.3
Frequency of Lifetime Use of Illicit Drugs
in the Dominican Republic

	Marijuana	Cocaine	Crack	Inhalants
1-2	48.3	44.2	0.0	44.6
3-5	25.3	23.1	56.7	27.0
6-9	4.4	3.0	0.0	13.0
10-19	7.4	5.4	0.0	5.4
20-39	2.5	14.4	0.0	1.2
40+	12.1	9.9	43.3	8.8

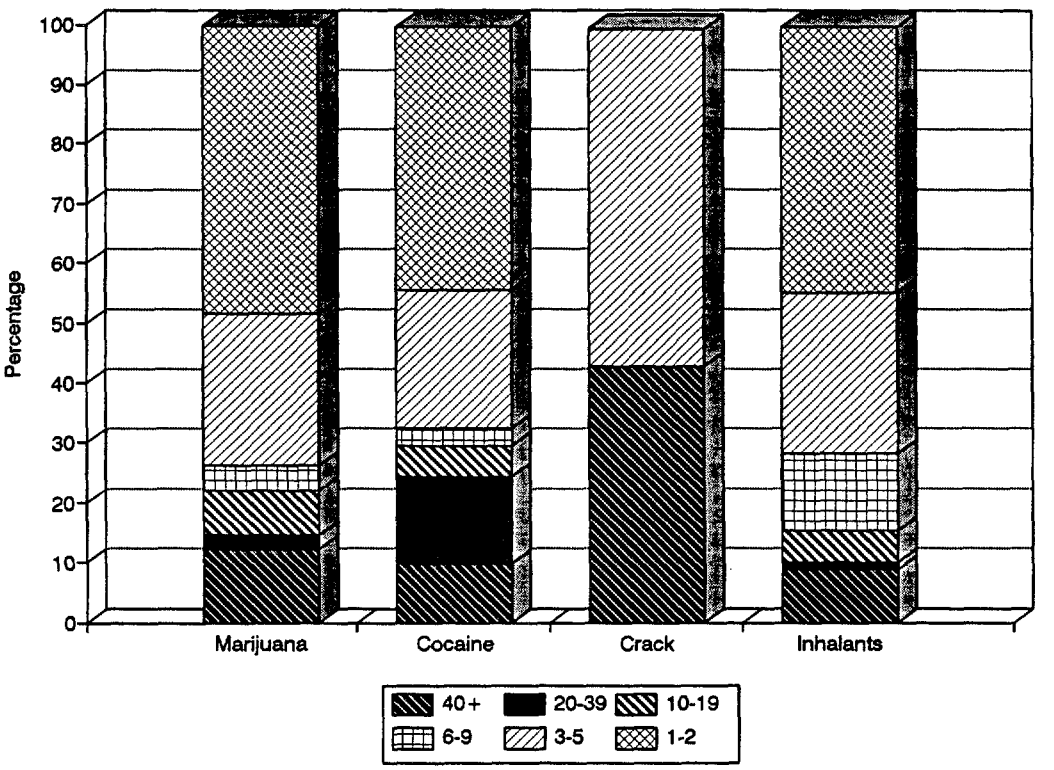


Table 4.9
Concurrent Use of Illicit Drugs and Alcohol in the Dominican Republic
(Weighted N = 6,411)

	Any concurrent Use	Concurrent use among persons who used illicit drugs with other substances			
	Among lifetime illicit drug users	Marijuana	Cocaine	Inhalants	Alcohol
Marijuana Users	36.0	-	30.9	3.1	62.1
Cocaine Users	50.1	48.6	-	4.5	73.9
Inhalants Users	9.0	0.0	0.0	-	71.4

Table 4.10
Correlations among Illicit Drugs, Alcohol and Tobacco Use in the Dominican Republic:
Lifetime Use (Unweighted N = 3016)

	Cocaine	Inhalants	Alcohol	Tobacco
Marijuana	.43*	.01	.08*	.14*
Cocaine		.01	.05	.03
Inhalants			.04	.01
Alcohol				.18*

* denotes significance at p<.0001

Table 4.11
Percentage of Lifetime Users with Personal Problems Due to Drug Use in the Dominican Republic
Types of Problems as a Percent of Users Indicating Problems

	Health	Family	Friends	Work /School	Authority	Others	Persons with Problems
Pharmaceuticals /Illicit Drugs	81.2	46.2	15.7	17.0	12.7	3.5	4.8 (Weighted N = 56)
Tobacco/Alcohol	34.0	42.3	23.8	23.8	3.7	4.5	9.7 (Weighted N = 438)

F. Personal Problems due to Drug Use

Respondents were asked whether they had any personal problems due to drug use, and if so, what kind of problems. Table 4.11 shows that among Dominicans who have used any pharmaceuticals or illicit drugs, only 5% of them recognized any problems related to drug use. Similarly, only lifetime tobacco or alcohol users reported problems. The most commonly expressed problems among pharmaceutical or illicit drug users were health related, followed by family problems. Among tobacco and alcohol users, however, health problems were reported less frequently than family problems. This probably relates to the relatively young age structure of the sample (age limit of 45) and the fact that serious health consequences of chronic tobacco and alcohol use often do not arise until later in life.

G. Perception of Drug Problems

Promoting drug awareness in the population at risk of drug use is the most immediate concern in designing and developing a drug prevention effort. Two questions were asked to measure public awareness of drug problems. Respondents were asked whether they think drug consumption in the Dominican Republic is a problem, and whether drug trafficking is a problem. The majority of urban Dominicans considered both drug consumption and drug trafficking as serious problems (96% for both).

Seventy-four percent of respondents had seen or heard a message concerning drug issues in the last month. As Table 4.12 indicates, television was by far the most common source of information, having reached most urban Dominicans (67%). Radio, posters, newspapers and magazines, in that order, are the next most important sources of information. Only 19% of Dominicans received drug related information through a community organization. Furthermore, the respondents who are older (35-45), live in Santo Domingo, or belong to the upper class are more likely to have received a message concerning drug use than those who are very young (12-14), live in mid-sized or small-sized cities, or belong to the middle or lower classes. Differentials of receiving a drug-related message between men and women are negligible.

Respondents reported that family (40%) and police (35%) are by far the strongest inhibiting factors against drug use, followed by the cost of drugs (12%) (See Table 4.13).

H. Summary

Illicit drug use in the urban areas of Dominican Republic is considerably lower than in urban areas of other Latin American countries (i.e., Panama, Peru, Guatemala, Haiti). Alcohol shows the highest prevalence followed by tobacco. Among urban areas, Santo Domingo has the highest lifetime and current use (last 30 day) of alcohol and marijuana, and the highest current prevalence of cocaine, while mid-sized cities have the highest lifetime and current prevalence of inhalants.

Table 4.12
Sources of Information Concerning Drug Use by Social and Demographic Characteristics in the Dominican Republic
(Weighted N = 6,411)

	Television	Poster	Radio	Newspapers & Magazines	Community Organizatio n	Other s	Total
Total	66.5	30.8	38.4	27.8	19.2	5.9	74.0
Santo Domingo	76.8	42.4	46.8	36.0	24.9	7.1	82.1
Mid-sized cities	67.4	24.1	32.9	21.2	12.4	3.7	74.4
Small-sized cities	54.9	23.7	33.6	24.1	18.4	6.3	65.1
Men	66.2	32.3	39.0	28.7	19.1	6.3	74.6
Women	66.8	29.5	37.8	27.0	19.4	5.6	73.5
12-14	56.1	21.4	29.3	19.5	13.5	3.7	66.8
15-19	68.0	32.8	39.7	28.4	20.7	6.4	73.6
20-24	68.1	32.6	40.0	31.9	18.4	7.1	77.8
25-29	67.3	29.7	35.4	26.0	17.6	5.1	74.4
30-34	70.4	29.3	36.6	27.7	18.4	6.4	76.5
35-39	68.9	33.8	42.3	30.7	23.3	7.1	74.7
40-45	63.8	32.9	43.6	27.2	22.5	4.3	71.5
Upper class	76.7	42.7	37.0	33.7	18.3	5.3	82.0
Middle class	70.1	37.0	40.6	32.0	24.1	7.0	76.3
Lower class	63.2	25.9	37.2	24.7	16.4	5.3	71.8

Table 4.13
Factors Inhibiting Drug Use in the Dominican Republic
(Weighted N=6,411)

Factors	Percent
Police	35.2
Family	39.8
Publicity campaign	6.1
Friends	0.8
Religion	4.1
Cost of drugs	11.5
Others	2.4
Total	100.0

Small-sized cities have the highest lifetime prevalence of crack.

Men are more likely than women to be current and lifetime users of illicit drugs, while women are more likely than men to have used pharmaceuticals. Inhalants are more likely to have been ever or currently used by the youngest age groups (12-24). Persons ages 20-29 are more likely than persons in other age groups to have tried marijuana and cocaine. More than half of first use of inhalants occurred before age 15. Most of first use of marijuana and cocaine occurred between ages 15-24, whereas all crack use started between ages 15-19.

Lifetime and current prevalence of marijuana is similar across social classes. Upper and middle class persons are more likely to have used cocaine in their life, but current use of cocaine is more common among the lower class. Illicit drug use is greater among persons who have not reached or not completed secondary school, blue collar workers and students. Frequency of illicit drug use suggests that, although the prevalence of marijuana, cocaine and crack is lower than the prevalence of inhalants, these drugs are used more intensively than inhalants among those who have ever used.

Illicit drugs were more often used with alcohol than with another illicit drugs, although marijuana and cocaine are often used concurrently. Likewise, a strong positive relationship was found between lifetime use of marijuana and cocaine.

The most commonly expressed problems due to illicit drug use were health related, while family problems were most often reported in the case of alcohol and tobacco use. The majority of urban Dominicans considered both drug consumption and drug trafficking as serious problems, and have seen or heard a message concerning drug issues in the last month. Television was by far the most common source of information. Urban Dominicans who are in the oldest barcket included in the survey (35-45), live in Santo Domingo, or belong to the upper class are most likely to have received a drug-related message via any source of information. Family and police are considered the strongest inhibiting factors against drug use.

In sum, this study indicates that overall there is not an major illicit drug use problem in municipalities of the Dominican Republic with a population of 20,000 or more at this time. It should be noted, however, that there is a high level of illicit drug use among the younger population. The use of marijuana and cocaine among this population is quite frequent and apparently increasing. The use of inhalants among the youngest age groups also is apparently increasing. The study also suggests that primary prevention of drug use is weak, since those who are at greatest risk (i.e., younger persons) are least likely to be aware of the problem.

CHAPTER V

FOCUS GROUP ANALYSIS

A. Background on the Study

In order to test the range of possible drug prevention messages that might be effective in the Dominican context, we conducted a focus group study using twenty-four groups. The focus groups consisted of six to ten participants, who ranged in age from twelve to forty-two years. The groups were divided by age into those 12-17 years, 18-28 years and 29-42 years. The focus groups were conducted in Santo Domingo and in cities in the interior of the country (San Pedro de Macorís, Hato Mayor, Barahona, Baní, Santiago de los Caballeros and Bonao). The groups were divided equally according to socio-economic stratum. Thus, there were eight groups of upper class participants, eight groups of middle class participants and eight groups of lower class participants. Table 5.1 describes the breakdown of groups by sites and characteristics.

All twenty-four groups were presented with three sets of story boards which consisted of four drawings. These drawings depicted three different messages: (1) a negative message, so- called because it presented the negative consequences of consuming drugs (e.g. if you take drugs you will end up in jail); (2) a positive message, so-called because it presented the consequences of **not** consuming drugs (e.g. you will be a happy and successful person if you do not consume drugs); and (3) a "ridiculous" message, so-called because it depicted drug users as ridiculous and pathetic. These messages were presented in the story board as they would appear on a television commercial. For example, they explain camera movements (e.g. the camera will view the model close up early in the commercial, but in the end will pan out so that the audience sees the true situation...what at first appears to be a normal person becomes a beggar) and what the announcer would say.

Within each social class the initial message was rotated for each group. Thus, the upper class focus groups began once with the positive message, once with the negative message, and once with the ridiculous message. This was true also in the middle and lower class groups. The discussions then generally followed this order:

- identification of the message;
- conversation designed to determine the effect of the message;
- conversation designed to determine which segments were most effective;
- conversation designed to determine whether the message had an impact;
- in-depth discussion, and a summary of ideas;

Table 5.1
Focus Groups Conducted By Location and Social Class

	Upper Class			Middle Class			Lower Class			Total
Location	12-17 years	18-28 years	29-42 years	12-17 years	18-28 years	29-42 years	12-17 years	18-28 years	29-42 years	
Santo Domingo	2	1	1	1	2	1	1	1	2	12
San Pedro de Macoris	1				1				1	3
Bonao						1				1
Hato Mayor								1		1
Barahona		1				1	1			3
Bani	1									1
Santiago			1	1				1		3
Total	4	2	2	2	3	3	2	3	3	24

- identification of the remaining messages and a repeat of the above process for each remaining message;
- coffee break;
- discussions regarding attitudes and opinions concerning drugs.

All conversations were taped and later transcribed.

B. Response to the Messages

In general, the groups preferred the negative message over the positive message, the positive message over the ridiculous message, and found little value in the ridiculous message. Specifically, the negative message was preferred by six of the eight upper class groups, six of the eight middle class groups, and by all of the lower class groups. The positive message was preferred by two middle class groups and one upper class group. The ridiculous message was rejected by an overwhelming majority; only one upper class group preferred it and believed it would be the most effective. The overall perception of the groups was that the negative message would be more effective with middle and lower classes and among 12-17 year olds. The responses are summarized in Table 5.2.

Interestingly, all twenty-four groups preferred a message which was not presented in the story boards. This was a mixed positive and negative message. The groups believed that such a message would be the most effective in reaching all socio-economic groups, the widest age range, and both users and non-users. An example of such a message is showing one drug free person who has just accomplished a great goal (e.g. graduation from the University), and one drug addicted person who is experiencing a great frustration (e.g. being committed for psychiatric care). In this way, both the consequences of use and abstinence are depicted.

1. The Negative Message

The negative message story board, displayed to the groups, depicted a young man who explains that drugs were "cool" and that he seldom gave thought to them. The camera then pans out and the youth is seen sitting in a jail cell, explaining that he now has plenty of time to think.

This message was popular among the groups for a variety of reasons. First, it is a common child-rearing technique of Dominican parents to focus on the negative. In other words, when a parent desires a certain behavior from the child (e.g. not stealing cookies from the cookie jar) the parent will explain the consequences associated with stealing cookies (e.g. the child will be spanked, grounded, scolded, etc.) Dominican parents do not tend to focus on the positive consequences of avoiding a behavior. Thus, a Dominican parent would not explain that by not stealing the cookies the child is becoming a more dignified and honest human being.

Table 5.2
Approach Preference and Predicted Effectiveness by Location and Class

	Upper Class			Middle Class			Lower Class		
Location	12-17 years	18-28 years	29-42 years	12-17 years	18-28 years	29-42 years	12-17 years	18-28 years	29-42 years
Santo Domingo	Negative and positive, upper class, and 12-17 year olds. Ridiculous, upper class, 12-17 year olds.	Negative, lower class and 12-17 year olds.	Negative, lower and middle class, 12-17 year olds.	Negative, no comment on stratum or age.	Negative, middle class, 12-28 year olds. Positive, no comment on stratum or age.	Negative, middle class, over 18 year olds.	Negative, middle and upper classes, 12-17 year olds.	Negative, 18 year olds and higher.	Negative, middle class, no age category agreement Negative, lower and middle class, 12-17 year olds.
San Pedro de Macoris	Negative, upper class, 12-17 year olds.				Negative, any class, any age group.				Negative, middle class, younger persons.
Bonao						Positive, middle class, 18 to 28 year olds.			
Hato Mayor								Negative, all strata, 12-17 year olds.	
Barahona		Positive, middle class, 18-28 year olds.				Negative, middle and upper classes, 12-17 year olds.	Negative, all strata, 12-17 year olds.		
Bani	Negative, lower class, 12-17 year olds.								
Santiago			Negative, lower class, 12-17 year olds.	Negative, lower class, 12-17 year olds.				Negative, middle class, 12-28 year olds.	

Second, the groups believed that the negative message would be the only type of message capable of reaching those already addicted to drugs. The groups believed that no message, no matter how severe, could effectively stop users from consuming drugs, but they felt that a sufficiently strong and dramatic negative message could make an addict stop and think.

Third, the groups considered the negative message the most effective at preventing abuse among non-users.

Fourth, the negative message is easier to understand. This was the most easily identified of the three messages presented. The purpose of the message was clear to the groups.

Fifth, the groups believed that the negative message could reach a wider range of ages. They felt that a general prevention message might be effective among youths ages twelve to seventeen, but a negative message could be effective in a range from twelve to twenty-eight. After the age of twenty-eight, the groups believed that no message of any kind could be helpful. This is because participants felt that if one had not acquired bad habits by the age of twenty-eight, there was little risk that one would ever acquire them. If one did acquire bad habits, at that age there would be no salvation for that person.

Sixth, the negative message seems to be more easily remembered due to its greater impact. The groups cited the commercial where a man cracks an egg into a frying pan. The man states that the egg represents the human brain, and the frying egg inside the pan represents the human brain after it has absorbed drugs. (This is a commercial designed by the Partnership for a Drug Free America.)

Finally, the groups found the message to be concrete, and an accurate depiction of reality. It was noted by many groups, however, that jail and other similar consequences were not a reality for the rich nor for drug traffickers.

It should also be noted that there were entire groups which made no negative comments about this type of message. This did not happen in the other two message categories. The few adverse comments that were made included the following:

- There have been negative messages around for quite a while and yet drug consumption is on the increase.

- Such messages will push the curious into experimentation to prove whether the commercials or the drug dealers are correct.

- The message constituted a threat.

The participants felt that the negative message would be most effective in the middle class, but would have an impact on the lower class as well. The groups did not believe the message would be effective in the upper class. They reasoned that there is so much corruption, influence purchasing, and affluence that not only could this class afford to purchase the drugs, but they could also afford to quickly buy their way out of prison.

Although the participants liked negative messages in general, they felt that such messages should not focus on the physical damage drugs can cause. This is because the groups believed that many people are attracted to drugs because they have problems that they cannot solve and lack the courage to commit suicide. The groups felt that such individuals would be even more drawn to drugs with the message that drugs are a means to a slow death. The groups also believed that negative messages should not depict jail as the ultimate consequence of drug use when trying to reach the lower classes. This was due to the general belief that poverty is so severe in the Dominican Republic that many poverty stricken individuals would feel there is nothing to lose. Jail might even come as a relief.

The participants believed that a more appropriate focus would be on mental and intellectual effects. A desperate person may not fear death, but is likely to fear mental incapacity, total reliance on others for well-being, and loss of ability to achieve goals. In summary, it appears that the preference for the negative message is related to the drama it portrays, a drama that is enhanced if it is made more appropriate to circumstances in the Dominican Republic.

2. The Positive Message

The positive message story board depicts an attractive, healthy young man on the beach who appears to have received congratulations from others present. The message is that one who avoids drugs will be a happy person.

This was chosen as the second best message, but it received little support because the groups thought it was too simplistic. Those who liked the message generally did so because it was positive and non-threatening. The discussions indicated that the participants thought that is all well and good to show the benefits of abstinence so long as the consequences of using drugs are also shown. This was a critical element. It was also apparent that the participants had a greater degree of difficulty in identifying the message.

The participants firmly believed that to successfully prevent drug abuse, a message had to be forceful, have a great impact, and be dramatic in its depiction of drug addiction.

The groups also found fault with the specific message being sent (i.e., that abstinence would translate into personal happiness). As one participant pointed out, he was healthy, strong, and drug free, just like the model in the positive message, but he was not happy. Again, poverty in the country is so severe and so widespread, that it was thought there are a tremendous number

of healthy, drug free and unhappy persons. The groups felt it was more appropriate to focus on the attainment of goals. They suggested showing that one cannot achieve goals nor advance oneself if one is addicted to drugs.

The groups did not believe that positive messages could have any effect on those already addicted to drugs. As stated above, the groups thought only very strong and very negative messages could have any effect upon that group. The positive message was believed to be the most effective among very young, middle class, non-users. The groups indicated that the messages would have no effect upon the rich because they are already happy, and would have no effect among the very poor because they are already very unhappy. Since the poor cannot go down any further, they may believe that drugs are the only way to move up. Since the poor will recognize the message as false (they do not take drugs and they are not happy; therefore, the message is wrong), they may be further tempted to find out if the drug dealers are correct (drug dealers advertise that drugs will produce happiness). Thus, not only would positive messages of happiness not help, they could do damage.

The participants thought that with the correct theme, positive messages could be somewhat effective. The groups suggested that the focus of the message should be goal achievement rather than attainment of happiness. The participants did not provide firm answers as to which social classes would be affected by such a message, but did indicate that it would be effective among non-users between the ages of twelve and twenty-eight.

In addition to the limited support for the type of message, the participants also criticized the presentation. It was felt that the young man on the beach must be from the upper class, because the poor can seldom go to the beach. When they do go, the poor do not look like the young man on the story board, either in terms of happiness or in terms of well-being.

3. The Ridiculous Message

The ridiculous message story board depicts a man who claims to be an expert in matters of drugs. He implies that he knows the secret to success in life. The camera pans out, and the audience sees that he is a beggar. He is asking a passerby for some change.

Few if any positive comments were made about the ridiculous message. There were a considerable number of adverse comments including:

- such messages will further sink addicts into the world of drugs by isolating and offend ing them;
- the message is more difficult to identify; it is too complex;
- the message would be most effective, if at all, among the upper class, because the more ;

comfortable one feels, the less one wishes to appear ridiculous;

- the message would have no impact on the poor who already must begin the street for money due to their economic situation;
- the message is unclear and confusing;
- addicts would laugh at it;
- it would make addicts uncomfortable;
- it makes fun of addicts; (Dominicans view addicts as people who have an illness, therefore it is inappropriate to ridicule them);
- it is ineffective.

C. Attitudes And Opinions About Drugs

There were five very distinct ways in which participants viewed the danger of drugs. The number one danger was physical: destruction of the person. The other four dangers were informally ranked as follows: mental/intellectual damage, damage to society due to the delinquency caused by drugs, damage to the family, and spiritual/moral damage.

A great variety of causes for drug abuse were given. They included: family problems, (e.g., lack of communication, inattentive parents, lack of faith, and divorce), experimentation, peer pressure, poverty, powerlessness (irresolvable problems and the lack of "courage" to commit suicide), availability of drugs, and corruption.

D. Interpretation of Results

Socio-cultural and sociological context seems very important for messages to convey anything. Relevance to specific groups to whom messages are being communicated is also important.

Focus groups interpreted the messages using criteria based on cultural and sociological relevance. Cultural and sociological relevance make messages more credible, thus increasing their potential impact.

Hispanic culture tends to have a dramatic interpretation of life.[6] Focus group participants showed a preference for dramatic messages. Messages with a negative appeal are preferred because of the drama they portray. That drama is related to the threat that drug consumption represents.

It was argued that the dramatic perception of life may have conditioned parents to express concern and protectiveness by emphasizing the negative consequences of behaviors. If the audience is used to being socialized through negative appeals (or threats), messages regarding drug use need to use the same approach.

Messages using positive appeals are not attractive for two reasons. One is the lack of dramatization. The other is the lack of realism. Happiness is portrayed using signs of financial well-being, but a drug free life is not necessarily a happy one. Happiness is determined by a series of factors.

The preference for dramatic message content does not mean that the way in which negative appeals are now presented is the culturally appropriate manner to attract attention and have impact on a Dominican audience. The consequences of using drugs need to be culturally relevant. Relating drug use to imprisonment is sociologically unrealistic, as the penal system in the Dominican Republic has special characteristics. Relating drug use to death may be ineffective, since those who do drugs are in fact "committing suicide slowly," and would thus have their expectations confirmed. The focus group participants believe that there are several negative outcomes of drugs. Drugs may have an impact on the individual (physical, intellectual or moral) or on society (society at large or the family). Intellectual impact on the individual is a preferred outcome from the cultural point of view, if one wants to have the intended result.

The messages with a positive appeal may be improved if they are made culturally sensitive. "Happiness" needs to be replaced with the ability to meet personal objectives. "Arrivismo" (social climbing) is also a very important aspect of Latin American culture. In other words, being ambitious and realizing personal objectives is an important value in Latin American culture. That value could be used to make the positive messages more attractive.

E. Conclusion

- One would expect that self-confidence or self-esteem would be good dissuadors of drug use in adolescents, and that personal goal attainment would play the same role among young adults. Conclusions of this study suggest otherwise, as dramatic content and realism are perceived to be key elements of effective messages, particularly for adolescents of the lower and middle class.

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6 See M. de Unamuno, El Sentimiento Trágico de la Vida en Los Hombres y en Los Pueblos. Las Americas Publishing Company, New York.

- It is not clear, however, what behavior these messages are intended to change: prevention of drug initiation, prevention of experimentation, or the conversion of users into non-users. The perception by study participants was that the messages may have more impact on preventing initiation than on converting users to non-users.

- Respondents suggested that a much better approach would be to combine negative and positive appeals in one message.

- Effective messages need to link culturally relevant content to a clear definition of objectives directed at a particular target audience.

CHAPTER VI

PREDISPOSITIONS TOWARDS DRUG USE

This chapter explores predispositions regarding drug use to assist in designing appropriate intervention strategies. Specifically, this chapter examines intentions, attitudes and social norms toward drug use. The conceptual framework for this study comes from the theory of reasoned action (cf. Middlestadt and Fishbein, 1990), which hypothesizes that drug use behavior is primarily determined by the intention to use, and that intention is in turn determined by a person's attitude toward that behavior and a person's view of what significant others (family, peer group, best friends) think of the behavior. Attitudes are in turn determined by a person's understanding and evaluation of what will occur when drugs are used. The norms provided by significant others are a function of both the existing beliefs of those significant others and a person's willingness to comply with those beliefs. Within this conceptual framework, the attitudes towards the behavior are "the perceived consequences that influence whether or not to execute a given action". The social norms are related to the "perception of social pressures towards the execution of a given action."

A. Operational Definition

The scale used to measure predispositions in this study is derived from the theory of reasoned action. This scale consists of three aspects -- intention, attitudes and social norms toward drug use. It is operationalized as follows:

Intention -- For alcohol and tobacco use, intention is conceptualized as the behavior of **reducing** or **quitting** the habit. With regard to the other substances (marijuana, cocaine, crack and inhalants), intention refers to the expressed affirmation or disposition to **try** the substances.

Attitudes --his aspect constitutes the evaluative element regarding the substances, based on the perception of positive or negative sensations or effects that result from the behavior of consumption. In the case of alcohol and tobacco, behavior refers to the reduction or interruption of the habit, whereas, for other substances, these effects are related to trying the substances.

Social Norms -- These relate to the manner of thinking and acting that persons attribute to others in their reference groups (friends, family members, acquaintances). In the case of alcohol and tobacco, this attribution is positive towards the reduction or cessation of consumption. In the case of other substances, the attribution is positive towards the initiation of use or trying the substance.

B. Construction of the Scale

1. Tobacco and Alcohol

Intention -- The first sub-scale refers to the expressed intention to "quit smoking" or "reduce consumption" in the next 12 months.

Attitudes -- The second sub-scale consists of three questions: "Is it a good idea", "beneficial", "agreeable" to quit smoking or reduce consumption of alcohol in the indicated period.

Social Norms -- There are three items in the third sub-scale. The first two refer to whether "the majority of people who are important to me", "my friends and family" and "most of my friends" think that "I should quit or reduce" my consumption. The third refers to "most of my friends have quit or reduced" consumption of tobacco or alcohol.

Perception of the Difficulty of Quitting or Reducing Consumption -- For tobacco and alcohol a fourth sub-scale was added, which refers to the perception of the difficulty of quitting or reducing consumption of tobacco or alcohol.

2. Marijuana, Cocaine, Crack, and Inhalants

Intention - In the first scale, there are two items: "I am going to try" and "I am willing to try" the substances.

Attitude -- The second sub-scale consists of four questions to evaluate sensations and effects: "it's a good idea" "it's beneficial", "agreeable", "exciting" to try the substance in the next 12 months.

Social Norms -- The following five questions are included in the third sub-scale to evaluate perceived norms: "most of the people who are important to me", "my family", "most of my friends" think that I should try the substance, "most of my friends have" and "I know someone who has" tried the substance.

Specific Social Norms -- There is only one item in the fourth sub-scale: "my boy-friend/girlfriend or spouse thinks" that I should try the substances.

3. Coding of Responses

Responses are coded on a continuous scale ranging from negative (0) to positive (2). The response "NO" is coded 0 as a negative response, the response "I DON'T KNOW" is coded 1 as undecided between negative and positive responses, and the response "YES" is coded 2 as a positive response.

It is important to note that for alcohol and tobacco, due to the way the questions were asked (about reducing or quitting of consumption), a higher number on the scale indicates a positive attitude towards reducing or quitting of consumption. For the other substances, a higher number on the scale should be interpreted as a positive attitude towards trying or using the substance.

C. Analysis

1. Predispositions

a. Tobacco and Alcohol

As Table 6.1 presents, more than half of smokers intend to quit smoking in the next 12 months (52.5%), and have a positive attitude toward quitting smoking. However, 30% of smokers did not intend to quit smoking. There is also a considerable proportion of smokers who have not perceived any pressure to quit smoking (6.9% negative, 50.4% undecided).

As with tobacco, the majority of alcohol consumers have a positive attitude towards the reduction of consumption (60.2%). However, there is a striking difference between smokers and alcohol consumers with regard to social norms and difficulty of reduction. Alcohol consumers do not perceive social pressure as much as smokers to reduce their consumption (0.6% compared to 42.7% of smokers), while the majority of alcohol consumers (77.4%) perceived less difficulty reducing their consumption than smokers (49.6%).

b. Marijuana, Cocaine, Crack and Inhalants

Table 6.2 presents predispositions toward illicit drug use. Most respondents reveal a negative intention toward trying marijuana, cocaine, crack, or inhalants (98.2%, 98.8%, 98.6%, 97.7% respectively). The majority of respondents also have a negative attitude toward trying illicit drugs, although they have more a positive attitude toward trying marijuana than cocaine, crack or inhalants. Consistently, respondents perceive more positive pressure to try marijuana than cocaine, crack or inhalants.

2. Correlations between Intentions and Other Sub-Scales

To understand the dynamic of predispositions, correlations between intention and the other sub-scales were examined for each substance.

Table 6.3 shows a strong positive association between intention to quit tobacco or reduce alcohol consumption and the item "it is a good idea to quit smoking or reduce consumption of alcohol." All of the other correlations were moderate. With regard to alcohol consumption, the social norms (i.e., friends/family think that I should reduce alcohol consumption) have the second

Table 6.1
Predispositions toward Quitting or Reducing Alcohol and Tobacco Use
(Values in %)

	Intention			Attitude			Social Norms			Ease of Reduction		
	Neg	Und	Pos	Neg	Und	Pos	Neg	Und	Pos	Neg	Und	Pos
Tobacco	30.1	17.3	52.5	2.8	43.2	54.0	6.9	50.4	42.7	18.2	32.2	49.6
Alcohol	31.2	8.6	60.2	7.3	34.8	58.2	15.1	84.3	0.6	9.0	13.6	77.4

** Neg = Negative attitudes; Und = Undecided attitudes; Pos = Positive attitudes

Table 6.2
Predispotions toward Trying Illicit Drugs
(Values in %)

Sub-scales	Response	Marijuana	Cocaine	Crack	Inhalants
Intention	**Negative**	98.2	98.8	98.6	97.7
	Undecided	1.6	1.1	1.3	2.2
	Positive	0.2	0.1	0.0	0.2
Attitude	**Negative**	78.9	84.8	83.8	84.9
	Undecided	21.0	15.2	15.2	15.1
	Positive	0.1	0.0	0.0	0.0
Social Norms	**Negative**	65.5	79.1	89.3	85.5
	Undecided	34.5	20.9	10.7	14.5
	Positive	0.0	0.0	0.0	0.0
Specific Norms	**Negative**	95.6	98.6	98.6	98.6
	Undecided	1.4	1.1	1.1	1.1
	Positive	0.3	0.3	0.3	0.3
Combined Scale	**Negative**	57.3	69.9	79.3	77.1
	Undecided	42.7	30.1	20.7	22.9
	Positive	0.0	0.0	0.0	0.0

Table 6.3
Correlations between Intentions to Reduce Drinking and quit Smoking
and the Other Sub-scales

Sub-scale	Items	Tobacco	Alcohol
Attitude	**Good idea to quit or reduce**	.4179**	.5881**
	Beneficial to quit or reduce	.1075*	.2309**
	Agreeable to quit or reduce	.2018**	.2855**
Social Norms	**Important others think I should quit or reduce**	.1771**	.3434**
	Friends/family think I should quit or reduce	.1808**	.4739**
	Friends have quit or reduced	.1882**	.2830**
Perception	**Perception of Control**	.3093**	.3949**
	Perception of Ease	.2720**	.2817**

Note: * denotes significant at .01 level; ** at .001 level on 1-tailed test.

strongest relationship with intention to reduce alcohol consumption.

Table 6.4 also shows that the strongest relationship is between intention to try illicit drugs and "it is good idea to try illicit drugs." With regard to marijuana, "beneficial to try marijuana"has the second strongest relationship with intention to try. As for cocaine and crack, social norms significantly influence the intention to try these substances. Pressure from family or significant others strongly influences the intention to try cocaine. Pressure from boyfriend/girlfriend or spouse has a strong relationship with the intention to try crack. In the case of inhalants, pressure from friends has the second strongest relationship with the intention to use.

3. Age

There were no significant differences among age groups with regard to social norms among smokers. Table 6.5 shows a significant difference, however, in social norms between the youngest group (12 to 14 years old) and other age groups among alcohol consumers. The youngest group perceives the greatest pressure from their reference group to reduce their consumption of alcohol. The group that perceives the least pressure is persons made up of ages 35 to 39.

As in the case of alcohol, there were significant differences among age groups in the perceived social pressure towards trying marijuana. The differences were most apparent in the age group 15 to 29 years old. Less pressure is felt in the youngest group and in those older than 29. Persons

ages 15-29 reported more pressure from their reference group than those 12-14 or 35-39 did. In case of cocaine, the differences are similar to those for marijuana. As for crack and inhalants, persons ages 15-19 experience the greatest pressure from their reference group.

4. Gender

Table 6.6 presents differences in social norms among men and women regarding quitting smoking. Women smokers perceived more pressure than men to reduce their consumption of tobacco. As for alcohol, more men than women expressed an intention to reduce their consumption and have a positive attitude toward reducing consumption. These results may come from the fact that men are more likely to consume more alcohol than women.

As for illicit drug use, men perceived greater pressure from their reference group (friends and family) to try the substances than women did. The pattern for intention to try illicit drugs showed similar differences between men and women. More men than women also expressed an intention or willingness to try illicit drugs. This follows the general pattern of drug prevalence discussed in chapter IV.

In sum, men have a more positive attitude than women towards trying illicit drugs, and they also are more likely than women to intend to quit smoking or reduce alcohol consumption.

5. Educational Attainment

Table 6.7 presents differences in predispositions toward drug use by educational attainment. For tobacco and alcohol users, social norms show a significant difference among educational groups. Smokers who completed university perceived less pressure from their reference group to stop smoking than those who had not completed university or had less than university education. Alcohol consumers who had some university education also perceived less pressure to reduce their alcohol consumption than those without any university education.

With regard to illicit drug use, Table 6.7 also shows significant differences in social norms by education attainment. Those who had more than primary education perceived greater pressure to try marijuana or cocaine than those who had primary education or less. As for inhalant use, persons who had no university education felt more pressure to try inhalants than those who had university education.

Table 6.4
Correlations between Intentions to Initiate or Continue Consumption and the Other Sub-scales

Sub-scale	Item	Marijuana	Cocaine	Crack	Inhalants
Attitude	**Good idea to try**	.5375**	.6079**	.6589**	.7574**
	Beneficial to try	.3168**	.3676**	.3495**	.2958**
	Agreeable to try	.1891**	.2478**	.1625**	.3391**
	Exciting to try	.1990**	.2338**	.2285**	.3256**
Social Norms	**Important others think I should try**	.1311**	.3864**	.3159**	.2972**
	Friends think I should try	.1788**	.3116**	.2495**	.4156**
	Family think I should try	.2161**	.4242**	.2970**	.3081**
	Friends have tried	.1744**	.2260**	.2543**	.3366**
	Acquaintances have tried	.1066**	.1563**	.2491**	.1863**	
Specific Norms	**Boyfriend/girlfriend or spouse thinks I should try**	.1596**	.3925**	.4075**	.2083**

* denotes significant at .01 level; ** at .001 level on 1-tailed test.

Table 6.5
Social Norms by Age Groups

	F Ratio	F Prob.	12-14 Years	15-19 Years	20-24 Years	25-29 Years	30-34 Years	35-39 years
Alcohol	3.0488	.0096	1.21	1.06	1.12	1.07	1.06	.98
Marijuana	9.1296	.0000	.11	.19	.20	.18	.16	.12
Cocaine	5.0052	.0001	.06	.12	.12	.10	.09	.06
Crack	3.1397	.0079	.04	.07	.05	.05	.04	.03
Inhalants	4.0761	.0011	.05	.09	.08	.06	.06	.04

6. Users of Different Substances by Level of Consumption

a. Users of Alcohol (12 month Prevalence)

i. Attitudes towards consumption of alcohol

Alcohol users varied in their perception of social norms depending on their level of consumption in the last 12 months. Those who expressed the greatest frequency of use, 2 or more times a month over the last year, expressed the least perception of social pressure to reduce their consumption of alcohol.

Table 6.6
Predispositions toward Drug Use by Gender

Substance	Sub-scale	Gender	Mean	Dev.	Error	t Value	p
Tobacco	Social Norms	Men	1.4365	.593	.036	-2.11	.036
		Women	1.5441	.570	.036		
Alcohol	Intention	Men	1.3793	.875	.031	4.0	.000
		Women	1.1937	.939	.034		
	Attitude	Men	1.5934	.605	.021	2.9	.004
		Women	1.5000	.670	.024		
Marijuana	Social Norms	Men	.2022	.300	.009	6.45	.000
		Women	.1370	.244	.006		
Cocaine	Intention	Men	.0135	.121	.003	1.68	.093
		Women	.0072	.082	.002		
	Social Norms	Men	.1265	.260	.007	5.23	.000
		Women	.0816	.206	.005		
Crack	Social Norms	Men	.0553	.186	.005	2.39	.017
		Women	.0406	.145	.004		
Inhalants	Intention	Men	.0252	.163	.005	2.11	.035
		Women	.0143	.114	.003		
	Social Norms	Men	.0783	.215	.006	2.82	.005
		Women	.0577	.176	.004		

From the manner in which the measures of perceived social pressure decline with the increase in level of consumption it could be argued that the perception of social norms, or lack thereof, plays an important role in the level of consumption. Supporting this idea, those that sense the greatest pressure not to drink are those that claimed not to have drunk their usual quantity of alcohol on any occasion in the last 12 months. (See Table 6.8.)

ii. Attitudes of alcohol users towards consumption of other substances

Alcohol users showed the same attitudinal tendencies towards consumption of marijuana and cocaine as they showed towards consumption of alcohol. Following the same pattern as noted above: to the extent that their consumption of alcohol increased, their perception of social pressure to try marijuana and cocaine increased. It appears that alcohol users belong to that part of the population that is more likely to find itself in an ambience favoring the consumption of these other substances. Once again the greatest difference in attitudes exists between those that did not drink, and those that drank the most in Table 6.7 & Table 6.8the last twelve months. (See Table 6.8.)

In the case of marijuana there were also significant differences in the general attitudes towards consumption between the different alcohol consumption groups with those that consume the most having the most favorable attitudes towards trying marijuana. This pattern reaffirms the other patterns indicated above Table 6.8 as well as indicating a certain consistency in the instrument.

The tendencies are even clearer if we look at the levels of consumption of alcohol in the last 30 days and compare them with attitudes towards the use of other substances. There is a definite pattern not only in the attitudes towards use of marijuana and cocaine but also in the attitudes towards the use of crack and inhalants. In all cases the tendency is consistent: the biggest consumers of alcohol, those that drank 6 or more times during the last 30 days, are those that show the most favorable general attitudes towards the consumption of the other substances. They perceive the most positive or favorable effects from the use of marijuana and cocaine as well as the most positive social pressure towards the use of all four substances.

These correlations can be explained in two ways. On the one hand, it could be argued that familiarity with the effects of alcohol consumption may make the search for new substance-induced sensations more appealing. (It is interesting to note that among the heavy consumers of alcohol, there are variations in the behavioral dimension of attitudes towards consumption, which are lacking in the other aspects.) On the other hand the above mentioned correlation may very well be caused by the environment in which the heavier drinkers find themselves, an environment more conducive to the use of other substances. It is a fact that heavy drinkers register a consistently

Table 6.7
Predispositions toward Drug Use by Educational Attainment

Substance	Sub-scale	F Ratio	F Prob.	< 2nd	Primary		Secondary		University	
					Part	Grad	Part	Grad	Part	Grad
Tobacco	Social Norms	2.6966	.0139	1.41	1.51	1.58	1.56	1.55	1.35	1.13
Alcohol	Social Norms	4.0166	.0005	1.02	1.17	1.14	1.07	1.07	.91	1.01
Marijuana	Attitude	3.1919	.0040	.07	.07	.07	.08	.11	.10	.09
	Social Norms	10.0179	.0000	.08	.12	.15	.20	.20	.20	.19
Cocaine	Social Norms	5.3604	.0000	.04	.07	.11	.13	.11	.11	.12
Inhalants	Social Norms	3.5596	.0016	.04	.06	.06	.09	.07	.05	.05

Table 6.8
Predispositional Differences By Level of Alcohol Consumption
in the Last 12 Months

Substance	Sub-scale	F Ratio	F Prob.	Level of Alcohol Consumption (0=low; 3=high)			
				0	1	2	3
Alcohol	Social Norms	2.9492	.0317	1.167	1.05	1.15	1.04
Marijuana	Social Norms	10.8405	.0000	.16	.18	.19	.26
	Combined	3.7774	.0102	.07	.07	.07	.10
Cocaine	Social Norms	4.7638	.0026	.09	.11	.11	.15
			Last 30 Days				
Marijuana	Attitude	3.0993	.0149	.07	.07	.06	.13
	Social Norms	10.6131	.0000	.18	.17	.27	.39
	Combined	8.4270	.0000	.07	.08	.09	.14
Cocaine	Attitude	2.2044	.0663	.05	.07	.06	.10
	Social Norms	4.8496	.0007	.11	.12	.16	.20
	Combined	5.5111	.0002	.04	.05	.06	.10
Crack	Attitude	2.2044	.0663	.05	.07	.06	.10
	Social Norms	3.9775	.0032	.03	.05	.08	.09
	Combined	3.2318	.0119	.03	.04	.04	.06
Inhalants	Social Norms	2.5877	.0353	.06	.07	.09	.13

different impression of the subjective norms influencing them.

b. Marijuana Users

i. Attitudes of marijuana users towards alcohol

There were significant differences in the attitudes of marijuana users towards consumption of alcohol depending on the level of consumption of marijuana in the last 12 months. Those that consumed the most marijuana expressed the greatest intention to reduce their consumption of alcohol. (See Table 6.9.)

ii. Attitudes of marijuana users towards marijuana

Marijuana users expressed the greatest variation in their attitudes towards consumption of marijuana based on their level of consumption. In all of the sub-Table 6.9scales, the group that reported having used marijuana 2 or 3 times in the last 12 months was significantly different from the group that had not used marijuana at all in the last 12 months. Those that had used marijuana in the last 12 months expressed their intention to continue to use, perceived more positive results from using, and perceived greater peer pressure, both in terms of the general and specific indicators, to continue using than those that had not used marijuana in the last 12 months. Overall the general attitude towards using marijuana is significantly more positive among those who are currently using the substance than those who have only tried it in the past. (See Table 6.9.)

iii. Attitudes of marijuana users towards cocaine and crack

Analyzing the attitudes of marijuana users towards the use of cocaine and crack a similar tendency to that mentioned above is observed. Once again it is the heavier marijuana users (3 or 4 times in the last 12 months) who express the greatest intention to consume cocaine and/or crack in the next 12 months. Thus, they differentiate themselves significantly from those that had not used marijuana in the last 12 months. In general terms, this group of "heavy" users has a more positive attitude towards consuming both cocaine and crack. (See Table 6.9.)

D. Summary

1. Alcohol and Tobacco

The majority of tobacco and alcohol users intend to quit smoking or reduce their consumption of alcohol. This implies that favorable conditions exist for the reduction of tobacco and alcohol consumption. However, alcohol consumers do not perceive the same degree of social pressure

Intention to quit smoking or reduce alcohol use is strongly influenced by attitude toward tobacco and alcohol use. Respondents who think that it is good idea to quit smoking or reduce alcohol use have more a positive intention to quit smoking or reduce alcohol use.

Women perceived more pressure to reduce their consumption of tobacco. As for alcohol, more men than women expressed an intention to reduce their consumption and have a positive attitude toward reducing consumption. The youngest group perceives the greatest pressure from their reference group to reduce their consumption of alcohol. With regard to social norms, tobacco and alcohol users show a similarity. Smokers who completed university perceived less pressure from their reference group to stop smoking than those who had some university education or had no university education. Alcohol consumers who had some university education also perceived less pressure to reduce their alcohol consumption than those who did not have any university education.

Table 6.9
Predispositional Differences By Level of Marijuana Consumption
in the Last 12 Months

Substance	Sub-scale	F Ratio	F Prob.	Level of Marijuana Consumption (0=low; 6=high)				
				0	1	3	4	6
Alcohol	Intention	3.5424	.0141	1.26	.00	2.00	2.00	2.00
Marijuana	Intention	4.8571	.0023	.09	.41	2.00	1.00	.00
	Attitude	4.6426	.0031	.11	.40	1.50	1.00	.50
	Social Norms	2.5093	.0540	.49	.48	.80	1.40	.40
	Specific Norms	11.0490	.0000	.00	.00		.50	.00
	Combined	6.4980	.0004	.18	.41	1.33	1.10	.23
Cocaine	Intention	4.2798	.0050	.02	.33	.50	1.00	.00
	Social Norms	2.9684	.0291	.28	.52	.80	1.20	.80
	Combined	7.9878	.0001	.11	.09	.32	1.05	.32
Crack	Intention	5.5471	.0010	.05	.00	1.00	.00	.00
	Combined	3.7713	.0099	.06	.11	.53	.22	.13

2. Marijuana, Cocaine, Crack and Inhalants

Most people in the urban areas of Dominican Republic reject the notion of trying marijuana, cocaine, crack or inhalants. They also in general hold negative attitudes toward use of these substances. Comparing substances, those interviewed have more a positive attitude toward trying marijuana than cocaine, crack or inhalants. With regard to illicit drug use, the item "it is good idea to try illicit drugs" has the strongest relationship with the intention to use. As for cocaine and crack, social pressure greatly influences the intention to use these substances.

Men perceived greater pressure from their reference group (friends and family) to try the substances than women did. More men than women also expressed an intention or willingness to try illicit drugs. As for marijuana and cocaine, less pressure is felt in the youngest group and in those older than 29. Persons ages 15-29 reported more pressure from their reference groups than those 12-14 or 35-39 did. As for crack and inhalants, persons ages 15-19 experience the highest pressure from their reference group. Those who had some secondary or higher levels of education perceived more pressure to try marijuana or cocaine than those who only had primary education or less. As for inhalant use, persons who had not had any university education felt more pressure to try inhalants than those with university education.

In the final chapter, we will review the findings of both the chapters on prevalence and the chapters on attitudes. We will use these data to put forth recommendations regarding the direction of campaigns to prevent the increase of drug use in the Dominican Republic.

CHAPTER VII

CONCLUSIONS AND RECOMMENDATIONS

This study examined the nature and extent of the drug problem in the Dominican Republic by measuring the prevalence of use in the population and the attitudes and orientations of the population toward drug use. Prevalence was measured through a national survey of the population. Attitudes were measured by the survey and through a series of focus groups. This chapter summarizes the main findings of the study and offers recommendations regarding the implementation of a prevention strategy for the Dominican Republic.

A. Main Findings

1. Regarding Prevalence

- Illicit drug use in urban areas of the Dominican Republic is considerably lower than in urban areas of other Latin American and Caribbean countries (e.g., Panama, Peru, Guatemala, Haiti).

- Alcohol and tobacco have the highest prevalence of all psychoactive substances.

- Comparing urban areas, Santo Domingo has the highest lifetime and current use (last 30 days) of alcohol and marijuana, and the highest current use of cocaine, while mid-sized cities have the highest lifetime and current use of inhalants and small-sized cities have the highest lifetime use of crack.

- Men are more likely than women to be current and lifetime users of illicit drugs, while women are more likely than men to have used pharmaceuticals.

- Lifetime and current use of inhalants are greatest among the youngest age groups (12-24).

- Persons ages 20-29 are more likely than persons in other age groups to have tried marijuana and cocaine.

- More than half of first use of inhalants occurred before age 15. Most of first use of marijuana and cocaine occurred between ages 15-24, whereas all crack use started between ages 15-19.

- Lifetime and current use of marijuana are similar across social classes.

- Upper and middle class persons are more likely to have used cocaine in their lifetime, but current use of cocaine is more common among the lower class.

- Illicit drug use is greater among persons who have not reached or not completed secondary school, and among those who identified themselves as blue collar workers and students.

- Measures of frequency of illicit drug use suggest that, although the prevalence of marijuana, cocaine and crack is lower than the prevalence of inhalants, these drugs are used more intensively than inhalants among those who have ever used them.

- Illicit drugs were more often used with alcohol than with another illicit drug, although marijuana and cocaine are often used concurrently.

- Likewise, people that have used marijuana were more likely to have also used cocaine.

- The most commonly expressed problems due to illicit drug use were health related, while family problems were most often reported in the case of alcohol and tobacco use.

2. Regarding Awareness

- The majority of urban Dominicans considered both drug consumption and drug trafficking as serious problems.

- The majority have seen or heard a message concerning drug issues in the month prior to being interviewed.

- Television was the most common source of information.

- Dominicans who are in the oldest age group studied (35-45), who live in Santo Domingo, or who belong to the upper class are most likely to have received a drug-related message via any source of information.

- Family and police are considered to be the strongest inhibiting factors against drug use.

3. Regarding Attitudes/From Focus Groups

- Contrary to expectations, self-confidence and self-esteem were not considered to be good dissuadors of drug use in adolescents, nor was personal goal attainment seen as playing the same role among young adults.

- This study suggests that dramatic content and realism are key elements of effective messages, particularly for adolescents of lower and middle class origin.

- Focus group participants felt that messages may have more impact on preventing initiation than on converting users into non-users.

- Respondents suggested that a better approach to drug prevention would be to combine negative and positive appeals in one message.

- The study indicated the importance of tailoring messages to the cultural values and norms of Dominicans, to their approach to inculcating norms regarding behavior, and to their perceptions of reality.

4. Regarding Attitudes/From the Survey

Alcohol and Tobacco

- The levels of intention to quit tobacco and reduce consumption of alcohol are both high. This means that there are favorable conditions for the reduction of both activities.

- The intention to quit smoking is influenced more by attitudes toward the substance than by social norms, while the reduction of alcohol consumption is more controlled by social norms than attitudes. In both cases, the perception of the possibility of controlling the habit is important in increasing the intention to quit.

- The frequent drinker does not perceive negative social pressure towards drinking. It appears that subjective norms have greatest influence over people who are young (12-14 years old), and women from the "upper" economic group. Consideration of motivational factors, with normative control being the principal element in the formation of intention, leads one to think that a reduction of consumption will be more difficult for alcohol than for tobacco.

- The levels of consumption of alcohol in the Dominican Republic are extremely high. Apart from the consumption of alcohol by itself, one must consider its associations with the use of illicit substances. Heavy consumers of alcohol who express the highest level of intention to use other substances, perceive in these other susbatnces more positive effects and sense more social pressure to use those substances. It therefore becomes necessary to develop global strategies towards the reduction of drug consumption that take into account the need to reduce alcohol consumption as a possible gateway or conditioning factor.

Marijuana, Cocaine, Crack and Inhalants

- In general terms, the motivational factors surrounding the initiation of use of marijuana, cocaine and crack are negative. This applies to the perception of consequences as well as to both the general and specific perceived social norms.

- Comparing marijuana to the other substances, we note a smaller proportion of subjects who consider that its use will produce negative effects, as well as less of a sense of normative coercion. It is probable that marijuana, because it is a better known

substance, has acquired a connotation of being "less dangerous" and "less prohibited" than other substances.

- The dynamic of marijuana also differs from that of cocaine and crack. For marijuana the dominating factor is attitudinal, while for cocaine and crack the preponderant factor is perceived social norms, especially those emanating from the group closest to the respondent, i.e., family and spouse.

- For inhalants, a combination of both attitudinal and general normative factors can be seen to be operating.

- The characteristics of the subjects that expressed positive intentions towards the use of these substance are quite consistent; they tend to be young males between the ages of 15 and 29 principally belonging to the "lower" economic stratum. In terms of education, they tend to be those who have completed secondary school or attended university.

5. Populations at Risk for Drug Use

Based on the findings from this study, the principal populations at risk for drug use in the Dominican Republic can be defined as follows:

- **Alcohol and Tobacco** -- Young men ages 12-19 in Santo Domingo and mid-sized cities.

- **Pharmaceuticals** -- Young women ages 15-29.

- **Marijuana, Cocaine and Crack** -- Blue collar or unemployed young men ages 15-24 in Santo Domingo who have less than secondary education.

- **Inhalants** -- Students ages 12-19.

6. Summary

This study indicates that a major illicit drug use problem does not exist in municipalities of the Dominican Republic at this time. However, because there is a high level of illicit drug use among the younger population, and because the use of marijuana and cocaine among that portion of the population reporting use is quite frequent and apparently increasing, there is a great potential for a rapid expansion of the use of marijuana and cocaine. The use of inhalants among the youngest age groups also is apparently increasing. The study suggests that current efforts at primary prevention of drug use are weak. Those who are at greatest risk (i.e., younger persons) are least likely to be aware of the problem. Moreover, the study underscores the need for messages directed to audiences in terms that are culturally appropriate and properly targeted by age and class background.

B. Recommendations

Given that the drug problem, in terms of the use of illicit substances such as marijuana, cocaine and crack, is not a widespread problem, we believe that the focus of any efforts needs to be in the area of primary prevention: action that is directed at preventing the onset of large scale drug use. An effective drug prevention strategy requires certain elements. These include a clear definition of target audiences, the formulation of specific, measurable, attainable, realistic and time-bound objectives, the development of appropriate messages that educate, motivate and persuade the target audience, the identification of appropriate channels to transmit the messages and the evaluation of the results to provide feedback for future efforts.

Definition of target, message, objectives and media all require appropriate formative research. The study described in this report provides the necessary basis to define many of these key elements. Based on the results of the survey and focus group studies, we make the following recommendations regarding the design of a drug prevention effort in the Dominican Republic:

1. Regarding Target Groups

- Primary prevention programs need to be strengthened and directed at future high risk target groups, e.g., young people under the age of twelve, with particular emphasis on males.

- Primary prevention needs to be undertaken in a national context and not just in the largest urban centers.

- Primary prevention needs to focus on all social classes, although with different types of messages (focus on different drugs, different justifications for avoiding use).

- It is important to segment the target population, placing special emphasis on the groups that show the highest levels of positive predispositions and intentions toward consumption. With regard to alcohol, this group would be men, age 25 and up, in the lower and middle economic strata of the population. For marijuana, the group that should be emphasized is young men between the ages of 15 and 29 years of age. For cocaine and crack, concern also needs to be directed to this same group of males.

2. Regarding Messages

- Primary prevention messages need to be subject to research procedures (e.g. use of focus groups) to pretest message content for cultural appropriateness and relevance to the target audience, as well as to post-test message impact on those audience.

- Awareness and education efforts need to build on the existing minimal understanding of the dangers of drug trafficking and use, by amplifying the sort of information

provided and more carefully targeting high risk groups.

- For tobacco: In order to fortify the intention to quit smoking it will be necessary to emphasize the positive effects more than the negative. The messages should tend to reinforce the "it's a good idea" to quit smoking, showing specific benefits that derive from this conduct. It is also important that the messages strengthen the perception of the ability to control the habit.

- For alcohol: Messages need to increase the perception that the individual's reference group wishes the individual to reduce consumption. This idea could be reinforced by promoting the positive effects of reducing consumption and stressing the ease of reducing consumption.

- For marijuana: The awareness strategy should be directed towards the reduction of positive attitudes towards consuming marijuana, i.e., the desirable effects . This requires an increase in the perception of the danger and unpleasantness associated with consumption. The school environment (secondary and university) could be used for specific interventions.

- For cocaine and crack: The messages should be aimed at reducing the intention to try and reducing the perceived social pressure towards trying these substances, giving special attention to the closest reference group (spouse, boyfriend/girlfriend, family).

- For inhalants: The messages aimed at reducing the intention to use inhalants should encompass both the attitude towards use and the social norms that condition use, thereby reducing the perception of social pressure from friends and acquaintances.

3. Regarding Media

- Use of the family as an integral part of prevention efforts would strengthen those efforts.

- Television needs to be an important channel for primary prevention efforts. Efforts should include use of regular programming as well as advertising.

4. Regarding Additional Requirements for Formative Research

- Given the low levels of prevalence, a follow-up prevalence study need not be undertaken for at least two years.

- Prevalence research in the general population needs to be supplemented by prevalence research in high-risk populations, through schools, street ethnography, case histories and other studies of special universes.

- Prevalence research needs to be conducted with careful attention to scientifically tested and accepted standards of definition of variables and field procedures.

- It is important to emphasize the need for a more detailed analysis of the ideas and concrete beliefs that relate to the use of each substance.

5. Regarding Campaign Objectives

Given the current low levels of prevalence, as indicated above, specific campaign objectives need to focus on primary prevention. This means that efforts are made to assure that campaigns are directed at preserving the high numbers of non-users, and at doing nothing to unintentionally provoke expanded interest in drug use. Therefore, measurable objectives need to focus on fortifying the intentions of users to reduce alcohol use, eliminate smoking and avoiding the use (not trying) of marijuana, cocaine, crack and inhalants. Specific objectives need to be defined in terms of the resources available for campaigns. Those resources include both the financial and organizational resources required to combine mass media and family/community based efforts in a coordinated, targeted set of activities.

Current low levels of prevalence provide the necessary breathing space for action, but the relationship of high levels of alcohol use and the intention to use other substances suggest that a failure to engage in primary prevention as soon as possible may lead to ever increasing levels of use.

APPENDIX I

QUESTIONNAIRE

16 de diciembre 1991

A1	ESTRATO SOCIO ECONOMICO			
PREGUNTAS PRELIMINARES				
P1	No. de cuestionario			
P2	Es la primera entrevista o la reentrevista	primera entrevista . . entrevista de validación	1 0	->p3
P2a	Si es la reentrevista ¿Cuál es el No. del cuestionario original?		___ ___ ___ ___	
P2b	Porcentaje de confiabilidad	%1-%100	___ ___	
P3	No. de visita en que se logró la entrevista	1-3	1 2 3	
P4	No. Ciudad		___ ___ ___	
P5	No. Barrio			
P6	Calle			
P7	No. de Calle			
P8	No. de Manzana			
P9	No. Viviendas en la Manzana		___ ___ ___	
P10	No. de Manzanas en el Barrio			
P11	No. de Entrevistador			
P11b	Genero	Hombre . . . . . Mujer	1 2	
P12	No. del supervisor			
P13	Las personas elegibles en la casa: (inicie la edad con 1 para hombres y 2 para mujers, ej. un muchacho de 115 años= 115)	No. Personas	___ ___	
P13a		Código de genero y edad	___ ___ ___	
P13b		Código de genero y edad	___ ___ ___	
P13c		Código de genero y edad	___ ___ ___	
P13d		Código de genero y edad	___ ___ ___	
P13e		Código de genero y edad	___ ___ ___	
P13f		Código de genero y edad	___ ___ ___	
P13g		Código de genero y edad	___ ___ ___	
P13h		Código de genero y edad	___ ___ ___	
P13i		Código de genero y edad	___ ___ ___	
P13j		Código de genero y edad	___ ___ ___	
No.	**PREGUNTAS**	**RESPUESTAS**	**CODIGO**	**PASE A PREGUNTA**
SALUD				
1	Durante los últimos 12 meses, Ud. diría que su salud fue:	Excelente . . . . . Muy buena . . . . . Buena . . . . . Regular . . . . . Mala	1 2 3 4 5	

2	¿Ha tenido que ir a una consulta médica o ha visitado un médico en los últimos 12 meses?	SI . . . . . . NO	1 0	
3	¿Ha estado hospitalizado en los últimos 12 meses?	SI . . . . . . NO	1 0	
TABACO				
101	¿Qué edad tenía Ud. la primera vez que fumó, o masticó tabaco?	EDAD . . . . . . NUNCA	__ __ 99	->P201
102	¿Qué cantidad de cigarrillos al día se ha fumado durante los últimos 12 meses?	No fumó . . . . . . Menos de un cigarrillo +o- 5 . . . . . . Media cajetilla . . . . Una cajetilla . . . . . Una y media cajetilla . Dos cajetillas o más .	1 2 3 4 5 6 7	->P201
103	¿Qué cantidad de cigarrillos al día se ha fumado durante los últimos 30 días?	No fumó . . . . . . Menos de un cigarrillo +o- 5 por día . . . . . Media cajetilla . . . . Una cajetilla . . . . . Uno y medio cajetilla . Dos cajetilla o más . .	1 2 3 4 5 6 7	
104	¿Alguna vez trató de dejar de fumar pero se dio cuenta que no podía?	SI . . . . . . NO	1 0	
NOTA	La parte que viene ahora, trata de conocer las ideas y actitudes que tienen respecto a una serie de conductas. A continuación le voy a leer algunas afirmaciones y se trata de que usted pueda decir en cada caso si eso se aplica o no a usted. Las respuestas no son ni verdaderas ni falsas, son solo opiniones que se tienen respecto a estas conductas.			
105	Yo voy a dejar de fumar en los próximos 12 meses:	NO..... SI..... NO SE.....	0 1 2	
106	Es una buena idea que deje de fumar en los próximos 12 meses:	NO..... SI..... NO SE.....	0 1 2	
107	Es dañino o beneficioso para mí, dejar de fumar en los próximos 12 meses:	DANINO..... BENEFICIOSO..... NO SE.....	0 1 2	
108	Es agradable o desagradable para mí, dejar de fumar en los próximos 12 meses:	DESABRADABLE..... AGRADABLE..... NO SE.....	0 1 2	
109	La mayoría de las personas que son importantesd para mí piensan que debería dejar de fumar en los próximos 12 meses:	NO..... SI..... NO SE.....	0 1 2	
110	Mis amigos y familiares piensan que yo debería dejar de fumar en los próximos 12 meses:	NO..... SI..... NO SE.....	0 1 2	
111	La mayoría de mis amigos han dejado de fumar:	NO..... SI..... NO SE.....	0 1 2	
112	Si usted quisiera, podría dejar de fumar:	NO..... SI..... NO SE.....	0 1 2	
113	Sería fácil para mí dejar de fumar:	NO..... SI..... NO SE.....	0 1 2	
BEBIDAS ALCOHÓLICAS				

201	¿Qué edad tenía la primera vez que tomó algúna bebida alcohólica?	EDAD . . . . . . NUNCA	___ ___ 99	->P301
201A	¿Cúal fue?	Ron . . . . . . Cerveza . . . . . . Otro	1 2 3	
202	¿De las siguientes bebidas que cantidad acostumbra tomar de una sola sentada?	Menos de una botella.... Una botella..... Dos botellas..... Más de dos botellas.....	1 2 3 4	
202a		Menos de una botella.... Una botella..... Dos botellas..... Más de dos botellas.....	1 2 3 4	
202b	¿Otro?_____	Menos de una botella.... Una botella..... Dos botellas..... Más de dos botellas.....	1 2 3 4	
203	En los últimos 12 meses, en cuántas ocasiones tomó esas cantidades en una sola sentada?	Ninguna . . . . . . Menos de una vez por mes . . . . . . 1 vez por mes . . . . . 2 veces o más por mes .	0 1 2 3	->P301
204	En los últimos 30 días, en cuántas ocasiones tomó esas cantidades en una sola sentada?	Ninguna . . . . . . una vez . . . . . . 2 veces . . . . . . 3-5 veces . . . . . . 6 veces o más	0 1 2 3 4	
205	¿Alguna vez ha querido dejar de beber pero no ha podido?	SI . . . . . . NO	1 0	
206	¿Consumió algun tipo de pastilla a alguna de las siguientes sustancias al mismo tiempo o luego de tomarse una bebida como cerveza, ron, vino, o whiskey. (mostrar tarjeta)?	NINGUNA . . . . . . UNO O MAS	0 1	->P207
			S / N	
206A	Pastillas	SI. . . . . . NO.	1 0	->P206D
206B	¿Cuáles?			
206C	¿Cuáles?	_____	___ ___	
206D	Sustancias inhalantes (cemento, thinner, gasolina)	SI O NO	1 / 0	
206E	Marihuana	SI O NO	1 / 0	
206F	Cocaína	SI O NO	1 / 0	
206G	Crack	SI O NO	1 / 0	
206H	Otras sustancias	SI . . . . . . NO	1 0	->P207
206I	Cuáles?	_____	___ ___	
206J	Cuáles?	_____	___ ___	
207	¿Alguna vez consultó a un médico u otro profesional por su consumo de bebidas alcohólicas?	SI . . . . . . NO	1 0	
NOTA	La parte que viene ahora, trata de conocer las ideas y actitudes que tienen respecto a una serie de conductas. A continuación le voy a leer algunas afirmaciones y se trata de que usted pueda decir en cada caso si eso se aplica o no a usted. Las respuestas no son ni verdaderas ni falsas, son solo opiniones que se tienen respecto a estas conductas.			
208	Yo voy a disminuir mi consumo de bebidas alcohólicas en los próximos 12 meses.	NO..... SI..... NO SE.....	0 1 2	

209	Es una buena idea que yo disminuya el consumo de bebidas alcohólicas en los próximos 12 meses.	NO..... SI..... NO SE.....	0 1 2	
210	Es dañino o beneficioso para mí, disminuir mi consumo de bebidas alcohólicas en los próximos 12 meses.	DAÑINO..... BENEFICIOSO..... NO SE.....	0 1 2	
211	Es agradable o desagradable, disminuir mi consumo de bebidas alcohólicas en los próximos 12 meses.	DESAGRADABLE..... AGRADABLE..... NO SE.....	0 1 2	
212	La mayoría de las personas que son importantes para mí piensan que debería disminuir mi consumo de bebidas alcohólicas en los próximos 12 meses.	NO..... SI..... NO SE.....	0 1 2	
213	Mis amigos y familia piensan que debería disminuir mi consumo de bebidas alcohólicas en los próximos 12 meses.	NO..... SI..... NO SE.....	0 1 2	
214	La mayoría de mis amigos han disminuído su consumo de bebidas alcohólicas.	NO..... SI..... NO SE.....	0 1 2	
215	Yo podría disminuir mi consumo de bebidas alcohólicas.	NO..... SI..... NO SE.....	0 1 2	
216	Sería fácil para mí disminuir mi consumo de bebidas alcohólicas.	NO..... SI..... NO SE.....	0 1 2	
ANALGESICOS				
301	¿En esta lista aparecen algunas pastillas para calmar el dolor, que los farmeceuticos llaman analgésicos (entregar tarjeta). ¿Cuál de ellos ha tomado Ud.:	NINGUNO . . . . . . UNO O MAS	0 1	->P401
301-CLAVE	NO . . . . . 0 CON RECETA MEDICA . . . . . 1 SIN RECETA MEDICA . . . . . 2 A VECES CON RECETA Y OTRAS NO 3			
301A	Norgesic	0 a 3 SEGUN LA CLAVE	0 1 2 3	
301B	Darvon	0 a 3 SEGUN LA CLAVE	0 1 2 3	
301C	Sosegon	0 a 3 SEGUN LA CLAVE	0 1 2 3	
301D	Demerol	0 a 3 SEGUN LA CLAVE	0 1 2 3	
301E	Meloka	0 a 3 SEGUN LA CLAVE	0 1 2 3	
301F	Novalgina	0 a 3 SEGUN LA CLAVE	0 1 2 3	
301G	Otros similares	0 a 3 SEGUN LA CLAVE	0 1 2 3	->p302
301H	¿Cuáles?			
301I	¿Cuáles?			
302	¿Qué edad tenía la primera vez que tomó el primero de estos productos sin receta médica?	EDAD . . . . . . NUNCA	___ ___ 99	->p304
303	Aproximadamente ¿con qué frecuencia consumió esos medicamentos sin tener receta médica en			
303 - CLAVE	NUNCA . . . . . 0 1-2 VECES . . . . . 1 3-5 VECES . . . . . 2 6-9 VECES . . . . . 3 10-19 VECES . . . . . 4 20-39 VECES . . . . . 5 40 Y MAS VECES 6			
303A	su vida?	1 A 6 SEGUN LA CLAVE	1 2 3 4 5 6	
303B	los últimos 12 meses?	0 A 6 SEGUN LA CLAVE	0 1 2 3 4 5 6	->p304

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303C	los últimos 30 días?	0 A 6 SEGUN LA CLAVE	0 1 2 3 4 5 6		
304	¿Alguna vez trató de dejar de usar estos medicamentos pero se dio cuenta que no podía?	SI . . . . . . NO	1 0		
305	¿Alguna vez consultó al médico por su consumo de estos medicamentos?	SI . . . . . . NO	1 0		
306	¿Cuáles son las formas como acostumbra a usar esos medicamentos?				
306A	inyectable	SI O NO	1	0	
306B	fumado	SI O NO	1	0	
306C	tomado	SI O NO	1	0	
307	Al usar algunos de estos medicamentos, ¿consumió también al mismo tiempo o poco después, alguno de los productos en esta lista? (TARJETA)	NINGUNO . . . . . . UNO O MAS	0 1		->p401
			S	N	
307A	Bebidas alcohólicas	SI O NO	1	0	
307B	Pastillas	SI. . . . . . NO.	1 0		 ->p307E
307C	¿Cuáles?	_____		__ __	
307D	¿Cuáles?				
307E	Sustancias inhalantes (cemento, thinner, gasolina)	SI O NO	1	0	
307F	Marihuana	SI O NO	1	0	
307G	Cocaína	SI O NO	1	0	
307H	Crack	SI O NO	1	0	
307I	Otras sustancias	SI . . . . . . NO	1 0		 ->p401
307J	Cuáles?	_____		__ __	
307K	Cuáles?	_____		__ __	
SEDANTES					
401	¿En esta lista aparecen algunos medicamentos para traquilizar los nervios que los farmeceuticos llaman sedantes. Cuáles de estas pastillas, ha consumido Ud.?:	NINGUNO . . . . . . UNO O MAS	0 1		->p501
401-CLAVE	NO . . . . . 0 CON RECETA MÉDICA . . . . . 1 SIN RECETA MÉDICA . . . . . 2 A VECES CON RECETA Y OTRAS NO 3				
401A	Diazepan, Valium	0 A 3 SEGUN LA CLAVE	0 1 2 3		
401B	Librax	0 A 3 SEGUN LA CLAVE	0 1 2 3		
401C	Frisium	0 A 3 SEGUN LA CLAVE	0 1 2 3		
401D	Ativan	0 A 3 SEGUN LA CLAVE	0 1 2 3		
401E	Tranquilax	0 A 3 SEGUN LA CLAVE	0 1 2 3		
401F	Equipax	0 A 3 SEGUN LA CLAVE	0 1 2 3		
401G	Albonar	0 A 3 SEGUN LA CLAVE	0 1 2 3		
401H	Tensil	0 A 3 SEGUN LA CLAVE	0 1 2 3		
401I	Urbadan	0 A 3 SEGUN LA CLAVE	0 1 2 3		
401J	Lexotan	0 A 3 SEGUN LA CLAVE	0 1 2 3		
401K	Benadryl	0 A 3 SEGUN LA CLAVE	0 1 2 3		
401L	Tonopan	0 A 3 SEGUN LA CLAVE	0 1 2 3		

401M	Otros similares	0 A 3 SEGUN LA CLAVE	0 1 2 3	->p402
401N	¿Cuáles?			
401O	¿Cuáles?			
402	¿Qué edad tenía la primera vez que tomó el primero de estos productos sin receta médica?	EDAD . . . . . . NUNCA	___ ___ 99	->p404
403	Aproximadamente ¿con qué frecuencia consumió esos medicamentos sin tener receta médica en...			
403 - CLAVE	NUNCA . . . . . 0 1-2 VECES . . . . . 1 3-5 VECES . . . . . 2 6-9 VECES . . . . . 3 10-19 VECES . . . . . 4 20-39 VECES . . . . . 5 40 Y MAS VECES 6			
403A	su vida?	1 A 6 SEGUN LA CLAVE	1 2 3 4 5 6	
403B	los últimos 12 meses?	0 A 6 SEGUN LA CLAVE	0 1 2 3 4 5 6	->p404
403C	los últimos 30 días?	0 A 6 SEGUN LA CLAVE	0 1 2 3 4 5 6	
404	¿Alguna vez trató de interrumpir su consumo pero se dio cuenta que no podía?	SI . . . . . . NO	1 0	
405	¿Cuáles son las formas como acostumbra usar esos medicamentos?		S / N	
405A	inyectable	SI O NO	1 / 0	
405B	fumado	SI O NO	1 / 0	
405C	tomado	SI O NO	1 / 0	
406	¿Alguna vez consultó al médico por su consumo de estos medicamentos?	SI . . . . . . NO	1 0	
407	Al usar algunos de estos medicamentos, ¿consumió también al mismo tiempo o poco después, alguno de los productos en esta lista?(Tarjeta)	NINGUNO . . . . . . UNO O MAS	0 1	->p501
			S / N	
407A	bebidas alcohólicas	SI O NO	1 / 0	
407B	Pastillas	SI..... NO.....	1 0	->p407E
407C	¿Cuáles?			
407D	¿Cuáles?			
407E	Sustancias inhalantes (cemento, thinner, gasolina)	SI O NO	1 / 0	
407F	Marihuana	SI O NO	1 / 0	
407G	Cocaína	SI O NO	1 / 0	
407H	Crack	SI O NO	1 / 0	
407I	Otras sustancias	SI . . . . . . NO	1 0	->p501
408J	¿Cuáles?			
407K	¿Cuáles?			
HIPNOTICOS				
501	En esta lista aparecen algunas pastillas para dormir que los farmeceuticos llaman hipnóticos. ¿Cuáles de estas pastillas ha tomado Ud.?:	NINGUNO . . . . . . UNO O MAS	0 1	->p601

501 - CLAVE	NO . . . . . 0 CON RECETA MÉDICA . . . . . 1 SIN RECETA MÉDICA . . . . . 2 A VECES CON RECETA Y OTRAS NO 3			
501A	Rohypnol	0 A 3 SEGUN LA CLAVE	0 1 2 3	
501B	Noctran	0 A 3 SEGUN LA CLAVE	0 1 2 3	
501C	Dormicum	0 A 3 SEGUN LA CLAVE	0 1 2 3	
501D	Mogadon	0 A 3 SEGUN LA CLAVE	0 1 2 3	
501E	Hipnotab	0 A 3 SEGUN LA CLAVE	0 1 2 3	
501F	Libetan	0 A 3 SEGUN LA CLAVE	0 1 2 3	
501G	Noptamid	0 A 3 SEGUN LA CLAVE	0 1 2 3	
501H	Dalmadorm	0 A 3 SEGUN LA CLAVE	0 1 2 3	
501I	Otros similares	0 A 3 SEGUN LA CLAVE	0 1 2 3	->p502
501J	¿Cuáles?	_____	__ __	
501L	¿cuáles?	_____	__ __	
502	¿Qué edad tenía la primera vez que tomó el primero de estos productos sin receta médica?	EDAD . . . . . . NUNCA	__ __ 99	->p504

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503	Aproximadamente ¿con qué frecuencia consumió esos medicamentos sin tener receta médica en...				
503 - CLAVE	NUNCA . . . . . 0 1-2 VECES . . . . . 1 3-5 VECES . . . . . 2 6-9 VECES . . . . . 3 10-19 VECES . . . . . 4 20-39 VECES . . . . . 5 40 Y MAS VECES 6				
503A	su vida?	1 A 6 SEGUN LA CLAVE	1 2 3 4 5 6		
503B	los últimos 12 meses?	0 A 6 SEGUN LA CLAVE	0 1 2 3 4 5 6		->p504
503C	los últimos 30 días?	0 A 6 SEGUN LA CLAVE	0 1 2 3 4 5 6		
504	¿Alguna vez trató de interrumpir su consumo pero se dio cuenta que no podía?	SI . . . . . . NO	1 0		
505	¿Cuáles son las formas como acostumbra a usar esos medicamentos?		S	N	
505A	inyectable	SI O NO	1	0	
505B	fumado	SI O NO	1	0	
505C	tomado	SI O NO	1	0	
506	¿Alguna vez consultó al médico por su consumo de estos medicamentos?	SI . . . . . . NO	1 0		
507	Al usar algunos de estos medicamentos, ¿consumió también al mismo tiempo o poco después, alguno de los productos en esta lista?(Tarjeta)	NINGUNO . . . . . . UNO O MAS	0 1		->p601
			S	N	
507A	Bebidas alcohólicas	SI O NO	1	0	
507B	Pastillas	SI. . . . . . NO.	1 0		->p507E
507C	¿Cuáles?				
507D	¿Cuáles?				
507E	Sustancias inhalantes (cemento, thinner, gasolina)	SI O NO	1	0	
507F	Marihuana	SI O NO	1	0	
507G	Cocaína	SI O NO	1	0	
507H	Crack	SI O NO	1	0	
507I	otras sustancias	SI . . . . . . NO	1 0		->p601
507J	¿Cuáles?	_____	__ __		
507K	¿Cuáles?	_____	__ __		

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ESTIMULANTES				
601	¿En esta lista (Mostrar tarjeta) hay varias pastillas utilizadas para controlar el apetito o para mantenerse despierto que los farmeceuticos llaman estimulantes.¿Cuál de ellas ha tomado Ud.?	NINGUNO . . . . . . UNA O MAS	0 1	->p701
601 - CLAVE	NO . . . . . 0 CON RECETA MÉDICA . . . . . 1 SIN RECETA MÉDICA . . . . . 2 A VECES CON RECETA Y OTRAS NO 3			
601A	Gamalate B-6	0 A 3 SEGUN LA CLAVE	0 1 2 3	
601B	Aktivanad	0 A 3 SEGUN LA CLAVE	0 1 2 3	
601C	Asparten	0 A 3 SEGUN LA CLAVE	0 1 2 3	
601D	Limbitrol	0 A 3 SEGUN LA CLAVE	0 1 2 3	
601E	Vivalan	0 A 3 SEGUN LA CLAVE	0 1 2 3	
601F	Reactivan	0 A 3 SEGUN LA CLAVE	0 1 2 3	
601G	Dexadrina	0 A 3 SEGUN LA CLAVE	0 1 2 3	
601H	Anabolex	0 A 3 SEGUN LA CLAVE	0 1 2 3	
601I	Fenicec	0 A 3 SEGUN LA CLAVE	0 1 2 3	
601J	Otros similares	0 A 3 SEGUN LA CLAVE	0 1 2 3	->p602
601K	¿Cuáles?			
601l	¿cuáles?			
602	¿Qué edad tenía la primera vez que tomó el primero de estos productos sin receta médica?	EDAD . . . . . . NUNCA	__ __ 99	->p604
	Aproximadamente ¿con qué frecuencia consumió esos medicamentos sin tener receta médica en...			
603 - CLAVE	NUNCA . . . . . 0 1-2 VECES . . . . . 1 3-5 VECES . . . . . 2 6-9 VECES . . . . . 3 10-19 VECES . . . . . 4 20-39 VECES . . . . . 5 40 Y MAS VECES 6			
603A	su vida?	1 A 6 SEGUN LA CLAVE	1 2 3 4 5 6	
603B	los últimos 12 meses?	0 A 6 SEGUN LA CLAVE	0 1 2 3 4 5 6	->p604
603C	los últimos 30 días?	0 A 6 SEGUN LA CLAVE	0 1 2 3 4 5 6	
604	¿Alguna vez trató de interrumpir su consumo pero se dio cuenta que no podía?	SI . . . . . . NO	1 0	
605	¿Cuáles son las formas como acostumbra a usar esos medicamentos?		S N	
605A	inyectable	SI O NO	1 0	
605B	fumado	SI O NO	1 0	
605C	tomado	SI O NO	1 0	
606	¿Alguna vez consultó al médico por su consumo de estos medicamentos?	SI . . . . . . NO	1 0	
607	Al usar algunos de estos medicamentos, ¿consumió también al mismo tiempo o poco después, alguno de los productos en esta lista?	NINGUNO . . . . . . UNO O MAS	0 1	->p701
			S N	
607A	bebidas alcohólicas	SI O NO	1 0	

607A	bebidas alcohólicas	SI O NO	1	0	
607B	Pastillas	SI. . . . . . NO.		1 0	->607E
607C	¿Cuáles?	_____		__ __	
607D	¿Cuáles?	_____		__ __	
607E	Sustancias inhalantes (cemento, thinner, gasolina)	SI O NO	1	0	
607F	Marihuana	SI O NO	1	0	
607G	Cocaína	SI O NO	1	0	
607H	Crack	SI O NO	1	0	
607I	Otras sustancias	SI . . . . . . NO		1 0	->p701
607J	¿Cuáles?	_____		__ __	
607K	¿Cuáles?	_____		__ __	
INHALANTES					
701	¿Cuál de las siguientes sustancias ha aspirado o inhalado con el propósito de sentir sus efectos? (MOSTRAR TARJETA)	NINGUNA . . . . . . UNO O MAS		0 1	->p801
			S	N	
701A	Pegamento (Cemento Petrónico)	SI O NO	1	0	
701B	Thinner.	SI O NO	1	0	
701C	Lacas, pinturas, y otros disolventes de pinturas.	SI O NO	1	0	
701D	Gasolina	SI O NO	1	0	
701E	Líquido corrector para máquinas de escribir.	SI O NO	1	0	
701F	Acetona y otros líquidos de limpieza.	SI O NO	1	0	
701G	Nafta o fluído para encendedor.	SI O NO	1	0	
701H	Otros similares	SI . . . . . . NO		1 0	->p702
701I	¿Cuáles?				
702	¿Qué edad tenía la primera vez que aspiró con ese propósito?	EDAD		__ __	
703	Aproximadamente ¿con qué frecuencia ha podido aspirar/inhalar una de estas sustancias en...				
703 - CLAVE	NUNCA . . . . . 0 1-2 VECES . . . . . 1 3-5 VECES . . . . . 2 6-9 VECES . . . . . 3 10-19 VECES . . . . . 4 20-39 VECES . . . . . 5 40 Y MAS VECES 6				
703A	su vida?	1 A 6 SEGUN LA CLAVE	1 2 3 4 5 6		
703B	los últimos 12 meses?	0 A 6 SEGUN LA CLAVE		0 1 2 3 4 5 6	->p704
703C	los últimos 30 días?	0 A 6 SEGUN LA CLAVE	0 1 2 3 4 5 6		
704	¿Alguna vez trató de interrumpir su consumo pero se dio cuenta que no podía?	SI . . . . . . NO		1 0	

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705	Al usar algunas de estas sustancias, ¿consumió también al mismo tiempo o poco después, alguno de los productos de esta lista?(Mostrar Tarjeta)	NINGUNO . . . . . . UNO O MAS		0 1	->p801
			S	N	
705A	Bebidas alcohólicas	SI O NO	1	0	
705B	Pastillas	SI. . . . . . NO.		1 0	
705C	¿Cuáles?	_____		__ __	
705D	¿Cuáles?				->p705E
705E	marihuana	SI O NO	1	0	
705F	cocaína	SI O NO	1	0	
705G	crack	SI O NO	1	0	
705H	otras sustancias	SI . . . . . . NO		1 0	->p801
705I	¿Cuáles?	_____		__ __	
705J	¿cuáles?	_____		__ __	
MARIHUANA					
801	¿Qué edad tenía la primera vez que le ofrecieron marihuana?	EDAD . . . . . . NUNCA		__ 99	
802	¿Qué edad tenía la primera vez que usó marihuana?	EDAD . . . . . . NUNCA		__ 99	->p901

	Aproximadamente ¿con qué frecuencia ha usado la marihuana en...				
803 - CLAVE	NUNCA . . . . . 0 1-2 VECES . . . . . 1 3-5 VECES . . . . . 2 6-9 VECES . . . . . 3 10-19 VECES . . . . . 4 20-39 VECES . . . . . 5 40 Y MAS VECES 6				–
803A	su vida?	1 A 6 SEGUN LA CLAVE	1 2 3 4 5 6		
803B	los últimos 12 meses?	0 A 6 SEGUN LA CLAVE	0 1 2 3 4 5 6		->p805
804	¿Qué cantidad de cigarrillos de marihuana se ha fumado en promedio en las épocas cuando fumaba más?	# de cigarrillos diarios	__ __		
805	¿Alguna vez trató de interrumpir su consumo pero se dio cuenta que no podía?	SI . . . . . . NO	1 0		
806	Al usar marihuana, ¿consumió también al mismo tiempo o poco después, alguno de los productos de esta lista? (Mostrar Tarjeta)	NINGUNO . . . . . . UNO O MAS	0 1		
			S	N	
806A	bebidas alcohólicas	SI O NO	1	0	
806B	Pastillas	SI. . . . . . NO.	1 0		->p806E
806C	¿Cuáles?	_____	__ __		
806D	¿Cuáles?				
806E	Sustancias inhalantes (cemento, thinner, gasolina)	SI O NO	1	0	
806F	Cocaína	SI O NO	1	0	
806G	Crack	SI O NO	1	0	
806H	Otras sustancias	SI . . . . . . NO	1 0		->p901
806I	¿Cuáles?	_____	__ __		
806J	¿cuáles?	_____	__ __		
CLORHIDRATO DE COCAÍNA					
901	¿Qué edad tenía la primera vez que le ofrecieron cocaína?	EDAD . . . . . . NUNCA	__ __ 99		
902	¿Qué edad tenía la primera vez que probó cocaína?	EDAD . . . . . . NUNCA	__ __ 99		->p1001
903	¿Cómo la ha consumido?		S	N	
903A	Aspirándola	SI O NO	1	0	
903B	Inyectándola	SI O NO	1	0	
903C	Otra	SI . . . . . . NO	1 0		->p904
903D	¿Cuál?	_____	__ __		
904	Aproximadamente ¿con qué frecuencia ha usado cocaína en				
904 - CLAVE	NUNCA . . . . . 0 1-2 VECES . . . . . 1 3-5 VECES . . . . . 2 6-9 VECES . . . . . 3 10-19 VECES . . . . . 4 20-39 VECES . . . . . 5 40 Y MAS VECES 6				

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904A	su vida?	1 A 6 SEGUN LA CLAVE	1 2 3 4 5 6		
904B	los últimos 12 meses?	0 A 6 SEGUN LA CLAVE	0 1 2 3 4 5 6		->p905
904C	los últimos 30 días?	0 A 6 SEGUN LA CLAVE	0 1 2 3 4 5 6		
905	¿Alguna vez trató de interrumpir su consumo pero se dio cuenta que no podía?	SI . . . . . . NO	1 0		
906	Al usar algunas de estas sustancias, ¿consumió también al mismo tiempo o poco después, alguno de los productos de esta lista?	NINGUNO . . . . . . UNO O MAS	0 1		->p1001
			S	N	
906A	Bebidas alcohólicas	SI O NO	1	0	
906B	Pastillas	SI. . . . . . NO.	1 0		->p906E
906C	¿Cuáles?	_____	__ __		
906D	¿Cuáles?	_____	__ __		
906E	Sustancias inhalantes (cemento, thinner, gasolina)	SI O NO	1	0	
906F	Marihuana	SI O NO	1	0	
906G	Crack	SI O NO	1	0	
906H	Otras sustancias	SI . . . . . . NO	1 0		->p1001
906I	¿Cuáles?	_____	__ __		
906J	¿Cuáles?	_____	__ __		
CRACK					
1001	¿Qué edad tenía la primera vez que le ofrecieron crack?	EDAD . . . . . . NUNCA	__ 99		
1002	¿Que edad tenía la primera vez que probó crack?	EDAD . . . . . . NUNCA	__ 99		->p1101
1003	¿En qué maneras ha utilizado la crack?		S	N	
1003A	Fumada pura	SI O NO	1	0	
1003B	Fumada con tabaco	SI O NO	1	0	
1003C	Fumada con marihuana	SI O NO	1	0	
1003D	Fumada con otra sustancia	SI . . . . . . NO	1 0		->p1004
1003E	¿Cuál?	_____	__ __		
1004	Aproximadamente ¿con qué frecuencia ha usado crack en				
1004 - CLAVE	NUNCA . . . . . 0 1-2 VECES . . . . . 1 3-5 VECES . . . . . 2 6-9 VECES . . . . . 3 10-19 VECES . . . . . 4 20-39 VECES . . . . . 5 40 Y MAS VECES 6				
1004A	su vida?	1 A 6 SEGUN LA CLAVE	1 2 3 4 5 6		
1004B	los últimos 12 meses?	0 A 6 SEGUN LA CLAVE	0 1 2 3 4 5 6		->p1005
1004C	los últimos 30 días?	0 A 6 SEGUN LA CLAVE	0 1 2 3 4 5 6		
1005	¿Alguna vez trató de interrumpir su consumo pero se dio cuenta que no podía?	SI . . . . . . NO	1 0		

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1006	Al usar crack, ¿consumió también al mismo tiempo o poco después, alguno de los productos de esta lista?	NINGUNO . . . . . . UNO O MAS	0 1		->p1101
			S	N	
1006A	bebidas alcohólicas	SI O NO	1	0	
1006B	Pastillas	SI.	1 0		->p1006E
1006C	¿Cuáles?	_____	__ __		
1006D	¿Cuáles?				
1006E	Sustancias inhalantes (cemento, thinner, gasolina)	SI O NO	1	0	
1006F	Marihuana	SI O NO	1	0	
1006G	Cocaína	SI O NO	1	0	
1006H	Otras sustancias	SI . . . . . . NO	1 0		->p1101
1006I	¿Cuáles?	_____	__ __		
1006K	¿Cuáles?	_____	__ __		
OTRAS SUSTANCIAS					
1101	¿Alguna vez consumió otra sustancia con la intención de verse o sentirse diferente, o para actuar de manera distinta a la habitual, y que no apareció dentro de lo que hemos visto?	SI . . . . . . NO	1 0		->p1201
1102	¿Qué edad tenía la primera vez que la usó?	EDAD	__ __		
1103	¿Cuál es el o los nombres que habitualmente la gente le da (Si es un remedio, dar su nombre comercial).	_____ _____	__ __		
1104	¿Qué efectos obtiene de ese producto?	_____ _____	__ __		
1105	Aproximadamente ¿con qué frecuencia consumió esos productos en				
1105 - CLAVE	NUNCA . . . . . 0 1-2 VECES . . . . . 1 3-5 VECES . . . . . 2 6-9 VECES . . . . . 3 10-19 VECES . . . . . 4 20-39 VECES . . . . . 5 40 Y MAS VECES 6				
1105A	su vida?	1 A 6 SEGUN LA CLAVE	1 2 3 4 5 6		
1105B	los últimos 12 meses?	0 A 6 SEGUN LA CLAVE	0 1 2 3 4 5 6		->p1106
1105C	los últimos 30 días?	0 A 6 SEGUN LA CLAVE	0 1 2 3 4 5 6		
1106	¿Alguna vez trató de interrumpir su consumo pero se dio cuenta que no podía?	SI . . . . . . NO	1 0		
1107	¿Cuáles son las formas como acostumbra a usar esas sustancias?		S	N	
1107A	inyectable	SI O NO	1	0	
1107B	tomado	SI O NO	1	0	
1107C	fumado	SI O NO	1	0	
1107D	otras	SI . . . . . . NO	1 0		->p1108
1107E	¿Cuáles?	_____	__ __		
1108	¿En qué circunstancia se acostumbra a usarlas?	_____	__ __		

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1109	Al usar alguna de estas sustancias, ¿consumió también al mismo tiempo o poco después, alguno de los productos de esta lista?	NINGUNO . . . . . . UNO O MAS		0 1	->p1201
			S	N	
1109A	Bebidas alcohólicas	SI O NO	1	0	
1109B	Pastillas	SI. . . . . . NO.		1 0	 ->p1109E
1109C	¿Cuáles?	_____		__ __	
1109D	¿Cuáles?				
1109E	Sustancias inhalantes (cemento, thinner, gasolina)	SI O NO	1	0	
1109F	Marihuana	SI O NO	1	0	
1109G	Cocaína	SI O NO	1	0	
1109H	Crack	SI O NO	1	0	
1109I	Heroína	SI O NO	1	0	
1109J	Morfina, codeína	SI O NO	1	0	
PROBLEMAS					
1201	A consecuencia de su uso del alcohol o tabaco, tuvo ud. algun problema...	NINGUNO . . . . . . UNO O MAS		0 1	->p1203
1201A	de salud?	SI O NO	1	0	
1201B	con su familia?	SI O NO	1	0	
1201C	con sus amigos?	SI O NO	1	0	
1201D	en el trabajo o en la escuela?	SI O NO	1	0	
1201E	con las autoridades?	SI O NO	1	0	
1201F	otros?	SI O NO	1	0	
1201G	cuáles?	_____			
1202	¿Con cual sustancia?	Alcohól . . . . . . Tabaco . . . . . . Ambas		1 2 3	
1203	A consecuencia de su consumo de pastillas y/o drogas tuvo ud. algun problema...	NINGUNO . . . . . . UNO O MAS		0 1	->p1301
1203A	de salud?	SI O NO	1	0	
1203B	con su familia?	SI O NO	1	0	
1203C	con sus amigos?	SI O NO	1	0	
1203D	en el trabajo o en la escuela?	SI O NO	1	0	
1203E	con las autoridades?	SI O NO	1	0	
1203F	otros?	SI O NO	1	0	
1203G	cuáles?	_____			
1204	¿Con cuales sustancias?				
1204A	pastillas para dormir	SI O NO	1	0	
1204B	estimulantes	SI O NO	1	0	
1204C	pastillas para el dolor	SI O NO	1	0	
1204D	sedantes o relajantes	SI O NO	1	0	
1204E	marihuana	SI O NO	1	0	
1204F	alucinógenos (LSD,PCP,hongo, paraquita etc...)	SI O NO	1	0	

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1204G	sustancias inhalantes (cemento, thinner, gasolina)	SI O NO	1	0	
1204H	cocaína	SI O NO	1	0	
1204I	crack	SI O NO	1	0	
1204J	heroína	SI O NO	1	0	
1204K	morfina, codeína	SI O NO	1	0	
1204L	Otras sustancias		1	0	
1204M	¿Cuales?	_____		__ __	

ACTITUDES				
NOTA	La parte que viene ahora, trata de conocer las ideas y actitudes que tienen respecto a una serie de conductas. A continuación le voy a leer algunas afirmaciones y se trata de que usted pueda decir en cada caso si eso se aplica o no se aplica a usted. Las respuestas no son ni verdaderas ni falsas, son solo opiniones que se tienen respecto a estas conductas.			
1301	Yo voy a probar marihuana en los próximos 12 meses:	NO . . . . . . SI . . . . . . NO SE	0 1 2	
1302	Yo estoy dispuesto a probar marihuana en los próximos 12 meses:	NO . . . . . . SI . . . . . . NO SE	0 1 2	
1303	Es una buena idea que yo pruebe marihuana en los próximos 12 meses:	NO . . . . . . SI . . . . . . NO SE	0 1 2	
1304	Es dañino o beneficioso para mí, probar marihuana durante los próximos 12 meses:	DANINO . . . . . . BENEFICIOSO . . . . . . NO SE	0 1 2	
1305	Es agradable o desagradable para mí, probar marihuana durante los próximos 12 meses:	DESAGRADABLE . . . . . AGRADABLE . . . . . . NO SE	0 1 2	
1306	Es excitante o aburrido para mí, probar marihuana durante los próximos 12 meses:	ABURRIDO . . . . . . Excitante . . . . . . NO SE	0 1 2	
1307	La mayoría de las personas que son importantes para mí piensan que yo debería probar marihuana durante los próximos 12 meses:	NO . . . . . . SI . . . . . . NO SE	0 1 2	
1308	Mis amigos piensan que yo debería probar marihuana durante los próximos 12 meses:	NO . . . . . . SI . . . . . . NO SE	0 1 2	
1309	Mi familia piensa que yo debería probar marihuana durante los próximos 12 meses:	NO . . . . . . SI . . . . . . NO SE	0 1 2	
1310	La mayoría de mis amigos han probado marihuana:	NO . . . . . . SI . . . . . . NO SE	0 1 2	
1311	Conozco a alguien quien ha probado marihuana:	NO . . . . . . SI . . . . . . NO SE	0 1 2	
1312	Mi novio(a), esposo(a) piensa que yo debería probar marihuana en los próximos 12 meses:	NO . . . . . . SI . . . . . . NO SE	0 1 2	
1313	Yo voy a probar cocaína en los próximos 12 meses:	NO . . . . . . SI . . . . . . NO SE	0 1 2	
1314	Yo estoy dispuesto a probar cocaína en los próximos 12 meses:	NO . . . . . . SI . . . . . . NO SE	0 1 2	
1315	Es una buena idea que yo pruebe cocaína en los próximos 12 meses:	NO . . . . . . SI . . . . . . NO SE	0 1 2	
1316	Es dañino o beneficioso para mí, probar cocaína durante los próximos 12 meses:	DANINO . . . . . . BENEFICIOSO . . . . . . NO SE	0 1 2	
1317	Es agadable o desagradable para mí, probar cocaína durante los próximos 12 meses:	DESAGRADABLE . . . . . AGRADABLE . . . . . . NO SE	0 1 2	

1318	Es excitante o aburrido para mí, probar cocaína durante los próximos 12 meses:	ABURRIDO . . . . . . Excitante . . . . . . NO SE	0 1 2	
1319	La mayoría de las personas que son importantes para mí piensan que yo debería probar cocaína durante los próximos 12 meses:	NO . . . . . . SI . . . . . . NO SE	0 1 2	
1320	Mis amigos piensan que yo debería probar cocaína durante los próximos 12 meses:	NO . . . . . . SI . . . . . . NO SE	0 1 2	
1321	Mi familia piensa que yo debería probar cocaína durante los próximos 12 meses:	NO . . . . . . SI . . . . . . NO SE	0 1 2	
1322	La mayoría de mis amigos han probado cocaína:	NO . . . . . . SI . . . . . . NO SE	0 1 2	
1323	Conozco a alguien quien ha probado cocaína:	NO . . . . . . SI . . . . . . NO SE	0 1 2	
1324	Mi novio(a), esposo(a) piensa que yo debería probar cocaína en los próximos 12 meses:	NO . . . . . . SI . . . . . . NO SE	0 1 2	
1325	Yo voy a probar crack en los próximos 12 meses:	NO . . . . . . SI . . . . . . NO SE	0 1 2	
1326	Yo estoy dispuesto a probar crack en los próximos 12 meses:	NO . . . . . . SI . . . . . . NO SE	0 1 2	
1327	Es una buena idea que yo pruebe crack en los próximos 12 meses:	NO . . . . . . SI . . . . . . NO SE	0 1 2	
1328	Es dañino o beneficioso para mí, probar crack durante los próximos 12 meses:	DANINO . . . . . . BENEFICIOSO . . . . . . NO SE	0 1 2	
1329	Es agadable o desagradable para mí, probar crack durante los próximos 12 meses:	DESAGRADABLE . . . . . AGRADABLE . . . . . . NO SE	0 1 2	
1330	Es excitante o aburrido para mí, probar crack durante los próximos 12 meses:	ABURRIDO . . . . . . Excitante . . . . . . NO SE	0 1 2	
1331	La mayoría de las personas que son importantes para mí piensan que yo debería probar crack durante los próximos 12 meses:	NO . . . . . . SI . . . . . . NO SE	0 1 2	
1332	Mis amigos piensan que yo debería probar crack durante los próximos 12 meses:	NO . . . . . . SI . . . . . . NO SE	0 1 2	
1333	Mi familia piensa que yo debería probar crack durante los próximos 12 meses:	NO . . . . . . SI . . . . . . NO SE	0 1 2	
1334	La mayoría de mis amigos han probado crack:	NO . . . . . . SI . . . . . . NO SE	0 1 2	
1335	Conozco a alguien quien ha probado crack:	NO . . . . . . SI . . . . . . NO SE	0 1 2	
1336	Mi novio(a), esposo(a) piensa que yo debería probar crack en los próximos 12 meses:	NO . . . . . . SI . . . . . . NO SE	0 1 2	

1337	Yo voy a probar inhalantes en los próximos 12 meses:	NO . . . . . . SI . . . . . . NO SE	0 1 2	
1338	Yo estoy dispuesto a probar inhalantes en los próximos 12 meses:	NO . . . . . . SI . . . . . . NO SE	0 1 2	
1339	Es una buena idea que yo pruebe inhalantes en los próximos 12 meses:	NO . . . . . . SI . . . . . . NO SE	0 1 2	
1340	Es dañino o beneficioso para mí, probar inhalantes durante los próximos 12 meses:	DANINO . . . . . . BENEFICIOSO . . . . . . NO SE	0 1 2	
1341	Es agradable o desagradable para mí, probar inhalantes durante los próximos 12 meses:	DESAGRADABLE . . . . . AGRADABLE . . . . . . NO SE	0 1 2	
1342	Es excitante o aburrido para mí, probar inhalantes durante los próximos 12 meses:	ABURRIDO . . . . . . Excitante . . . . . . NO SE	0 1 2	
1343	La mayoría de las personas que son importantes para mí piensan que yo debería probar inhalantes durante los próximos 12 meses:	NO . . . . . . SI . . . . . . NO SE	0 1 2	
1344	Mis amigos piensan que yo debería probar inhalantes durante los próximos 12 meses:	NO . . . . . . SI . . . . . . NO SE	0 1 2	
1345	Mi familia piensa que yo debería probar inhalantes durante los próximos 12 meses:	NO . . . . . . SI . . . . . . NO SE	0 1 2	
1346	La mayoría de mis amigos han probado inhalantes:	NO . . . . . . SI . . . . . . NO SE	0 1 2	
1347	Conozco a alguien quien ha probado inhalantes:	NO . . . . . . SI . . . . . . NO SE	0 1 2	
1348	Mi novio(a), esposo(a) piensa que yo debería probar inhalantes en los próximos 12 meses:	NO . . . . . . SI . . . . . . NO SE	0 1 2	
DATOS SOCIO-DEMOGRAFICOS				
1401	Indique el sexo del entrevistado.	HOMBRE . . . . . . MUJER	1 2	
1402	¿Cuántos años cumplió en su último cumpleaños?	EDAD	__ __	
1403	¿Cuál es el lugar de nacimiento?	_____	__ __	
1403A	Zona Rural o Urbana?	Urbana=1 o Rural=2 . .	1 2	
1404	¿Cuál es su estado civil?	casado . . . . . . unido/concubinado . . . viudo . . . . . . separado/divorciado . . soltero	1 2 3 4 5	
N.E.S.				
1501	En los últimos 6 meses, ¿trabajó en alguna actividad remunerada?	SI . . . . . . NO	1 0	->p1501B
1501A	¿Qué hace?	Ama de casa . . . . . . Estudiante . . . . . . Jubilado . . . . . . Rentista . . . . . . Desempleado	1 2 3 4 5	p1502

1501B	Profesionales, Tecnicos y Ocupaciones Afines		01	
	Gerentes, Administradores y Funcionarios de Categoria Directiva		02	
	Empleados de Oficina y personas de ocupaciones afines		03	
	Comerciantes, vendedores y ocupaciones afines		04	
	Agricultores, ganaderos, pescadores, cazadores, trabajdores forestales y afines		05	
	Conductores de medios de transporte y afines		06	
	Artesanos y operarios de hilanderias, vestuarias y calzados,carpinteria,industria de la construccion y mecanica		07	
	Otros Artesanos y Operarios		08	
	Obreros y Jornaleros		09	
	Trabajadores en Servicios Personales y afines		10	
	Trabajadores en ocupaciones no identificables o no declarables y otros trabajadores		11	
	Miembros de las Fuerzas Armadas		12	
1502	¿Cuál es el último grado o curso aprobado, en la enseñanza regular?	ninguno o hasta 2o grado	1	
		primaria incompleta . .	2	
		primaria completa . . .	3	
		secundaria incompleta .	4	
		secundaria completa . .	5	
		universitaria incompleta	6	
		universitaria completa	7	
			8	
1503	¿Es usted jefe de familia?	SI	1	->p1601
		NO	0	
1504	¿El jefe de familia trabajo en alguna actividad remunerada?	SI	1	->p1504B
		NO	0	
1504A	¿Qué hace el jefe de familia?	Ama de casa	1	p1505
		Estudiante	2	
		Jubilado	3	
		Rentista	4	
		Desempleado	5	
1504B	Profesionales, Tecnicos y Ocupaciones Afines		01	
	Gerentes, Administradores y Funcionarios de Categoria Directiva		02	
	Empleados de Oficina y personas de ocupaciones afines		03	
	Comerciantes, vendedores y ocupaciones afines		04	
	Agricultores, ganaderos, pescadores, cazadores, trabajdores forestales y afines		05	
	Conductores de medios de transporte y afines		06	
	Artesanos y operarios de hilanderias, vestuarias y calzados,carpinteria,industria de la construccion y mecanica		07	
	Otros Artesanos y Operarios		08	
	Obreros y Jornaleros.		09	
	Trabajadores en Servicios Personales y afines		10	
	Trabajadores en ocupaciones no identificables o no declarables y otros trabajadores		11	
	Miembros de las Fuerzas Armadas		12	
1505	¿Cuál es el último grado o curso aprobado por el jefe de la familia, en la enseñanza regular?	ninguno o hasta 2o grado	1	
		primaria incompleta . .	2	
		primaria completa . . .	3	
		secundaria incompleta .	4	
		secundaria completa . .	5	
		universitaria incompleta	6	
		universitaria completa	7	

GENERAL					
1601	Las personas dicen que el consumo de drogas es un problema en la Rep. Dominicana.	Si es un problema muy grave . . . . . . Si es un problema grave Si es un problema no muy grave . . . . . . No es un problema . . .		1 2 3 4	
1602	Las personas dicen que el tráfico de drogas es un problema en la Rep. Dominicana.	Si es un problema muy grave . . . . . . Si es un problema grave Si es un problema no muy grave . . . . . . No es un problema . . .		1 2 3 4	
1603	¿Ha visto u oido un mensaje contra las drogas en los últimos 30 días?	SI . . . . . . NO		1 0	->p1604
1603A	¿Dónde? En la television.	SI O NO	1	0	
1603B	En letreros o afiches.	SI O NO	1	0	
1603C	En la radio.	SI O NO	1	0	
1603D	En los periódicos o revistas.	SI O NO	1	0	
1603E	Organizaciones comunitarias	SI O NO	1	0	
1603F	Otro	SI O NO	1	0	
1603G	¿Cúal?	_____		__ __	
1604	¿Ha hablado con alguien en los últimos 30 días sobre el asunto de las drogas?	SI O NO	1	0	
1605	¿Cuál de los siguientes elementos restringe más al uso de las drogas?	La Policia . . . . . . La familia . . . . . . La publicidad en contra las drogas . . . . . . Los amigos . . . . . . La religion . . . . . . El costo de las drogas Otro		1 2 3 4 5 6 7	
1605A		¿Cuál?		__ __	

ABIERTA				
1701	¿Cuál sería la principal acción que habría que realizar para evitar que se extienda el consumo de drogas en nuestro país?	-Acciones orientadas fortalecimiento y educación de la familia. -Acciones orientadas mayor control y sanción narcotráfico. -Acciones orientadas mayor control y sanción consumidor. -Educación/concientización social gral. -Educación/concientización juventud. -Creación fuente de trabajo. -Otro: _____	1 2 3 4 5 6 7	___
ANOTACION DEL ENCUESTADOR				
1801	¿Su impresion final es que el entrevistado ha sido sincero?	NO . . . . . . SI . . . . . . NO ESTA SEGURO	0 1 2	
1802	¿Según usted, podría pensarse que el entrevistado es un usuario de drogas ilicitas que no respondió sinceramente a la encuesta?	NO . . . . . . SI . . . . . . NO ESTA SEGURO	0 1 2	
1803	Si sus respuestas fueron afirmativas o de duda, explique brevemente sus razones.			

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