

An Institutional Ethnography of Prevention and Treatment Services for Substance Use Disorders in the Dominican Republic

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No conflict of interest to declare.

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Abstract:

The Dominican Republic is thought to have significant epidemics of illicit drug use but lacks surveillance and formal analyses of the policy context of drug prevention and treatment services. We conducted an institutional ethnography of 15 drug service organizations in Santo Domingo and Boca Chica, Dominican Republic, to explore barriers and resources for drug abuse prevention and treatment. Here, we present a typology of drug service organizations based on their services, methods, and approach. We then draw on interviews with representatives of drug service institutions to describe the primary barriers to drug treatment and prevention services for drug users. We conclude with a focus on the policy priorities that could improve the conditions of health care for marginalized drug users in the Dominican Republic.

Key words: Dominican Republic, drug service organizations, institutional ethnography, drug users, drug policy.

Introduction

Illicit drug use is increasingly perceived as a public health problem in the Caribbean, including the nation we focus on here, the Dominican Republic (DR) (Caceres, Shedlin, & Deren 2000; Guilamo-Ramos et al., 2015). While there is an active intravenous drug use (IDU) epidemic in neighboring Puerto Rico (Thrash et al. 2018), to date not a single peer-reviewed epidemiological study has measured the prevalence of IDU in the DR. Beyond the peer reviewed literature, two studies in the DR have attempted to assess the prevalence of IDU (CONAVIHSIDA, 2012; OEA et al., 2013), suggesting a small (0-2.4%) prevalence of IDU among drug users overall, but a high prevalence of injection as the means of consumption (50.6%) among heroin users. The last surveillance study of HIV and IDU, conducted in 2007, estimated that unsafe injection contributes to 0.77% of HIV transmission in the Dominican Republic (WHO & PAHO, 2007). However, this figure has been disputed by civil society organizations (Day, 2012), and reports from front-line service providers, government departments, civil society organizations, and international health organizations (CONAVIHSIDA, 2012; IHRA, 2014; OEA et al., 2013) suggest that IDU is a growing problem in the DR. For decades, policymakers have expressed concern about the country's capacity to respond to the local heroin epidemic (Dormitzer et al., 2004; Hagan & Palloni, 1998).

To date, few peer-reviewed studies have examined the availability or content of services for problematic illicit drug use in the DR (Day, 2012; Klein, Day, & Harriott, 2004; Mathers et al., 2010). This absence of academic research means that little is known about the actual programs, services, and approaches—including therapeutic practices and philosophical orientations—of the DR's drug service organizations. It is therefore nearly

impossible to assess the degree to which such services follow evidence-based practices for drug prevention and treatment. Furthermore, there has been no analysis of how the DR's services for problematic drug use are shaped by economic, institutional, and political factors.

To advance knowledge of the therapeutic content and institutional context of drug services in the DR, this article presents the findings of an institutional ethnography of drug service organizations in Santo Domingo and Boca Chica, Dominican Republic, conducted as a component of a larger National Institute on Drug Abuse-funded mixed method study of HIV and drug use risk among men employed in the tourism sector. Institutional ethnography uses ethnographic techniques of participant observation and inductive inquiry to describe how the regulatory, legal, and normative functions of institutions are developed and maintained, as well as the ways these are enacted or resisted in practice (Garcia, Muñoz-Laboy, & Parker, 2011; Padilla, Reyes, et al., 2012).

This article is organized as follows. First, we provide an overview of the drug policy climate in the Dominican Republic. Next, we present an overview of organizations that provide services for people with problematic drug use (focusing on illicit drug use, not alcohol) and summarize basic characteristics of these organizations (see Table 1). We briefly identify and describe the most critical constraints on drug service organizations and the most significant gaps in service provision, according to our informants. Then, we draw upon the ethnographic findings to describe in greater detail the therapeutic content and philosophical approaches of existing drug service organizations, and explore a number of locally relevant dimensions of institutional and political context shaping drug

services in the DR. In the conclusion, we offer recommendations for policies and institutional responses to problematic drug use based on our findings.

Background on Drug Policy Climate in the Dominican Republic

Treatment and prevention for substance use disorders in the DR are sharply limited, consisting mostly of abstinence-based residential programs and outreach initiatives that provide hot meals and clothes to homeless drug users (IHRA, 2014). A local survey identified 91 service organizations in the DR, which reported providing care to a total of 2,182 drug users (OEA, CICAD and CND, 2013). The majority of organizations were identified as residential centres, followed by private clinics and outpatient centres. Most organizations subscribe to abstinence-based approaches, while harm reduction approaches and medically-assisted treatment are scarce (Day, 2012; IHRA, 2014; Klein et al., 2004).

The lack of harm reduction approaches or medically assisted treatment is partly a consequence of the DR's legal framework governing controlled substances. Law 50-88 on Drugs and Controlled Substances (30 May, 1988), which was modelled on similar zero-tolerance approaches propagated by the United States under Ronald Reagan's Presidency, is the cornerstone of the DR's response to illicit substances. According to Article 7 of the law, anyone found in possession of small amounts of illicit substances, such as LSD, opium or opium's derivatives (including methadone), may be legally classified as a *narcotraficante* (narco-trafficker) and sentenced to decades of incarceration.

Law 50-88 explicitly prohibits methadone use. However, owing to the specific wording of the law, which emphasizes constrictions on controlled drugs, those opiate agonist treatments (OAT) that are not explicitly named and prohibited by Law 50-88 (e.g., buprenorphine) are theoretically permitted for use in clinical contexts. At the time of writing, the United Nations Office on Drugs and Crime (UNODC) recently completed a small-scale pilot of opiate agonist treatment for a group of 50 active heroin users in the DR (IHRA, 2014). If successful, this is intended to provide a justification for continued investment in ORT and a modification to the existing law to legally permit such therapies. The results for the pilot are not yet available.

Since Law 50-88 applies to the possession of small quantities of drugs, including those that are left over in used syringes, anyone found in possession of a used syringe could theoretically be sentenced equivalently to narco-traffickers. That said, the DR's first Needle Exchange Program (NEP) began in 2012, making the DR one of only two countries in the Caribbean (along with Puerto Rico) to have NEPs (Day, 2012).

The development of services for people with problematic drug use in the DR has historically been led almost entirely by civil society organizations. Currently, just two institutions receive state funding to provide direct services for problematic drug use, and both operate exclusively within the capital of Santo Domingo (the Centre for the Integral Attention of Dependences, and the Centre for the Integral Assistance of Children and Adolescents that Consume Psychoactive Substances). All other services are operated by civil society organizations, most of which are unlicensed (OSF, 2016).

Methods

This paper draws on a subset of the findings from a mixed-methods study funded by the National Institute on Drug Abuse (NIDA) that examines the syndemic conditions for HIV and drug abuse in the tourism areas of Santo Domingo and Boca Chica, Dominican Republic. The current analysis is restricted to the ethnographic data from the institutional ethnography conducted for the study during the years 2014-2016. The purpose of the institutional ethnography was to provide a broad social, political, and economic context for understanding vulnerabilities to HIV/AIDS and drug addiction. As part of our institutional ethnography we proceeded with formal and informal interviews with key stakeholders that work on issues related to drug use in the Dominican Republic at various levels, from front-line service providers to government officials and drug treatment activists. As part of this, we had the opportunity to interview agents from both national and international agencies including the National Drug Council (CND), the National Drug Control Directorate (drug enforcement agency), and regional experts of the United Nations Office on Drugs and Crime (UNODC). The National Drug Control Directorate (DNCD, by its Spanish its acronym) is the institution created in 1988 by Executive Decree and Law 50-88 to enforce the controlled substances law and regulations of the Dominican Republic. Additionally, we participated in several meetings of the National Inter-Institutional Coordination Board for Drug Policy Reform (“Mesa de Drogas”), a space created with two purposes: (1) to unite the representatives of the civil society, state institutions dependent to the Executive Power of the Republic and the United Nations; and (2) to coordinate the national strategy for drug reform in the Dominican Republic by

complying with the Special Session of the United Nation General Assembly on the world drug problem.

Although we interviewed stakeholders from different levels and sectors, for this paper, we focus on the narratives of representatives from 15 public and private substance use service organizations in Santo Domingo, the largest urban area in the country composing one-third of the national population, and Boca Chica, a neighbouring beach town, both of which are located in the National District, were the focus of the funded research, and were geographical areas in which prior qualitative research suggested high rates of both illicit drug use and HIV/AIDS (Guilamo-Ramos, Bouris, and Matiz-Reyes 2010). Organizations were included in the study if they met one of the following inclusion criteria: (1) provided drug and HIV/STD prevention services, (2) provided on-site residential or ambulatory treatment for problematic illicit drug use, or (3) provided both HIV services and drug treatment (see Table 1).

We visited and observed approximately 45% (15 of 33) drug service organizations in this area, as listed in an official registry of such organizations provided to our team by the Dominican National Drug Council (this registry was later independently confirmed with the United Nation Office on Drugs and Crime). The time we spent with individual institutional representatives during the ethnography was variable; in some cases, we spent long days and even months conducting collaborative work. In other cases, our visits involved more cursory meetings with on-site managers and staff for key informant interviews, and a tour of the facilities that often permitted more informal interactions with staff and volunteers. In all cases, participant observation was conducted at each of the organizations in conjunction with each key informant interview.

All the organizations that we visited focused on one or more of the following areas of work: drug education, counselling, and prevention; drug policy, advocacy, and enforcement; residential drug treatment; and clinical services. All participants in the key informant interviews (N=64) were mid-to-high-level representatives of these organizations—such as directors, program managers, or program outreach staff—or other people associated with the organization that provided our team a perspective on its institutional culture or functioning. Recruitment and coordination for interviews with organizations and institutional representatives were achieved through community contacts from prior studies by our research team and new community contacts obtained through participant observation.

All of the authors are fluent in Spanish, and each of the four ethnographers (Mark Padilla, José Félix Colón-Burgos, Armando Matiz-Reyes and Nelson Varas-Díaz), wrote extensive hand-written jottings during these visits, which were expanded into field notes following participant observation sessions. We chose this technique for capturing our interview and observational data because we deemed this most effective at eliciting open, honest responses to questions that might be perceived as too sensitive to permit audio recordings. Capturing ethnographic data via jottings during fieldwork and their subsequent elaboration into full field notes is a standard ethnographic technique (Emerson, Fretz, & Shaw, 2011), and because we often conducted these visits with two ethnographers, one was often able to capture verbatim speech and other details in hand-written notes that might have otherwise been lost.

Our analysis consists of a systematic coding of the ethnographic field notes using a two-staged technique. First, we conducted open coding of all field notes, carried out

independently by two coders followed by weekly team discussions regarding all coding decisions, to identify emerging issues or themes, remaining grounded in the words or phrases of participants or issues that struck the ethnographers as important in understanding the drug policy climate. Second, we classified these diverse themes into higher-order categories, placing particular emphasis on the policy barriers faced by drug service organizations in addressing addiction, as well as the assets or resources available to them. We subsequently presented these findings to all drug service organizations that had participated in the study and incorporated their responses into our analysis as a form of member checking. Findings were distributed to all participants to foster policy dialogue at all levels. All participants verbally consented to participate in the interviews. The study was review by the Florida International University Institutional Review Board (IRB-13-0183).

Findings

Table 1 describes the interviewed organizations that consented to participate and reported provision of services to people with problematic drug use in the Dominican province of Santo Domingo.

[Insert Table 1 here]

Almost all the interviewed organizations had their central office located within the main metropolitan area (National District) of the capital province of Santo Domingo. Only one organization (n=1, 7%) reported providing direct services to people with problematic drug use in two provinces (Santo Domingo and Santiago). Service provision for all other organizations was limited to the capital province. Of the 15 interviewed

organizations, five (n=5, 33%) provided faith-based services. Eleven of the interviewed organizations (n=12, 80%) reported themselves as non-governmental and not-for-profit organizations (NGNPO). Among the remaining four organizations, one was a private for-profit (n=1, 7%) and two were governmental (n=2, 13%). One of the two governmental organizations (GO) was a minor division of the tourist police force that is specifically responsible for referring homeless children and adolescents to treatment service providers. Of the 12 NGNPO's, eight (n=8, 53%) reported that their primary source of funding was the Dominican government. According to Dominican Law 72-02, a portion of the drug trafficking seizures (seizures of property and money, e.g.) is distributed by the state to NGNPO's that provide drug treatment and prevention in the Dominican Republic. The rest of the NGNPOs (n=4, 27%) reported that their primary source of funding was an international donor.

Ambiguous Meanings of "Treatment"

One of the central areas of murkiness in the perceptions of policymakers involved the contradictory or inconsistent definitions of what constitutes "treatment." According to the National Institute on Drug Abuse, drug treatment includes any service that is "intended to help addicted individuals stop compulsive drug seeking and use" (2012, p. 9). The majority of the Dominican organizations interviewed (n=9, 60%) did not provide evidence-based drug treatment in that their services did not seek to help people stop drug-seeking or use through established interventions. Instead, most organizations provided various forms of social support for people with problematic drug use, such as referrals and provision of basic subsistence such as food, clothes, and showers. Just six (n=6,

40%) organizations reported providing treatment for problematic drug use, but interviews revealed significant ambiguity about how treatment was understood by the staff of these organizations. Of the six organizations that reported providing treatment, just two of them actually provided clinical services, which we defined as the presence of clinically trained personnel on staff. Both of these organizations were private clinics whose patients paid significant fees for services, meaning their clientele was primarily of high socioeconomic status. However, even in these facilities the actual medications and clinical treatments available were limited, consisting of over-the-counter analgesics for individuals who might be experiencing severe withdrawal symptoms, certain mental health therapies, and clinical monitoring of rehabilitation by a physician.

Drug service organizations that do not employ clinically trained staff are the primary resources available for working class or poor drug users in Santo Domingo. We spoke to representatives of four such organizations. Instead of clinical or evidence-based harm reduction approaches, they provided non-clinical services that were often described as “treatment,” such as abstinence-based residential rehabilitation, Bible-study, spiritual counselling, and unconventional forms of psychotherapy such as *terapia de confrontación* (confrontation therapy), a group therapy process in which people are encouraged to confront each other about their personal weaknesses.

A senior staff member, “Jesus”, of an organization that employs the latter method, which is also the largest rehabilitation program in the country, spoke to us at length about the technique over the course of various interviews. Through these conversations, it became clear that “treatment” modalities such as confrontation therapy are linked to a theory of the causality of addiction that begins in personal characteristics that presumably

need to be redirected. When we inquired why they offered no harm reduction services, Jesus noted: “drug users don’t only get infected with needles.” “There is a tendency to promote the notion that HIV is transmitted from the exchange of needles,” he explained, “but this is incorrect.” His assistant elaborated that their approach is “evidence-based” because “the majority of the HIV cases don’t have to do with needles, but rather disinhibition,” explaining that infection occurs more often because an individual is under the influence of drugs, resulting in “promiscuity” because he or she engages in risky behaviour and “is not aware at that moment.” He explained that most of the men in the residential program (the program is composed almost entirely of men) “lose control because of their illness” [meaning drug abuse], and this is what causes their infection. Jesus reinforced this interpretation, noting that “the needle [for drug injection] costs 5 pesos, so it’s not a problem for them to obtain them. They sell them in the pharmacy without requiring a prescription.” In other words, these upper-level staff members of the largest drug rehabilitation program in the country argued that the Dominican population is not suffering from a lack of access to clean needles, since these can be easily found in any drug store at a low price. “Once in a while they exchange needles,” Jesus admitted, but it is not the most important explanation for infection among drug users. The resistance to providing needle exchange was therefore embedded in a larger theory about drug addiction that presupposed an individual’s failing character was primarily responsible, thereby justifying the neglect of harm reduction principles. Meanwhile, just a few miles away at a neighbouring organization our team had interviewed heroin users who were desperate for a new cycle of funding for the harm reduction organization where

they volunteered, in order to sustain the needle exchange program in the barrio of Capotillo on which they relied daily.

At the same time that they argued against harm reduction, representatives of residential programs promoted “confrontation therapy” – the centrepiece of their rehabilitation program – which has the goal of making the individual aware of his/her “behavioural failing” and “re-educating” him/her into “a new lifestyle.” Treatment in the residential program has an obligatory residence requirement of 1 year and 2 months. If an individual leaves the program voluntarily and wishes to return, they are allowed to re-enter, but they must begin their cycle of treatment over again if they wish to complete it. When an individual is permitted to leave for a period of time, they are drug tested upon return. Those who test positive are assigned to a special residence program called “Prevention of Relapse,” which has a longer period of residence. “It is very difficult for a person to be rehabilitated in one attempt,” an informant observed. They reported that approximately 50% of program participants who complete their residential program are successful, but offered no data to support this claim.

Some drug treatment programs offered another unconventional form of psychotherapy called *terapia de trabajo* (work therapy), which we observed during our ethnographic visits and interviews. This commonly consists of making confectionaries and trinkets, selling them on the street, and contributing any revenue to support the treatment facility. In a recent report on Dominican drug rehabilitation programs funded by the Open Society Foundation (2015), confrontation therapy and work therapy are cited as examples of non-evidence-based approaches that violate clients’ human rights and dignity.

In general, we found a lack of consensus as to what constitutes treatment and what constitutes effective treatment. Most of the services described as “treatments” were not clinical in that they did not involve trained clinical personnel and did not include interventions that are accepted in the scientific literature as effective, such as opiate agonist treatment or needle exchange programs. The few organizations that had clinical personnel on site were only available to the wealthy. Indeed, during an interview with a high-level employee at the National Council on Drugs, the governmental body that is charged to provide norms and guidance for drug prevention and rehabilitation in the country, the interviewee stated, “There is absolutely no heroin treatment in my country,” and lamented the fact that the majority of organizations that seek to treat people with problematic drug use do not employ evidence-based methods. Despite this, many of these organizations use the term “treatment” to refer to what are actually unregulated, idiosyncratic approaches that leave the vast majority of individuals without access to effective care.

Disparities in Drug Services

Across the board, representatives of drug service organizations emphasized that severe economic constraints limited the capacity of their organizations to sustain services, and many providers listed specific resources that they needed but were unable to afford. These needs included transportation for clients, private rooms in which to conduct one-on-one therapy, beds for residential facilities, and basic equipment, such as syringes for injection drug users or pipes for crack users. During the ethnography, we found the physical conditions of the residential treatment facilities to be sparse and lacking critical

resources. At a harm reduction organization that conducted one of the few NEPs, we saw signs posted at the door of one organization reading, “There are no needles.” A high-level government employee we interviewed highlighted the lack of public investment in drug use and prevention, stating, “The investment of money in drug treatment has been zero.” Nearly all of our interviewees emphasized that severe economic constraints were a daily challenge for their organization’s basic survival.

When we visited two private clinics that did employ clinically trained staff, representatives acknowledged to us that their clinical services were prohibitively expensive for the vast majority of the drug-using population. These organizations were both located in Santo Domingo’s wealthier residential neighbourhoods, where upper or upper-middle class residents predominate, as well as many ex-patriots or long-term foreign residents from the United States and Europe. We met with one organization’s Executive Director, ‘Joaquin,’ for a scheduled interview, and he gave us a tour and an extensive background. One of Joaquin’s primary criticisms of the policy response to drug abuse in the country was the lack of public sector funding for evidence-based treatments, leaving the vast majority of clients without affordable and effective services. “The cost accrues to the family,” he explained, noting the burden to extended families that some of his clients experience, who are more economically privileged than the majority of the population in need of such services. “It simply isn’t sustainable,” Joaquin lamented. “Mental health funding is less than 20 million pesos [approximately \$400,000 US] a year, and there’s only one psychiatrist for every 6,000 residents.” At an average cost of \$500 US per month, he confessed that his organization’s services were inaccessible to the vast majority of individuals in need.

Among the organizations we observed, there were very few that provided specialized services for specific target populations. Four (n=4, 27%) provided services to children and adolescents. Nearly all of the providers we interviewed worked principally with men, and we found only one organization that specialized in working with women, and none that specialized in Lesbian, Gay, Bisexual, and Transgender (LGBT) populations. Some providers explained that they lacked the resources or expertise to work with these groups. The director of one NGNPO explained that they did not work with women because they did not have female employees and their model of intervention was designed for men, commenting as follows: “Work with women is more complicated. You need women to work with women. They wanted to insert the model of treatment for men with the model for women and it didn’t work.”

LGBT populations were particularly underserved. Some faith-based providers and some re-education programs said that they would not accept LGBT drug users, and some of those that did observed they had tried to “treat” LGBT people for their “condition” (meaning their sexual orientation). During one visit to a faith-based residential treatment program that focused on the poor, the director explained to us the “complexities” of treating the LGBT individuals in his centre. He stated that his organization could not adequately approach LGBT communities because the organization uses a particular outreach strategy, which is to focus on “true drug users,” rather than those whose primary identification is with other communities. However, he emphasized that their mission is to accept all who arrive: “There’s no rejection,” he commented. Immediately after making this remark, he admitted that there were some residents in their treatment centre who had

“that condition” (i.e., a non-normative sexual orientation or gender identity), which was treated in therapy.

When asked about a hypothetical case of a transgender woman coming to the residential facility seeking care, the director admitted that this would be “complicated” because this individual’s “true sex” would be determined by their biology, and they would have to “respect the norms of the institution.” It would not be possible for such an individual to dress as female, as this would “contaminate the rest of the residents.”

Our research strongly confirmed systemic and worrisome disparities in access to drug services, which are largely inaccessible to the poor. Those services that are accessible offer no clinical or evidence-based interventions. Our research supports what some key informants observed: that LGBT populations in particular are suffering from constrained access, since even the services for the poor are denied them.

Religio-moral versus scientific ideologies

Another significant finding of our research involves the various religious, moral, and scientific ideologies that undergird drug service organizations, and which exist in complex tensions that ebb and flow in drug policy and practice. Interviews with service providers revealed significant tensions regarding what was deemed appropriate methods of treatment, for example. Many service providers were highly critical of organizations that use unconventional forms of psychotherapy. During an interview with an international organization funded through grants from the U.S., a local director raised the issue of the reliance on confrontation therapy, prayer, and Bible study as methods of treatment, which, she said, “are not effective” and “have no basis in science.”

Across organizations, many of our informants expressed the need for greater access to “evidence-based methods,” which was used as a shorthand for needle exchange and OAT. Just two of the interviewed organizations said that evidence-based methods informed their approach, referring to needle exchange in both cases. This suggests that while many service providers understand the need for evidence-based interventions, the larger institutional mandates, public health strategies, and governmental priorities do not reflect their perspectives.

On the other hand, some of the faith-based organizations available primarily to the poor were highly critical of the two existing needle exchange programs. Several informants from these organizations doubted the scientific basis of NEPs and called into question their efficacy in reducing HIV transmission. This rejection of evidence-based methods was not a universal characteristic across NGNPOs, however. One of the faith-based organizations we have observed is a drug service organization in Santo Domingo that uses a harm reduction approach combined with religious and moral forms of rehabilitation. In many ways, this organization is representative of the approaches used in the few drug service organizations that are available to the poor. Their philosophy is self-consciously hybrid, incorporating a faith-based approach to rehabilitation that is at the core of the treatment approach. “The Bible has science,” said the Executive Director of the organization. He explained that it is essential to use a combination of evidence-based practice (harm reduction) and the power of “Biblical teaching.” It was evident from many of the stories told by organizational representatives that these leaders’ own religious calling was informing their core belief that a religiously informed approach to healing

was critical for treatment success, independent of any particular scientific data regarding efficacy.

Representatives at several drug service organizations indicated that religious leaders contribute to the low availability of harm reduction services for people who use drugs, since their philosophy is to promote faith as a form of therapy rather than providing scientifically proven interventions. For example, one interviewee at a struggling NGO in the poor neighbourhood of Capotillo pointed to the Catholic hierarchy as a factor that weakens the public health response to drug addiction. When asked what barriers he confronts in providing needle exchange programs and other harm reduction services, he simply said, “The Cardinal,” a reference to the recently ousted Cardinal Nicolás de Jesús López Rodríguez, a highly conservative member of the Roman Catholic church who has openly stigmatized marginalized groups in the Dominican Republic for decades. This interviewee then continued, “The church insists that harm reduction is bad,” resulting in a constant struggle at their organization to maintain their needle exchange program and other services.

Dominican Drug Law 50-88 and Drug Criminalization

The legal context of the Dominican drug law creates a significant barrier to drug policy and was emphasized by many participants. Law 50-88 prohibits the use of methadone, by name, in clinical contexts and thus poses a direct legal challenge to the introduction of opioid agonist treatment in the DR. Although we came across instances in which an individual had managed to obtain methadone or other treatments (e.g., suboxone), we found that these medications were generally unavailable to most drug users. Law 50-88

only prohibits controlled substances that are specifically named in the law (e.g., LSD, opium or opium derivatives). Thus, as a government employee explained to us that buprenorphine and suboxone, which are not named by the law, may theoretically be used in the absence of legal reform.

The DR's legal framework posed an additional problem for needle exchange programs. Since law 50-88 applies to possession of small quantities of drugs, including those that are left over in used syringes, anyone found in possession of a used syringe could theoretically be sentenced equivalently to narco-traffickers (OAS, 1988). At the two harm reduction agencies that we visited, staff described working at the edge of legality and regretfully told us that both their volunteers and the drug users that they serve could be arrested at any time for possession of used needles. As one informant, the Director of one of two organizations providing harm reduction services, lamented: "Law 50-88 is unfair; it limits our ability to help sick drug users, and a sick person with a needle is judged as a narco-trafficker." Several interviewees referred to occasions in which drug users that they were working with were arrested for possession of needles, and a number of our informants mentioned that police routinely perpetrate violence against drug users. An outreach worker described one incident in which, following a series of thefts that were believed to be perpetrated by drug users attempting to purchase crack, police in Capotillo began a "cleansing campaign" in which drug users were indiscriminately beaten and several were killed. Reflecting on the incident, which provoked a mass protest, he said that the issue with Law 50-88 is that it gave "absolute power to the police to repress drug users."

Despite the evident diversity in philosophy and outlook among the drug treatment institutions we visited, nearly all of our informants emphasized the need to reform Law 50-88. One informant, an employee of an NGO working on immigration issues, described the sad irony that even as the U.S. moves towards a public health approach through greater funding for harm reduction and through the decriminalization of marijuana, the U.S. continues to promote zero tolerance policies in the DR. “The policy here is defined by international lines,” explained a representative from an international NGO with an office in Santo Domingo, referring to the fact that although the DR receives funds from the U.S. federal government to support drug treatment and prevention, it is not permitted to spend those funds on evidence-based harm reduction approaches. Another informant at an NGO advocating for greater access to harm reduction services, perceived the promotion of prohibitionist drug policies by the U.S. federal government as part of a longer history of U.S. oppression of Caribbean countries. “Before it was communism—now it’s drugs,” he said, making an analogy between communist paranoia that was exported from American politicians and the responses to drugs in the U.S., which are often replicated in the DR. While efforts to change the criminal justice logic that permeates drug services and to develop harm reduction approaches are ongoing, these efforts have been almost exclusively led by advocacy groups and civil society. In particular, some drug policy experts and NGO representatives have formed the *Mesa de Drogas* (Drug Table), a forum for representatives from governmental to non-governmental organizations to talk about drug policy and work collectively to advocate for change. Nevertheless, currently, the National Council on Drugs—the government

department charged with overseeing drug policy—remains committed to upholding Law 50-88.

Discussion

This paper is the first institutional ethnography of drug prevention and treatment organizations in the Dominican Republic, and fills important gaps in describing the overall policy context of drug services and their limitations. We have found that few organizations implement evidence-based policies and interventions that are based on technologies and modalities of therapy that have been proven scientifically to be effective, such as needle exchange programs and OAT. Many of the organizations we examined are ambiguous regarding the operational definition of *therapy*, ranging from the provision of basic analgesics to the use of *confrontation therapy*, *biblical teaching*, and *work therapy* to reorient drug users. In essence, such approaches blame the individual with problematic drug use for his/her own “personal failings,” leaving in place the institutional practices and policies that contribute to drug addiction. The lack of evidence-based approaches to treatment, bolstered by the legal and policy climate that favours incarceration over rehabilitation, are therefore unaddressed while the heroin epidemic continues to thrive.

Our analysis shows that Law 50-88, more than any other specific policy, exerts an enormous effect on access to treatment, replicating a draconian punitive approach borrowed from the United States and placing legal constraints on evidence-based and harm reduction approaches. An individual is treated as a narco-trafficker if they are found

with methadone, for example, which is specifically forbidden in the law. Across multiple countries, studies have shown that the severe criminalization of heroin often contributes to the fear of carrying drugs and paraphernalia among PWID, which in turn undermines needle exchange programs and contributes to on-site consumption patterns in drug copping areas and shooting galleries (Friedman, Perlis, & Des Jarlais, 2001; Rhodes et al., 2006). Fortunately, there is currently a pilot project led by UNODC and local collaborating organizations to provide OAT treatment to some heroin users for the first time (IHRA, 2014), but the larger context of drug policy and the constraints imposed by Law 50-88 must be addressed for a sustained solution to the problem of access to a range of evidence-based drug treatments.

Finally, we identified areas of severe constraints on access, which were most clearly expressed among women and LGBT persons; there are no specifically designed drug services or residential treatment facilities for LGBT persons, and very few for women. For the poor and working classes, who cannot access the private residential treatment centres and are often required to sell products as a condition of their residence, the situation is also dire. Such individuals, who are the vast majority of those in need of such services, are left without evidence-based clinical treatment options. This lack of services for the poor combined with the overall neglect of drug services in state budgets is a perfect storm for the most vulnerable.

This analysis has one primary limitation. The participants interviewed were all based in the National District, which is the largest urban area and highest population in the country, but who did not speak primarily about conditions faced in other regions of the country. Our focus on this area was due in part to its large population, centrality to

policy makers, and prior research suggesting high drug use and HIV/AIDS epidemics. The applicability of our findings to the national context is supported, however, by the inclusion of national drug policy representatives, who made many generalized comments cited in our findings, such as, “There is absolutely no heroin treatment in my country,” or, “The [governmental] investment of money in drug treatment has been zero.” We thus feel confident that the patterns we have identified are representative of patterns throughout the country.

To improve the drug policy climate in the DR, we recommend several parallel strategies. First, nascent coalitions, such as the “Drug Table” that has provided a forum for drug service representatives to dialogue on policy, should be supported and formalized. The members of such coalitions can be effective voices for policy change, particularly regarding needed changes to Law 50-88, though significant political barriers continue to stymie this effort. Recent policy analyses of significant reversals in drug policy in countries such as Australia, Portugal, and Belgium, for example, have revealed that multisectoral coalitions including actors from civil society, drug activist groups, and governmental representatives are critical to creating the climate for effective policy advocacy and legal change. In the 1990s, both Portugal and Belgium took dramatic steps toward decriminalising illicit substances, with Portugal’s resulting law 30/2000 becoming the most extensive drug decriminalisation initiative to date. Both countries shared political support for multi-sectoral commissions to advise government and legislators on the implementation of evidence-based drug policies. Portugal’s commission, including doctors, lawyers, psychologists and activists, recommended an end to the criminalization of drug users, regardless of the substance involved, and a growth in federal expenditures

for drug treatment and harm reduction strategies, changes that were adopted officially in 2000 (Drug Policy Alliance 2019). Belgium's coalition – similarly composed of representatives from science, non-governmental organisations, the media, and other interest groups – recommended *de facto* decriminalisation of all cannabis use for personal consumption in 2002 (Tieberghien 2017).

Multi-sectoral coalitions in the DR could similarly function to share best practices for drug prevention and treatment with policy makers. The lack of protocols and manuals for effective and standardized drug treatment must also be addressed at the state level, and the National Council on Drugs should lead this effort and convene trainings for the diverse group of organizations currently conducting treatment. These protocols should define what appropriate treatment is, incorporate scientific evidence on harm reduction approaches, and adapt evidence-based interventions to the Dominican context and specific vulnerable populations (such as LGBT and women). These are all measures that have proven effective in the foregoing examples of systemic drug policy change. The punitive system of incarceration that is mandated by Law 50-88 further promotes the worst treatment outcomes, and functionally sustains the drug epidemic. In sum, we believe the legal constraints imposed by the punitive law are the primary policy target, requiring focused and organized action from the scientific community, drug-service organizations, and the public sector, in order to forge a policy climate that upholds the most effective evidence-based drug interventions as a fundamental feature of public health.

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Table 1. List of participating organizations that provide drug-related services in the Province of Santo Domingo						
Organization	Org. Type	Primary Funding source	Sector	Served Province(s)	Main population served	Service provision reported by inst/org.
1. Fundación Dominicana para la Reducción de Daños (FUNDOREDA)	Non-profit	International institution	Non-governmental organization	Santo Domingo	Drug users and sex workers	Outreached social health and harm reduction services.
2. Mesón de Dios	Non-profit	Dominican government	Non-governmental, faith based, organization	Santo Domingo and Santiago	Drug users	Outreached social health and harm reduction services. Faith-based educational intervention for drug use and abuse prevention. Faith-based, clinical treatment and residential rehab services.
3. Casa Abierta	Non-profit	Dominican government	Non-governmental organization	Santo Domingo	General population	Educational intervention for drug use and abuse prevention.
4. Hogar CREA Dominicano	Non-profit	Dominican government	Non-governmental, faith based, organization	Santo Domingo	Drug users	Non-clinical treatment, non-conventional psychotherapy and residential rehab services
5. Hogar CREA Internacional	Non-profit	Dominican government	Non-governmental, faith based, organization	Santo Domingo	Drug Users	Non-clinical treatment, non-conventional psychotherapy and residential rehab services.
6. Fundación Volver	For-profit	Participants	Non-governmental, private, faith based, organization	Santo Domingo	Drug Users	Clinical treatment and residential rehab services.
7. Fundación Fenix	Non-profit	Dominican government	Non-governmental organization	Santo Domingo	Drug user and other general population	Clinical treatment and residential rehab services.

8. Centro de Atención Integral a Niños y Adolescentes en Consumo de Sustancias Psicoactivas (CEINNASP)	Non-profit	Dominican government	Governmental Public Health	Santo Domingo	Homeless children and adolescent that consume drugs.	Educational intervention for drug use and abuse prevention, specific to children and adolescents.
9. Fundación Dominicana de Lucha Contra las Drogas (FEDELUCD).	Non-profit	Not informed	Non-governmental, faith based, organization	Santo Domingo	Drug users	Faith base educational intervention for drug use and abuse prevention.
10. Niños del Camino	Non-profit	Dominican government	Non-governmental organization	Santo Domingo	General and homeless children/youth	Outreached social and health services with homeless children and youth.
11. Fundación de Red de Jóvenes Unidos de Guachupita (FURJUG)	Non-profit	Dominican government	Non-governmental organization	Santo Domingo	General youth	Outreach and social services with people that live on the street, drug users, PLWHA, and incarcerated persons.
12. Intituto Dominicano para el Estudio de la Salud Integral y la Psicología Aplicada (IDESIP)	Non-profit	International institution	Non-governmental organization	Santo Domingo	General population	Clinical services in the area of mental health (clinical psychology, educational psychology and neuropsychology) training, research and development on mental health conditions not specific to drug use or abuse.
13. Caminantes	Non-profit	International institution	Non-governmental organization	Santo Domingo	General children and youth	Outreached social services with children and youth.
14. Ministerio Evangélico Rescatados del Lodo.	Non-profit	Dominican government	Non-governmental, faith based, organization	Santo Domingo	Drug users	Faith-based non-clinical treatment, non-conventional psychotherapy and residential rehab services
15. Cuerpo Especializado de Seguridad Turística CESTUR	Non-profit	Dominican government	Governmental	Santo Domingo	Homeless children and youth	Outreached social services with children and youth in the tourist sector.