Rapid Assessment and Response on HIV/AIDS among Especially Vulnerable Young People in Serbia

Report prepared by Prof. dr Viktorija Cucic

Canadian International Development Agency
Agence canadienne de développement International
Canada

unicef
United Nations Children's Fund

Rapid Assessment and Response on HIV/AIDS among Especially Vulnerable Young People in Serbia

Report prepared by Prof. dr Viktorija Cucic

Canadian International Development Agency
Agence canadienne de développement international
Canada

unicef
United Nations Children's Fund

Published by: UNICEF Belgrade
For publisher: Jean-Michel Delmotte, Head of UNICEF Office

Report prepared by: Prof. dr Viktorija Cucic
Proof reading: Benedict Clibborn
Design: Konstantin Petrovic
Cover photograph: Graffiti from Skopje, FYROM
Layout: ELKO PRINT, Milos Milojevic; Printed by: RADUNIC Printing House, Belgrade
Print run: 400
Published: November, 2002

The opinions expressed in this publication are those of the authors and do not necessarily reflect the policies or views of UNICEF. The designations employed in this publication and the presentation of the material do not imply on the part of UNICEF the expression of any opinion whatsoever concerning the legal status of the country or territory, or of its authorities, or the deliminations of its frontiers.

UNICEF Belgrade
Svetozara Markovica 58
11000 Belgrade, Yugoslavia
Tel: (+381 11) 3602 100
Fax: (+381 11) 3602 199
E-mail: office@unicef.org.yu

CONTENT

Project organisation 4
Acknowledgments 5
Abbreviations 6
Executive Summary 7
Introduction 9

SITUATION ANALYSIS 10
1. SERBIA AT THE TIME OF THE RAR PROJECT 10
2. VULNERABLE GROUPS BEING STUDIED IN SERBIA 11
3. DRUG ABUSE IN SERBIA 13
4. SEX WORKERS - PROSTITUTION IN SERBIA 17
5. MEN HAVING SEX WITH MEN - HOMOSEXUALITY IN SERBIA 18
6. HIV/AIDS IN SERBIA 19

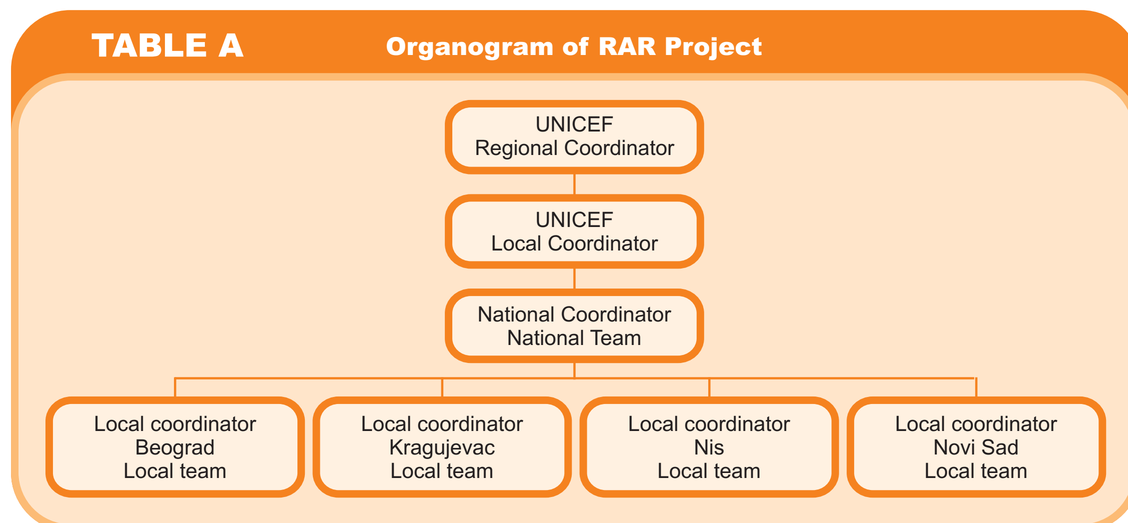
RAR PROJECT 22
1. AIMS AND OBJECTIVES OF THE RAR PROJECT 22
2. RAR PROCESS 22
3. METHODOLOGY 24
4. SAMPLE 26
5. ETHICAL CONSIDERATIONS 29
6. DATA ANALYSIS 30
7. FINDINGS 30
8. DISCUSSION 78
9. RECOMMENDATIONS 80

BIBLIOGRAPHY 83

ANNEXES 84
A. WORKSHOP TRAINING 84
B. QUESTIONNAIRES 91
C. INTERVIEW STRUCTURE - HEALTH WORKERS 108
D. INTERVIEW STRUCTURE - SCHOOL PRINCIPALS 110
E. QUESTIONNAIRE FOR IDENTIFYING INTERVENTIONS 111
F. INTERVIEW STRUCTURE - DECISION MAKERS 113
G. EXAMMPLES OF MEGA GRIDS 115
H. PHOTOGRAPHS 145

PROJECT ORGANISATION

TABLE A Organogram of RAR Project



UNICEF

Regional Co-ordinator
Ms. Elsie Wong

Local Co-ordinator
Dr Jelena Zajeganovic-Jakovljevic

NATIONAL TEAM

1. Prof. Dr Viktorija Cucic
Republic Coordinator
2. Prof. Dr Vesna Bjegovic,
Local Field Coordinator for Belgrade
3. Asoc. Prof. Dr Dragana Ignjatovic-Ristic,
Local Field Coordinator for Kragujevac
4. Asoc. Prof. Dr Bojana Ilic
Local Field Coordinator for Nis
5. Vladan Beara
Local Field Coordinator for Novi Sad

LOCAL FIELD TEAM BELGRADE:

1. Danijel Meskovic
2. Sasa Nikolic
3. Boris Micovic
4. Branislav Miskovic
5. Tatjana Stamatovic
6. Darko Cehic
7. Vladimir Veljkovic
8. Isein Fetoski
9. Andrej Ilankovic
10. Milos Loncarevic
11. Dragan Protilupac

LOCAL FIELD TEAM NIS:

1. Marko Stefanovic
2. Gordana Nikolic
3. Miodrag Djordjevic
4. Lidija Djurdjic
5. Marija Tasic

LOCAL FIELD TEAM KRAGUJEVAC:

1. Andrea Markovic
2. Mirjana Rikanovic
3. Zoran Rastovic
4. Vesna Andrejevic
5. Mirjana Jovanovic
6. Sandra Nikolic Labovic

LOCAL FIELD TEAM NOVI SAD:

1. Boris Popov
2. Slavoljub Zaric
3. Atila Kovac
4. Vlatko Salaj

ACKNOWLEDGMENTS

The RAR Project was undoubtedly one of the most comprehensive research studies carried out in the field of HIV/AIDS in Serbia. For all of us working in the Project was a unique experience

Instructions, directions, guidance and support that were conferred by UNICEF, by way of its officers Ms. Jane Gronow and Ms. Jelena Zajeganovic, were of particular importance to us.

We owe special thanks to Ms. Elsie Wong, RAR Regional Coordinator, for her generous assistance, her patience and the length of time that she was willing to dedicate to this engagement.

Without the help and co-operation given to us by the Ministry of Health of Serbia, the Ministry of Internal Affairs of Serbia and the Republic AIDS Committee, this project could not have been realised.

We also owe a special thanks to the members of the National and Community Advisory Boards in Belgrade, Kragujevac, Nis and Novi Sad (see below) who shared their expertise and experience, both individually and from their institutions and organisations. Through this, they contributed to the success of the RAR project. Their crucial role can be also found in the implementation of the recommendations and interventions developed from the research.

The study was also bestowed exceptional significance by the National RAR Team members whose interest and commitment rendered our meetings substantial and useful.

The driving force in the field was provided by the highly motivated Local RAR Teams who brought their determination and diligence to the whole study.

Finally, we are indebted to all the young people in Serbia who let us turn their life stories and problems into a study whose aim is to help youth. Without them and their consent to co-operate with us, this research would not have been realised.

THE RAR TEAM

National Advisory Board: Bjeloglav Dragisa, Brajevic-Lalovic Milanka, Dragicevic Dragana, Dujic Aleksandar, Grujic Mira, Ilic Dragan, Jaksic-Kandida Maja, Jovic Radovan, Kinta Rasma, Matovic-Miljanovic Sanja, Mihajlovic Ljiljana, Novakovic Mile, Protulipac Dragan, Petrovic Oliver, Petrovic Ranko, Ramah Aleksandar, Sedlecki Katarina, Senlis Eleonore, Fridman Vesna.

Community Advisory Board - Belgrade: An|elic Sla|ana, Babic Ljiljana, Dimitrijevic, Milan, Djorelijevski Lambe, Koso Silvija, Miskovic Branislav, Micovic Boris, Paunic Mila, Petrovic Ranko, Rajin Gordana, Raketic Dijana, Salemovic Dubravka, Stankovic Zana, Curcic Jelena, Vujovic Sreten, Zakula Nevenka

Community Advisory Board - Kragujevac: Bosnjakovic Radmilo, Cvetanovic Predrag, Evtov Dragana, Joksimovic Mirjana, Lukic Vladan, Marinkovic Dejan, Milojevic Igor, Pajevic Vesna, Popovic Nenad, Petrovic Radmilo, Radosavljevic Dragana, Rosic Mirko, Samardzic Goran, Savcic Gordana, Simonovic Branislav, Stevanovic Zarko, Zecevic Ana

Community Advisory Board - Nis: Arsenijevic Verica, Boskovic Slobodanka, Gagovic Predrag, Jovanovic Bojan, Nikolic Violeta, Petkovic Branislav, Radovic Miodrag, Sretkovic Dusica, Spasic Miroslav, Stankovic Bojana, Stevanovic Nebojsa, Stojanovic Katica, Todorovic Ivana, Ciric Goran

Community Advisory Board - Novi Sad: Bozic Rajna, Ber-Bozic Aleksandra, Bijanko Jasminka, Jovisevic Ostoja, Miladinovic Sonja, Miljanovic Predrag, Radulovic Natalija, Radulovic Vesna, Savic Vesna, Stanulovic-Kapor Nila, Stefanovic Danica, Rosic Snezana, Vuckovic Nikola

ABBREVIATIONS

AIDS . . . . . .acquired immune deficiency syndrom
CAB . . . . . .Community Advisory Board
CIDA . . . . . .Canadian International Development Agency
DDD . . . . . .Don't Do Drugs (NGO engaged in substance abuse prevention)
DM . . . . . . .German mark (German national currency in the time of the research)
EVYP . . . . .especially vulnerable young people
FRY . . . . . . .Federal Republic of Yugoslavia
GDP . . . . . .gross domestic product
HIV . . . . . . .human immunodeficiency virus
HR . . . . .harm reduction
IV . . . . .intravenous
IVDU . . . . . .intravenous drug users
IPH . . . . . . .Institute of Public Health
JAZAS . . . . .Yugoslav Association against AIDS
KI . . . . .key informant
MSM . . . . . .men who have sex with men
NGO . . . . . .non-governmental organisation
NA . . . . . . .not available / no answer
OD . . . . . . .overdose
PLACE . . . .priorities for local AIDS control efforts
PLWHA . . . .people living with HIV/AIDS
RAR . . . . . .rapid assessment and response
S.A.A. . . . . .same as above
STI . . . . . . .sexually transmitted infections
STW . . . . . .sex trade workers
UN . . . . .United Nations
UNAIDS . . . .Joint United Nations Programme on HIV/AIDS
UNICEF . . . .United Nations Children's Fund
US$ . . . . . .American dolar (American national currency)
WHO . . . . . .World Health Organisation
YDU . . . . . .Young drug users

EXECUTIVE SUMMARY

The Rapid Assessment and Response on HIV/AIDS among Especially Vulnerable Young People Project (RAR) in Serbia is a part of a regional UNICEF project simultaneously implemented in five countries of South Eastern Europe.

The objectives of the RAR for Serbia were derived from the main RAR objectives, which are the following:

- to assess the extent and nature of HIV risk by exploring the context and characteristics of risk behavior, health and social consequences as well as present state of intervention targeting especially vulnerable young people (EVYP);
- to increase awareness and support of local communities towards EVYP and to provide initial intervention activities; and,
- to propose the general, as well as the specific, local framework for HIV/AIDS preventive action according to the key findings of the RAR.

The RAR assessment activities were conducted in four cities:

- Belgrade, Nis, Novi Sad and Kragujevac

Cities were selected according to the following criteria:

- the largest cities;
- the presence of good infrastructure;
- available sources for data collection;
- the number of people living with HIV/AIDS (PLWHA);
- the presence of a University;
- a highly mobile population; and,
- the existence of a trafficking route for drugs.

The target population for this assessment was young people from 10 to 24 years old and considered to be the most vulnerable with regards to HIV infection in Serbia. In each city, the specific objectives were defined in order to highlight specific characteristics of the following EVYP groups selected for the RAR:

- young drug users, predominantly intravenous drug users (IVDUs) (in all cities);
- young men who have sex with men (MSM) (Belgrade, Nis, Novi Sad); and,
- young sex trade workers (STW) (Belgrade, Kragujevac).

Data collection was carried out in November and December 2001 and in January 2002. Methods for data collection among the target groups in all cities were based on the principle of triangulation and included existing information (routine medical statistics and published papers), questionnaire surveys among the three target groups, focus groups, structured and unstructured interviews and observation of "hot spots".

A total of 879 EVYP completed the questionnaires. After excluding those who were older then 24, the numbers of young people in three target groups completed the particular questionnaire are the following:

- 464 young drug users (Belgrade: 242, Nis: 91, Kragujevac: 75, Novi Sad: 56),
- 299 young MSM (Belgrade: 169, Novi Sad: 76, Nis: 48, Kragujevac: 6), and
- 116 young STWs (Belgrade: 76, Kragujevac: 32, Nis: 8)

DATA ANALYSIS

All data collected was validated through triangulation. Quantitative data collected from the questionnaire for all 4 sites was entered centrally and for the purpose of this preliminary report was analysed only by means of descriptive statistics. Qualitative data was analysed through activity and MEGA grids. MEGA grids contained qualitative information about context, risk and protective behaviour, health and social consequences and intervention.

KEY FINDINGS

- Psychoactive substances are easily accessible to young people. Although particularly common among young drug users, drugs are also significantly used by young men who have sex with men and sex trade workers:
  - 31.1% MSM and 56.9% STW use psychoactive substances; 18.4% MSM and 22.4% STW use it intravenously.
  - Mean age of first use of drugs: 16.2 DU; 16.2 MSM; 16.7 STW.
  - Mean age of first use of drugs intravenously: 18.2 for DU; 17.2 for MSM; 17.2 STW.
- Among the population of drug users, IVDUs were specificallytargeted in this study, thereby explaining the relatively high rates of heroin use. While in the wider group of drug users, as well as in other groups, the most frequently used drug is Cannabis, as well as Ecstasy and Pain Killers (Analgesics) and two or more drugs at the same time:
  - Cannabis: 81.7% DU; 23.4% MSM; 49.1% STW
  - Heroin: 65.5% DU; 2.3% MSM; 29.3% STW
  - Ecstasy: 36.9% DU; 9% MSM; 23.3% STW
  - Analgesics: 41.6% DU; 4.7% MSM; 21.6% STW
  - Two or more drugs at the same time: 88.4% DU; 18.7% MSM;
- Among those using drugs intravenously, the exchange of needles and syringes is frequent:
  - 57.1% IVDU; 43.7% MSM and 84.6% STW who are also IVDU.
- The mean age of first sexual intercourse corresponds to that of the general population, which ranges from 15.4 in STW to 16.5 in MSM. The onset of selling sexual services in young STW is 18.7 years on average.
- A relatively small number of people use condoms every time that they have intercourse and when that is correlated to the risks of more frequent anal intercourse in MSM, the large number of partners in STW and intercourse under the influence of substances, the risk of infection is multiplied:
  - "Always" using condoms during sex: 17% DU; 41.5% MSM (50.8% during anal sex); 60.3% STW
  - Average number of sexual partners in the last year: 5.2 DU; 10.2 MSM; 193 STW
  - Sexual intercourse under the influence of substances: 90.7% DU; 19.4 % MSM; 98.5% STW
- The main reasons for not using condoms are discomfort, trusting the partner, the price of condoms and in young STW, the most frequent reason is the client's request and a higher prices for sex without condom.
- Most of the respondents consider themselves to be at risk of HIV and STIs, approximately half of them have been tested for HIV, their knowledge about HIV is satisfactory, and the most important role in providing information to the members of all three groups belongs to the media and much less to health and social workers. It is alarming that 23.3% young STW state that there is no place to get information.
  - Judging their own risk of HIV or other STI as high or moderate: 78.3% DU; 85.2% MSM; 75.9% STW
  - Media as the main source of information: 75.4% DU; 69.6% MSM; 65.5% STW
  - Health and social workers as sources of information: 14.7% DU; 14.7% MSM; 15.5% STW
- Education on HIV/AIDS, psychoactive substances and sexual and reproductive health is not a part of the official school curricula and education through extracurricular activities is infrequently conducted and only in some towns.
- Existing community prevention programmes mostly target the general population. The number of interventions aimed at especially vulnerable young people is very small - almost nonexistent.

RECOMMENDATIONS

The recommendations listed at the end of this publication are to be used by institutions, organisations and individuals - particularly by the Republic AIDS Committee - as guidelines for overcoming identified problems and for preventing the spreading of HIV infection among young people.

INTRODUCTION

According to UNAIDS and WHO estimates, approximately 40 million people in the world are living with HIV/AIDS. Although the African continent is still the most affected, the infection has spread across all-boundaries. In the past number of years, the incidence of HIV has risen quickly in Eastern Europe, particularly in the Russian Federation. An estimated 250,000 people were newly infected in Eastern Europe in 2001 (UNAIDS/WHO).

Nearly one half of the newly infected people are youth between the ages of 15 and 24. Many among them are not aware that they have been infected. Those most affected by the infection are key to its control. At the United Nations General Assembly Special Session on HIV/AIDS, where the Federal Republic of Yugoslavia participated, the following goal was adopted: by 2005, UN Member states will make efforts to ensure that 90% of young people have access to information, knowledge and life skills (within and outside of the school system) and youth friendly health services which will provide increased protection from HIV infection. Special emphasis has been placed on targeting the young people most vulnerable to HIV infection (IDUs, sex workers etc.) through a commitment to making all these key interventions available to 60% of young people in these vulnerable populations.

The countries of South Eastern Europe, including the Federal Republic of Yugoslavia, are currently reported as having low rates of HIV infection. The low prevalence of HIV gives us the opportunity to prevent the outbreak of HIV/AIDS in this country.

The key to success in low-prevalence settings where HIV is not yet a risk to the wider population is to enable the most vulnerable groups to adopt safer sexual and drug injecting behavior, interrupt the virus's spread among and between those groups, and buy time to bolster the wider population's ability to protect itself against the virus. (UNAIDS/WHO December 2001, p. 6)

UNICEF's Rapid Assessment and Response project (RAR) is targeted directly at the most vulnerable young people. As part of UNICEF's regional project "HIV/AIDS Prevention with Young People in South Eastern Europe", funded by the Canadian International Development Agency (CIDA), the RAR project was carried out in 5 countries, including 26 cities, across Eastern Europe from October 2001 to February 2002.

Parallel RAR projects were carried out in the following countries :

- Albania
- Bosnia and Herzegovina (Federation of Bosnia and Herzegovina and the Republic of Srpska)
- Croatia
- Federal Republic of Yugoslavia
- Former Yugoslav Republic of Macedonia

SITUATION ANALYSIS

1. SERBIA AT THE TIME OF THE RAR PROJECT

The Republic of Serbia is a country with a population of around 10 million people. As a result of 10 years of regional conflicts in the Balkans and because of imposed sanctions, Serbia as part of the FRY became deeply isolated from the international community.

Relations between the FRY and the international community have thawed as of late due to the election of late 2000, which resulted in the transfer of government to the Democratic Opposition of Serbia.

The economy of Serbia, just like the whole of FRY, is confronted with multiple complex problems. After stagnating in the 80's the GDP begun its continuous fall throughout the 90's.

Further GDP decline was caused by the sanctions imposed in 1992 and hyperinflation in 1993 (the second highest inflation registered in history). The long lasting isolation and economic crisis exacerbated the economic situation and made solving the problems very complicated.

The country's economy can be described as low in production, dominated by state/social ownership, and inefficient with monopolistic structures and outdated technology. The management is centralized; there is lack of motivation coupled with poor performance.

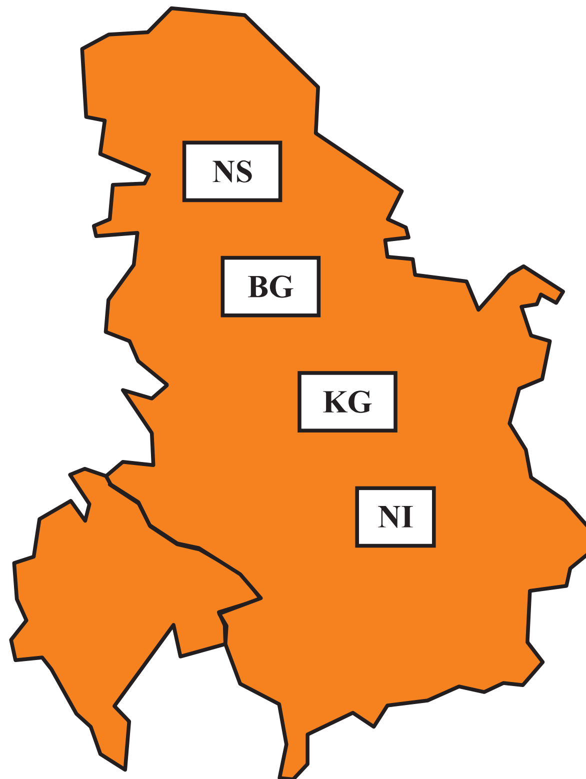
Data about unemployment are not accurate, but according to the Economic Institute in Belgrade the rate is 26 %.

Alternative economic activities are a very important source for GDP, but at the same time it is very difficult to gather related and reliable data about them. While representing an alternative source of income for many people and acting as a "social buffer " the alternative economy has enabled some groups of people to generate extra profit through tax evasion. At the same time a vast number of Serbian people, including a significant number of young people work for employers in the alternative market. They are paid extremely low wages, most often are exploited and work without any standard protection. The social system is incapable of meeting the needs of a large number of pensioners, providing free health care for all, free education, and supporting disabled people or war veterans.

The Health care system is in crisis. In Serbia real per capita spending has fallen from US$240 in 1989 to US$59. In 2000 the deficit of the Serbian Health Insurance Fund accounted for around 2 % of the GDP. The fiscal crisis in health care and health insurance systems is having an impact on the quality of health care services. Ten years of limited investments and maintenance has left most of the facilities in serious disrepair. Drug and medical supplies have been difficult to procure and provide to patients.

The health status of Serbia's population has seriously deteriorated, resulting in much higher morbidity and mortality rates. Years of living under severe stress and a trauma-ridden environment have brought depression, hopelessness, confused values and distrust in the future, followed by general negligence toward health and increased risk behaviour, especially those that could lead to HIV transmission (drug abuse, risk sexual behaviour).

Cities in which RAR was operating



2. VULNERABLE GROUPS BEING STUDIED IN SERBIA

2.1 THE VULNERABILITY OF YOUNG PEOPLE IN SERBIA

In recent years numerous sources reported information on the high vulnerability of young people in our country. The UNICEF study of 1999 emphasizes that the youth of Yugoslavia is the most endangered in Europe. (FRY Progress Report, March 1999).

Generally speaking, youth is considered to be the age of optimum health and of the widest biological possibilities, of low morbidity and mortality rates. Research also shows that young people's health status is directly related to their health behaviour. The crucial factors of morbidity are a gamut of various risk behaviour forms and their effects upon health. The most frequently cited forms of risk are taking a psychoactive substance or risky sexual behaviour, or a combination of these two.

These are the very patterns of behaviour that show a constant upward trend in our country.

Although the pattern of causes of death in the young population shows no remarkable changes and, like in other European countries, the most common causes mentioned are the so-called "external causes" (partaking in 70% of all the causes in male and 30% in the female young population at the age range of 15 to 24), it is necessary to point out that in the period 1992-1997 the number of suicide related deaths among young people has risen considerably (from 5.5% in 1992 to 8.7%), and suicide rates are also on the increase (Cucic, 2000).

What factors cause the high vulnerability of young people?

For all generations of children that were growing up in Serbia after 1990 the transition from childhood into youth coincided with a very difficult period of time that the country was going through. All the options that a community should offer a young person in order to overcome the stormy period in a

human life cycle, such as family, school, or state, were either denied or limited in Serbia. Living in war surroundings, under incessant and aggressive war propaganda, in fear and insecurity, with images of human suffering and disasters, being exposed to violence and crime, with families torn apart by problems of economic survival and with teachers who were existentially in peril themselves - young people were left with no support or succour, without a model to identify 'one's self' with, and with only vague values and a sense of permanent deprivation.

Neediness and chaotic organization, together with lack of motivation, compromised the work of all support services which were not able to carry out their functions. Health and social protection and education operated within a very limited framework, while the police was for the most part engaged in guarding the lives and riches of the ruling oligarchs.

Over 50% of young people wanted to leave the country, and at the same time 84% of them wished for a better life than their parents had. (UNICEF, 2000)

Part of the research that was conducted in our country presents at least a fragmented review of factors that increased and still keep increasing the vulnerability of young people to different forms of risk behaviour and morbidity linked to it, and especially to drug addiction. With a very high number of young people it is not a matter of just one factor, but of a series of factors simultaneously present, and thus exercising all the more influence on vulnerability

Some of the most important factors are:

- Life in economically underdeveloped community
- High unemployment rate
- High crime prevalence
- High drug abuse prevalence
- Minority or refugee status
- Discrimination
- Different assimilation levels among generations
- Low expectation concerning the community in regards to success
- Alcoholism and other addictions of parents
- Abuse and neglect of children by parents
- High degree of family stress, including economic problems
- Unemployment or insufficient employment of parents
- Socially isolated parents
- Single-parent families with no other sustenance
- Family instability and high level of marital conflicts and/or family violence
- Inadequate parenthood and few parent/child contacts
- Absence of clear policy and rules at school
- Inadequate activity and low motivation of support professions: health and social protection, education

A great number of young people in Serbia developed one or more types of risk behaviour as a result of all these factors present. As a certain number of these types (addiction and sexual types) will be elaborated upon later, here we mention only the following:

Early contact with smoking, which is considered to be of great importance, according to scientific writings, for the development of other types of addictive behaviour. According to data presented by the research study "The Health Behaviour of Secondary School Pupils" one child out of five smokes before reaching 15 years of age. In this type of behaviour, at that age, our country ranked first among 28 other countries that had participated in the WHO study. At the age of 24 the number of smokers goes up to 50%. (Institute for Social medicine, Belgrade, 1999). A high percentage of young people under the age of 15 experienced drinking alcohol and getting drunk. 77.6% of boys and 66.4% of girls have experienced alcohol before reaching the age of 15, while 37% of them have been drunk. 6% of young people under 15 were inebriated more than a dozen times or more. At the age of 24 almost every single young person had experienced alcohol, and 48% experienced intoxication. 8% of pupils under 15 years of age carry some sort of weapon to school

As they get older the proportion changes in relation to self-control. 41% of young people under the age of 24 had a fierce conflict with a close person wishing to hit him or her, but only 3.5% actually took part in a fight.

It should be added that about one half of young people up to 24 years of age felt lonesome at a time, and that the structure of leisure time at their disposal is devoid of activities (47% watch TV for more than 4 hours a day).

Youth vulnerability and their lives in high risk surroundings such as Serbia can be documented by an entire range of statements, such as: an inability to establish close relationship with a father (45%), or few opportunities to participate in any decision making process, even when it directly concerns the young.

2.2 VULNERABLE GROUPS SELECTED FOR RAR IN SERBIA

Three vulnerable groups were selected for the RAR study:

- Injecting drug users (IDUs)
- Sex workers
- Men having sex with men

There are some common reasons why these three groups were picked out, as well as a few specific ones for each groups:

All three groups are characterised by a highly significant interrelation to the risk of incepting an HIV infection on the one hand, and lack of sufficient and relevant information on the phenomenon itself on the other, whether in relation to the magnitude of the phenomenon, its epidemiological and socio-medical characteristics, or particularly to different forms of risk behaviour that are present in certain groups.

The common public attitude, that is distinctive for its high degree of discrimination and stigmatisation, is also characteristic for all three groups, forcing members of these groupings to retreat into some form of concealment, that way making them "hard to reach groups", and thus also making them barely accessible to any preventive action. Preventive activities in all three groups are rudimentary, often inadequate, and lack broad social support.

All three groups are characterized by ongoing mutual communication and by the fact that sexual relations - heterosexual, bisexual, or homosexual - are the common path that connects these three groups, either one with another or with the rest of the population.

The IDU group is characterized by high AIDS morbidity and mortality rates, therefore requiring not only preventive programs, but also programs for therapeutic interventions, as well as for care, which is, in most cases, not accessible in a satisfactory manner.

The purpose of the RAR study is to procure information to be used in future interventions aimed at establishing a better status for the examined groups and lowered risk of HIV infection on the one hand, and to decrease the risk of spreading the epidemic into other population segments on the other.

3. DRUG ABUSE IN SERBIA

3.1 HISTORICAL PROSPECTIVE

Drug abuse was a topic in this country by mid-60. Just the same, as it was small in extent and enclosed inside narrow population segments, mostly among people in their 30s or older (veterans, medical staff, intellectuals, chronic patients), and being for the most part morphinomanic in character, the phenomenon drew little attention, and then only in the limited arena of professionals and experts, thus leaving the general public oblivious to it. The leading problem discussed in this field at the time was alcoholism, spreading far and wide, followed by a series of health and social consequences. That was the reason the Red Cross started organizing and establishing a network of facilities (dispensaries) for the treatment of alcoholics in Serbia in 1955. A Dispensary for Alcoholism, as a state institution, started operating in 1961 in Belgrade.

The surge of the hippie movement in the 70's brought along an increase in drug abuse. The first patient admitted for treatment at the Dispensary was registered in 1971. This marked the introduction of broadened admittance indications to this institution - besides treating alcoholism, it also started dealing with drug abuse problems. The Centre for Drug Addiction was founded at this institution in 1987, and in 1993 it developed into the Institute for Addictive Diseases.

Along with the Centre, drug addiction is also dealt with by the Institution for Mental Health (later, the Institute), and other psychiatric establishments, mainly in Belgrade. The advancing problem resulted in initial attempts to measure its size and characterize it. In 1978/1979 the Law on Health Records for the territory of Yugoslavia was adopted, obliging and requiring the collecting of data on users of narcotics, types of abused drugs, the health status of patients, social consequences, and similar.

In the period between 1980 and 1986 registers were introduced in Serbia to record chronic mass non-infectious diseases, including the drug abuse register. The Institute kept the register for Addictive Diseases. Despite devoted efforts and preparations to put it into function, the register has remained out-of-date and was eventually closed, due to a number of reasons, the most serious of which were the financial.

alid data on the number of addicts and on certain characteristics of the phenomenon could not be obtained that way and this remains the same to this day.

The inception of the HIV infection (the first AIDS case was recorded in 1987) and the high infection incidence among drug addicts activated, on the one hand, professional discussion on available therapeutic options, and on the other, it increased discrimination and stigmatisation of an already stigmatised group.

Attempts at introducing the methadone program in the Institute encountered strong professional resistance, which went as far as to treat it like a criminal activity, and those who advocated it suffered certain consequences.

Ever since 1992/1993 we have witnessed the rapid growth of addiction, particularly the age structure of addicts has modified. More often than not it refers to teenagers in high schools or even at elementary grades. The facts that could document this point are not considered as valid.

The illegal market, however, began pandering new drugs formerly not present in the country (cocaine, mescaline, and amphetamine), as well as large quantities of marijuana. A large supply of drugs at relatively low cost, together with completely devastated social and environmental conditions, and war on top of it all, conditioned the heightened rate of drug abuse. Notwithstanding the existing specialized Institute, or "The First Yugoslav Scientific Forum On Addictive Diseases" in 1994, and in spite of the established "Yugoslav Association for the Protection and Improvement of Public Health in Relation to Addictive Diseases", the true scope of the phenomenon has not been defined yet, nor have its characteristics or effects been analysed systematically. Even though sporadic individual efforts were attempted, neither adequate programs nor interventions have ever been defined at a professional level. Describing the situation one of the few experts and activists in this field Vesna Korac writes, "In spite of numerous changes that drug abuse and drug addicts have undergone in the last twenty years in our country, public opinion and the general attitude (even among some professionals) remains essentially the same: irrational in its nature, negative as for its direction, and basically - repressive." (1992)

That was the situation at the time the RAR project was initiated.

3.2 CURRENT STATE

As mentioned before, there are no precise epidemiological data on the number of drug addicts in our country. Some works and studies mention two estimates. According to one (Nenadovic, 1995) there are about 30.000 drug addicts in Serbia, with nearly 20.000 of them in Belgrade, and the other estimation is based on a WHO Report's citation for the year 1991 where some 13 to 16 thousand drug addicts were discussed (Djokic, 1995). In order to figure up the number of addicts per 100.000 inhabitants the first estimation was used, as it is more recent and refers to the territory of Serbia, unlike the latter which refers to Yugoslavia before secession.

According to such estimation, Serbia ranks among territories with a very high number of drug addicts per 100.000 inhabitants. The same method, when used with the Belgrade population, shows a frightening number of drug addicts per 100.000 inhabitants, i.e. 1230 addicts per 100.000 inhabitants.

Instead of figures, here is what the literature states: "Threatening and frightening are the enormous amounts of drugs provided in the illegal market of Belgrade, but also in almost any other city in Serbia and Yugoslavia." (Nenadovic, 1995). The same author goes on to report on children who use drugs at elementary school age level (marijuana), and also on the lethal outcome of drug abuse among children of 13 to 15 years of age.

The press, largely quoting statements given by experts, also recounts a great number of addicts. The daily "Politika" (15 October 2001, "Five Narcotics Discovered") reminds us of "the statistics which testify to the fact that more than 60 per cent of teenagers here have had experience with drugs and (or) have remained in random or even constant connection with it." An even more sombre picture is given by the daily "Blic" (11 November 2001, "Tears Flowing, Pain Excruciating"), where figures stated for drug addicts are up to 60%. Citing from research conducted in the "Play For Life, Not To Drugs" campaign, "Blic" states that 4.2% pupils in fifth and eighth grades of elementary school have used some drug, which in turn of absolute numbers is 16.000 (article "Five Out Of One Hundred Eighth Graders Used A Drug", 26 October 2001). The daily "Glas javnosti" ("Dollies Eating Kids", 7 November 2001) gives a figure for Belgrade of 20.000 drug addicts.

The daily "Danas" in a special weekly edition "Drugs: Imprint Of Close Death" (31 January 2002) suggests that the precise number of addicts in the FRY can only be guessed upon at present, to say nothing of those young people who had experienced drugs. It goes further to state that, "it is often heard among experts that Belgrade is on top as per number of drug addicts, followed by Bar and Sombor."

Research results in this field that are found in literature cannot be compared easily due to different methodology approaches (in particular, the choice of samples and instruments).

The study "Health Behaviour of School Children" , completed according to the WHO methodology applied in a study of the same name, with a sample of 5.500 children in Belgrade of ages 11, 13, and 15, pointed out that 6% of polls had some experience with drugs. This implies an overall experience with any type of drug.

A detailed analysis proves that marijuana is the most commonly used drug among the young. The proportion of young people in the entire sample of those who have ever had experience with this drug is 2.9% with notable differences as per age. At the elementary school level, which is between the ages of 11 and 13, the number of those who smoked marijuana is 0.75%, with no significant differences as per sex. At the first secondary school grade, i.e. at 15 years of age, 7.2% of young people of both sexes tried marijuana, but boys outnumber girls by far.

Glue (inhalant) is second per rate of usage in our country, and then follows the combination of alcohol with pills, and cocaine comes last.

Drugs are most commonly used at parties, a friend's place, or an acquaintance's apartment. Nightclubs are the last place where drugs are experienced for the first time.

Raves are extremely popular with young people for their special mood and music that stimulates them. Even though these are young adolescents, 16% of them go to these parties, and 21.6% of them have been offered drugs at these places. School is also the place where there is a high chance of being introduced to drugs.

According to the same methodology, but without a representative sample, the study was enlarged to cover Serbia, and also to encompass the student age. Results for ages 11-15 in 27 Serbia cities (5.137 young people included) are very similar to those found in Belgrade (Jankovic, 2000): 5% of the young have experienced marijuana. Research among the student population of five university cities in Serbia (total of 5.385 students) shows that 29% of students have on average tried marijuana by the age of 17. According to research findings (Paunovic, 2000), it seems this is the critical age for contact with other drugs as well. So in the same period 7.4% of students tried hashish, 2.7% took ecstasy, and 2% of them used heroin at a somewhat later age, at 18 on average.

The study by Vujovic "The Young and SIDA" (1999), encompassing young people in elementary and secondary schools (17 as mean age), states 1% in elementary and 1.7% of those in secondary schools who use heavy drugs.

The police (Ministry of Interior) also registered an increase in drug abuse, assessing it from the point of its operation and number of seizures (the National RAR Team, December 12, 2001). Our country, as pointed out by the police, is located along the Balkan drug route (mostly heroin), which starts in Turkey and goes across our country. Marijuana is grown in rural areas (along the rivers Sava, Dunav, and Morava), and even though it is not of the same quality as "albanka" it can be bought at our markets. Synthetic drugs mostly come from abroad, but there were attempts at producing them in our laboratories. According to police detection there are juveniles who both deal and use drugs.

As stressed in the beginning, the epidemic situation in Serbia is quite obscure.

3.3 INTRAVENOUS ADDICTION AND HIV

There are no data in literature on the number of intravenous drug addicts. The sole recorded estimation states that out of the total number of addicts, 15% are considered I.V. drug addicts (Đokic, 1995).

The risk behaviour of I.V. addicts is also insufficiently discussed about. Šuvakovic (1998) analysed several characteristics among 500 intravenous drug users who came to seek help in health institutions. Out of them 47.8% always use their own syringe and needle, and 43% have used other people's equipment at least once.

77% of them never use condoms, and 21% of respondents had more than 5 sexual partners in a year. Seropositivity was registered with 11%.

It might be relevant to single out of these characteristics the fact that one fourth were in prison for one or another crime connected to drug abuse, also that 53.7% are unemployed, and that 8% are married (17.4% with children). Šuvakovic also states that 16 infants born HIV-positive had parents addicted to drugs.

3.4 HEALTH INSTITUTIONS AND DRUG ADDICTION

The information obtained in the following institutions were analysed:

- The Institute for Addictive Diseases
- The Institute for Mental Health
- The City Institute for Health Protection
- The City Institute for Urgent Medical Aid
- The Institute for Health Protection of Serbia
- The Military Medical Academy
- The Institute for Psychiatry
- The Institute for Infectious Diseases
- The Institute for Health Protection of Students, Belgrade

The data were presented at the National RAR Team meeting on February 29, 2002. Some of the most important observations are:

- The City Institute for Health Protection keeps a register of drug addiction for Belgrade as of 1980. Up to 1992 registering was sporadic, and since 1993 three institutions report on this: the Clinical Centre of Serbia, the Institute for Addictive Diseases, and the Institute for Mental Health. Until 31st of December 2000 there were 2.628 addicts registered in Belgrade, and another 413 in the fist half of year 2001. 75% of registered persons are males, the mean age is 24.4. The mean age of female persons is 25.4. A difference can be perceived as compared to 1993 when the average age for both sexes was 31. At the age of 15 to 19 there were 17.6% registered, and 41% at ages 20-24. Up to 24 years of age there were 58% registered in total. An evident difference is again found in comparison to 1993, as only 7% of drug addicts were registered at the age of 24. The existing register does not offer any data on I.V. addicts (no section to notify it)..
- The City Institute conducted an anonymous testing in 2001, and 0.7% tested positive out of 844 persons who came to get tested. There is a significant downward trend in the number of those who applied for admission for addiction, from 18-20% in former years to 2.3% now.
- In 2001 seven health institutions (the Institute for Addictive Diseases, the Institute for Mental Health, the Institute for Infectious and Tropical Diseases, the Military Medical Academy, the Institute for Health Protection of Students, the City Institute for Urgent medical Aid, the Institute for Psychiatry) treated 1.635 drug addicts. There is no possibility to determine out of these routine data whether a person was treated in several institutions, or if s/he was readmitted.
- The Institute for Addictive Diseases regularly admits addicted patients for treatment since 1987, with 382 patients per year on the average. Since 1996 the number surpassed 450 to reach the figure of 846 in 2001. This specialized institution has admitted 5.732 drug addicts so far (i.e. as many illnesses recorded, not persons). Men dominate in sex structure. The age

[1] Institut for Social Medicine of the Medical Facultz in Belgrade (Cucic, 1999).

structure differs from year to year, so that in 1999 the age interval was 16-21, with one-year long drug experience at first admittance. Up to 1996 there were 50% of intravenous addicts, and HIV-positively was detected in 53% of these. Since 1997 there were 89% of I.V. addicts, while HIV positively was registered with 11%. In 2001 there were 80% of I.V. addicts with an exceptionally low HIV positively of 0.1%.

- The City Institute for Urgent Medical Aid in Belgrade intervened in 320 drug addiction cases, mostly heroin addicts, with overdose symptoms. During the year 16 persons died. The greatest problem, as pointed out, is insufficient equipment for emergency interventions in urgent cases.

4. SEX WORKERS - PROSTITUTION IN SERBIA

4.1 HISTORICAL PROSPECTIVE

Prostitution is a social phenomenon the onset of which is hard to determine in any community, notorious for constant persistence in different forms, and with varying intensity in the course of developmental phases of a community. There are no complete and reliable data on the prevalence of prostitution, while there are quite a few doubts as to its definition and the terminology used.

Serbia too has a long history of organized prostitution. As per a decree by the Principality of Serbia's Ministry of Interior of 10 December 1871, the first brothel was opened in Belgrade in 1929.

Belgrade had around 100.000 inhabitants in the first decade of the last century, with the prostitution problem surging to alarming proportions. Random response of the authorities was a mass and encompassing raid: the first such raid in Serbia happened on May 6, 1899. Despite the raids organized against the city underground, however, the health authorities kept voicing alarming warnings on the advancement of "venerealia" and on "flourishment" of clandestine prostitution.

There were houses of ill repute in Yugoslavia up to 1945, even though prostitution was legally regulated in various ways in the Yugoslav states.

The period between 1945 up to the beginning of the 80's was, on the one hand, characterized by denial of the phenomenon and its existence, and by locating it into the sphere of stigmatisation and crime, on the other. The 1964 figures show that there were around 7.000 prostitutes in the former Yugoslavia in that year. The data point to an increase in misdemeanours among prostitutes in Serbia in the period of 1978 to 1984 (from 62 to 103 women fined). The largest number of fined prostitutes was in Belgrade (60%). The first systematic elaboration of the subject in a scientific study (Radulovic, 1986) states that Yugoslavia has formally adopted the law on abolition with some elements of prohibition. The Yugoslav Penal Code stipulates the instigation of prostitution (pandering and human trafficking) as crime. According to the Yugoslav penalty regulations, a woman committed to prostitution transgresses law and order and is to be punished according to effective decrees.

A movement for legalization and decriminalisation of prostitution had emerged by the beginning of 90's, principally provoked by the onset of AIDS in our country. Insufficiently articulated and without a devoted support of professionals, it proved to be of short breath and little accomplishment. It was significant, however, as the first public voice raised in connection to this fact of life.

The last 10-15 years are characterised by an intensification of all the factors known to be contributing to prostitution. The wars in former Yugoslavia, and a heightened number of all forms of violence, affected women in particular. A new practice arose in the form of international trafficking of women with the purpose of buying and selling them for sexual exploitation. The changes in the transitional countries in our vicinity, together with problems in the territory of former Yugoslavia, led to a drastic increase in the number of women involved in the business. The basic reason for this growth of engaged prostitution can be traced back, according to expert opinion, to the economic conditions and inability to find jobs in their native countries (National Action Plan for Women of Yugoslavia - Institute for Economy, Belgrade 2000). There are no data concerning the phenomenon in our country, moreover it is not even considered to be characteristic for this country, but only a reflection of events in neighbouring countries (Albania, Romania).

Social and economic factors, however, contribute undoubtedly to the increase in prostitution. Among these are the mentioned economic crisis, unemployment, and expatriation. The figures show that

women composed two thirds of all the refugees coming in the first wave, and they made 50% in 1996. The situation gets even more complex if displaced persons from Kosovo and Metohija are added, as women again made the majority of them.

Growing unemployment rates also affected women in particular. By the mid-sixties the number of unemployed women was 52 thousand, and in 1998 it reached the 480.000. Unemployment among women grew constantly and faster than overall unemployment. According to 1998 figures, the unemployment rate for men was 18.9% and 33.6% for women. The greatest part of these unemployed women was aged between 18 and 25 (28.4%).

A large number of existing programs and activities in the country are focused on reproductive health and on women as the mother, so that programs are aimed at women themselves, at unemployed women with a bunch of risk factors stemming from their surroundings, and at life conditions known to foster the development of prostitution.

4.2 CURRENT STATE

The existing information for this group is extremely rare, no matter what source is referred to. A study of the phenomenon was published in a book that appeared at the very onset of the HIV/AIDS epidemic (D. Radovic, 1986).

A seminar exam paper in social medicine (Đekic, 1998) covered 60 prostitutes, out of which one half hustled in streets while the other worked in agencies. Notwithstanding the limitations of the used methodology, the paper pointed out that those girls working in agencies are "better protected", they use condoms, moreover of better quality, and they have tests frequently.

The press shows heightened interest for the phenomenon as of late. The articles published can offer at least a partial picture. So the daily "Blic" (24.01.2001) states that the police intervened in January at 441 "marked objects", checked IDs of 1.017 persons, and incarcerated 150 of them. Similar figures can be found in the weekly "Nedeljni telegraf" (20.02.2002), which reports that there are about 3.000 women in Belgrade who prostitute themselves, one half registered with the police. The escort agencies in Belgrade where police intervened closing some of them are also mentioned. The mean age of the girls is 18-23, most of them coming form the countryside. The article reflects the police readiness to root out the phenomenon. Prostitution around the Blue Bridge which emerged during 1997 (Ekskluziv, No. 24, 2002) is one of the lowest forms of prostitution and also the most dangerous one. There are no data on risk behaviour, use of condoms, and similar.

The initiative of a group of prostitutes in Belgrade by the end of 2001 to found their own trade union with the aim of protecting their rights and securing them health and social protection (NS, 29.11.2001).

5. MEN HAVING SEX WITH MEN - HOMOSEXUALITY IN SERBIA

The measure to which risk sexual behaviour between men plays a part in the development of HIV/AIDS epidemic has not been recognized in full in our country, very much like in so many other regions. Wherever such recognition prevails at any rate, it also breeds animosity and discrimination, together with marginalisation of such persons, thus making preventive activities ever harder to execute. This is the characteristic form of reaction in our country.

It is estimated that 16-20% of males can be considered to be homosexuals, and bisexuals vary from 5 to 15% in different countries. We do not even have approximate data for our country, either on the first or the latter phenomenon.

Homosexuality is traditionally proscribed and highly stigmatised in our culture. According to federal legislation it was liable to punishment up to 1994, even though not a single case of legal prosecution was recorded.

Activism in this field was nonexistent in our country all until the break up of former Yugoslavia (except for a solitary statement of a distinguished intellectual at a Communist Party congress some 20 years ago). The first organized forms of activities in this field appeared as part of general strivings and

struggles for certain civil initiatives and human rights in the midst of the most fierce war events and tensions, when non-governmental organizations were founded to deal with "the different ones".

In January 2000 the first Conference on Sexual Minorities was held in Novi Sad, with the participation of international delegates and representatives of various communities.

The meeting proceeded without any incident, unlike the Gay Parade in June 2001 when the participants were brutally attacked by a raving mob.

Discrimination, severe threats, and physical perils at organized gatherings are typical for the present status of homosexuals in our country. The pro-Fascist and ultra-nationalist groups are domineering, but there are also some human rights activists who are of the opinion that homosexuals should be given the opportunity to cure their "sickness".

6. HIV/AIDS IN SERBIA

6.1 REPORTED HIV/AIDS DATA

The first two cases of AIDS were reported in Yugoslavia in 1985. The epidemic has steadily shown a slow but constant growth ever since. As pointed out in the introduction, up to 30.06.2001 there were 922 patients registered, 97% out of these in Serbia.

There are registered patients almost in every town in Serbia, but the biggest number of affected ones is in Belgrade (654), followed by Niš (with 20 persons affected), Novi Sad (16), Po□arevac (11), and then Kragujevac (with 9 patients). Data on HIV-positive patients are not known for other cities in Serbia.

Together with the FRY, Serbia has reported low-level incidence and prevalence of HIV/AIDS, but it is higher than in other states of the former FRY. Also it has the same characteristics that have led to an increase in HIV/AIDS rates in other countries in Eastern Europe and Central Asia: social and economic crisis; increasing poverty and unemployment; rapid social changes; a breakdown in provision of services - both private and governmental; increased prostitution, trafficking and drug abuse; and changes in sexual behaviour and norms. Serbia also experiences the same patterns of HIV/AIDS transmission. These include higher rates of injecting drug users (IDU) and increased sexual risk behaviour (particularly amongst young people).

All official data on HIV/AIDS are obtained through the Federal Institute for Public Health (IPH), Belgrade, but only for HIV cases reported in Belgrade, while AIDS cases have been reported for the whole FRY. There is no mechanism for countrywide reporting. Additionally, most data are based on AIDS reports only and do not include people who are HIV-positive.

According to the last published data of 1.12.2001, the FRY reported 922 cases of AIDS, out of these 75% are already dead. 97% of all reported AIDS cases are from Serbia and 80 % from Belgrade, the capital city. By routes of transmission the vast majority of AIDS cases belong to IV drug addicts (47 %) and then comes heterosexual transmission with 19%.

Trends in the last three years, when compared to previous years, show a slight increase in rates of sexual transmission and a statistically insignificant decrease in infections among injecting drug users (IUDs) (52% to 47%).

Since 1987, in Belgrade alone, there have been 1234 registered cases of persons who were HIV-positive. Twenty-one of the infected persons are under the age of 18. Nevertheless, these figures must be treated with caution as they are incomplete and at times are based on outdated and weak data.[2] The WHO estimates the number of HIV-positive cases to be closer to 10,000 in the FRY. To date, there is no information to ascertain the bridge of infection between IDU and Studs.

The Federal IPH and IPH Belgrade figures from available epidemiological data recorded since the beginning of the HIV/AIDS epidemic in 1987 to June 2001 are shown in Table 1

Table B. **HIV/AIDS Cases**

Total number of HIV/AIDS cases (1987-Jan. 2001)		Modes of Transmission						
		IDU	Sexual Transmission among Hetero-sexuals	Sexual Transmission among Homo/ Bisexuals	Blood and blood products	Unknown cases	Prenatal cases	Haemo-dialysis
HIV Cases*	1.234							
AIDS cases	922	438	177	129	103	67	7	NA
Total number of HIV/AIDS cases* (1987-Jan. 2001)	1.234	742	226	104	55	57	19	3
Percentage of total number of HIV/AIDS cases* (1987-Jan. 2001)		61,5%	18,7%	8,6%	4,6%	4,7%	1,8%	0,2%

* Figures are based on official statistics from the Federal Institute for Public Health. Most WHO and other independent groups woring in the area dispute the official statistics as relying on outdated data.

31% of all AIDS cases are women. The numbers of AIDS cases among women are higher in 1997-2001 than in the beginning of epidemic 1987-1991 (26, 6%). The percentage of women of the total number of HIV positive people in the country is 30%

6.2 RESEARCHES IN THE FIELDS OF KNOWLEDGE, ATTITUDES, AND BEHAVIOURS IN THE GENERAL POPULATION RELATING TO HIV/AIDS

AIDS has certainly induced many people to start research in the fields of knowledge and information. Due to considerable differences in research methodology, however, chiefly in using the instruments and in the choice of samples, a great number of those studies cannot be compared. "AIDS and Social Response", a study (by Savin et al.) published in 1992, offered the first serious picture of what is called the social reaction to the advent of a dangerous lethal disease, spreading of which is correlated with human behaviour. The results suggested high level of ignorance, fears, delusions, and discrimination, both among the general public and physicians. The physicians have stigmatised patients like addicts or homosexuals to a high degree, together with those connected to them.

The addicts encompassed by the study emphasized their feelings of being marginalized and isolated even before the onset of AIDS, and these were aggravated by AIDS itself.

Vujovic, in his study of the young in Belgrade (S. Vujovic, 1999), also found discriminatory attitudes toward "junkies" and homosexuals who, once infected, "got what they deserved".

There is some degree of empathy when it concerns close and dear ones. When asked hypothetically what would their reaction be in such a situation, 60% of polled Belgrader's expressed their potential readiness to tend and care for their kin (V. Cucic et al., 2002).

With years of preventive activities understanding grew as well, together with the level of general information. Taken from the sample of the general population in Belgrade, ages 15 to 49, "the knowledge indicator on preventive practice" was already rather high in 1997 (95%), only to grow further up to 97% in 2000 (V. Cucic et al., 2002).

Vujovic assesses the level of knowledge among young people as moderate, on a scale of 0-16 the medium value for men is 6, and 8 for girls.

Improvement of knowledge and information has not affected the status of HIV-positive persons in a community or a health institution. A psychologist at the Clinic for Infectious Diseases testifies to count-

less difficulties and troubles that those persons have to face when attempting to realize their health protection, with the exception of few health workers who react humanely ("Life In Isolation, Deprived of Rights", article in the daily "Politika" of 23.02.2002)

As research results show, enlarged knowledge does not correlate to changes in behaviour, although certain progress is noted.

AIDS has brought about changes in sexual behaviour of 38% of young people in Belgrade (Vujovic, 1999), and 30% of the general population (Cucic, 2002). Somewhat more realistic assessment of one's owns risk is also improving. So, young people who have no sexual relations yet assess their risk of getting AIDS as lower than among the general public, and those who assess their risk as equal to that of others are for the most part the young who have sexual relations. Among the general population, 15% of persons between the ages of 15 to 49 estimate there is a chance of getting HIV. Sex differences are not statistically significant (Cucic, 2002).

Changes in usage of condoms are evident if usage incidence is observed. It grew by 15% in the period from 1997 to 2000. Still, condoms are not used in rural regions in 45% of incidents, and 26.5% in urban environments.

The number of irregular sexual partners in the general population also rose, from one partner on average in 1997 to two in 2000.

The number of those who either charged for irregular sexual contact or paid for sex, entering in that way the sphere of commercial sex, is higher in 2000 and makes 3.7%, with considerable differences in sexes (2.3% males, 6.4 females).

There are no reliable data on sexually transmitted diseases in our country. The reason can be found in an absence of protocols for questioning, registering, and treating the patients and their partners. Legally, only some of the causes are to be reported mandatory, so that, for example, only 504 cases of infected persons were registered in 1997 in the whole territory of Yugoslavia (The Institute for Economy, 2000).

RAR PROJECT

1. AIMS AND OBJECTIVES OF THE RAR PROJECT

RAR - rapid assessment and response is an innovative research approach/method designed to assess rapidly a current vulnerable situation in a community. It is, also, a new philosophy of research and a combination of quantitative and qualitative methods.

Objectives of the RAR for each selected city in Serbia were derived from the main RAR objectives, which were the following:

- To assess the extent and nature of HIV risk by exploring context and characteristics of risk behaviour, health and social consequences as well as the present state of intervention targeting EVYP.
- To increase awareness and support of local communities towards EVYP and provide initial intervention activities, and
- To propose a general as well as specific local framework for HIV/AIDS preventive action according to the key findings of the RAR.

However, within each city, the specific objectives were defined in order to highlight specific characteristics of the following EVYP groups selected for the RAR:

- In Belgrade target groups were: young drug users, young gay population and young sexual trade workers,
- In Novi Sad target groups were: young drug users and young gay population,
- In Kragujevac target groups were: young drug users and young sexual trade workers, and
- In Nis groups were: young drug users and young gay population.

2. RAR PROCESS

2.1 RAR TEAM

According to the job description, the Republic Coordinator was engaged to coordinate activities among four local RAR teams and to organize the national counselling body. The National Counselling Body comprises experts of various profiles, from those institutions that have the mandate to deal with AIDS or to work with young people. So the counselling body included representatives of the ministries of health, education, internal affairs, those representing the Institute for Health Protection, the Institute for Addictive Diseases, the Institute for Health Protection of Mother and Child, the Clinic for Infectious Diseases, the Institute for Health Protection of Students, an institution studying mass media, and representatives of the civil sector: JAZAS Organization, the JAZAS Youth, PLWH and other organizations, medical students organizations, and others.

Due to specific conditions in Belgrade, where both local and national institutions are located, the National Counselling Body operated together with the local counselling body, which comprised individuals from institutions that are important to Belgrade. Both bodies were founded immediately after the RAR workshop and held their first meetings on 21st November 2001. Four meetings were held so far:

- Constitutive meeting, definition of project scope and tasks
- 1. Discussion on operations of the Ministry of Internal Affairs aimed at suppression and prevention of drug addiction and other forms of risk behaviour; the role in RAR
- 2. Activities of the civil sector and the RAR Project
- Activities of health services and the RAR, problems and difficulties
- Key findings of the RAR Project and frame of action

There was ongoing dialogue in between the meetings with certain members, particularly with representatives of health institutions in our National and local teams, and each member was given a specially structured questionnaire in order to make a list of interventions that exist in the member's original organization whose representative s/he is.

Each local field coordinator was responsible, according to the same principle, for the consolidation of the Local Field Team and of the Community Advisory Board (CAB).

The local field teams differed as per city. So in Belgrade the team of 10 members had only one professional - a physician, with all the rest as persons with experience relevant to the problem they had to deal with. There were more professionals partaking in other teams.

2.2 TRAINING WORKSHOPS

In October 2001 in Neum, UNICEF organised a training in WHO RAR methodology for the National RAR Team made up of national and local co-ordinators. As a result of the professional leadership from the representatives of UNICEF, WHO, Fund for an Open Society - International Harm Reduction Network, Canadian Public Health Association and engaged consultants, national teams from all SEE countries have adopted the RAR methodology and have developed concepts for the realisation of national projects.

The RAR National workshop was organized from November 15 to 17, 2001, at the Institute for Social Medicine, Statistics, and Research of the Medical Faculty, Belgrade. All four local team members participated in the workshop.

The objective of the workshop was to train the field team members in knowledge and skills necessary for the implementation of the RAR project.

The purpose of the workshop:

- To acquaint the field team members with the RAR principles and practices
- To make sure the field team members are indeed acquainted with the RAR principles and practices
- To build up and improve the field team members' skills so as to enable them to:
    - Assist at focus group meetings
    - Take key information interviews
    - Carry out polls
    - Perform observations and mapping
    - Keep exact evidence and manage data
    - Analyse data using grids of activities /for the agenda and evaluation, (See Annex A)

2.3 COMMUNITY ADVISORY BOARD (CAB)

All CABs were constituted immediately after the National Advisory Board was founded, with the aim of helping to create a climate which would accommodate the RAR, give support to the RAR, participate in planning interventions, and to serve as advocates for the field activities. The CAB was mainly successful in performing its tasks.

2.4 TIMELINE OF ACTIVITIES

Month	Activity
October	Regional training workshop in Neum Establishment of local RAR Team
November	Training workshop in Belgrade
November	Establishment of National Advisory Board and CAB. Local team meetings, Field work Data collection Field work, Existing information collecting National Board meeting
December	Fieldwork, data collection, field team meetings. Data Entry and first analysis National Board meeting
January	Field work, National Board meeting Data Entry and analysis
February	Workshop in Sarajevo Writing report CAB meetings National Board meeting

2.5 PROBLEMS AND SUCCESSES

The RAR Team of Serbia had no great difficulties in its work. There was good cooperation between teams, high motivation, and good work discipline. In Belgrade, minor problems occurred when certain institutions refused to give secondary data.

The shortness of time for the realization of all the planned duties was the only true obstacle.

3. METHODOLOGY

The RAR assessment activities were conducted in 4 sites: Belgrade, Nis, Novi Sad and Kragujevac, selected according to the following criteria: largest cities, good infrastructure, available sources for data collection, number of PLWHA, presence of the University, a large mobile population and trafficking route for drugs. The target population for this assessment was young people from 10 to 24 years old and considered to be the most vulnerable with regards to HIV infection in Serbia:

- young drug users, predominantly intravenous drug users (IVDUs) (in all cities);
- young men who have sex with men (MSM) (Belgrade, Nis, Novi Sad); and,
- young sex trade workers (STW) (Belgrade, Kragujevac).

3.1 DATA COLLECTION

Data collection was done during November, December 2001 and January 2002. Methods for data collecting among target groups in all cities were based on triangulation and included existing information (routine medical statistics and published papers), questionnaire survey among three target groups, focus groups, structured and unstructured interviews and observation of hot spots. For the purpose of triangulation qualitative data were also collected by means of focus group and interviews with different service providers and policy makers. However in order to highlight the problems of EVYP interviews and focus groups were also organised with students, teachers, parents, journalists, owners of popular places, popular persons from the field of culture and art.

Existing information

Three kinds of existing information were used by RAR in Serbia

- Routinely collected data, relating to data on HIV/AIDS infection and its characteristics
- Documentary sources, such as published papers of former studies, reports of health institutions, and the press
- Data gathered from the national RAR team members

Some of the existing information was used for situation analysis and a description of vulnerable groups in the first.

New information

Gathered through different techniques:

- Questionnaires
- Focus groups
- Interviews
- Observations
- Mapping

3.2 QUESTIONNAIRE

The quantitative research instruments were 3 questionnaires for 3 target groups containing 18 core survey questions, which were designed at the Regional Training Workshop in Neum and pilot tested in Sarajevo. Additional questions (closed and open ended) were designed to examine the knowledge related to HIV/AIDS transmission, as well as highlighting the problems of every target groups with regards to their risk behaviour, health consequences of such behaviour, subjective assessment of existing preventive intervention and their possible improvements (ANNEX B). In such way the questionnaire for young drug users consisted of 39 questions and 86 variables, questionnaires for young MSM also involved 47 questions and 86 variables, while questionnaires for young STW had 49 questions and 101 variables. All questionnaires could be divided into several parts:

- Socio demographic characteristics of respondents (age, sex, level of school attended, marriage status);
- Drug use behaviour (mean age when first use drugs, areas where usually use drugs, type of drugs, combination of drugs, injections of drugs, experience with sexual intercourse under the influence of drugs, sharing of drug-injecting equipment);
- Sexual behaviour (mean age of the first sexual intercourse, number of different sexual partners, the practice of using condoms during sexual intercourse, reasons for not using condoms, experience with sexual intercourse in return for money, drugs, or something else);
- Health seeking behaviour (the places where the respondent can get information about HIV and STIs, assessment of the personal risk for HIV infection or other STIs, experience with testing for HIV/AIDS, Hepatitis B and Hepatitis C, experience with STIs, but also with other health consequences related to risk behaviour, utilisation of health care services in this respect);
- Knowledge and prejudices with regards to HIV transmission; and
- Assessment of existing and future preventive interventions (possibilities for joining the NGOs dealing with the specific problems and its prevention, satisfaction with their works, proposals for future preventive actions).

Each young person from target groups recruited to participate in a particular focus group or interview also completed the questionnaire. All the time information from questionnaires were highlighted more deeply through qualitative data from other sources with the help of national and local CABs and validated through triangulation.

3.3 FOCUS GROUPS

For the purpose of deepening and validating the data gathered by questionnaire survey focus groups were organised with different participants: key informants, health care workers, students, teachers). The number of focus groups and type of participants are presented for all 3 target groups and 4 cities in the tables within heading Sample Size.

3.4 INTERVIEWS AND KEY INFORMANT INTERVIEWS

Different interviews were done with key informants, students, young residents of reformatory, teachers, health care workers, policy makers, pharmacies at private pharmacies, NGOs activists, STW macros, owners of tech clubs, show biz people (musicians), taxi drivers. Besides unstructured interview with the members of target groups, which were served for broadening the findings from the survey questionnaires, for the purpose of interviewing the following 5 types of structured interviews with specific questions were designed (ANNEX C-F):

- For key informants (with questions relating to their experience and satisfaction with specific health care services),
- For the policy makers (with questions about their assessment of the risk behaviour among young population, dimension of the problems associated with such behaviour, causes of such behaviour, existing prevention, emergency of intervention and plans for future actions),
- For specific health care providers (with questions about assessment of the problem with drug abusers among young people according to the routine medical documentation in their institutions, quality of diagnostic and therapeutic procedures and follow up of patients after hospitalisation, participation in out of institutions activities, plans for future activities)
- For the directors of schools (with questions about the presence of risk behaviour in schools, presence of preventive practices which include students, parents and teachers and plans for future activities), and
- For different services providers (about existing experience in prevention activities targeted different groups of young people and possibilities, plans for future interventions.

Additional interviews in Belgrade were done by chatting through the Internet with 113 MSM at the web address www.gay-serbia.com though without age data, that was not collected because of confidentiality.

3.5 OBSERVATIONS

Many observations were made, only in Belgrade in total 21 (12 observation of hot-spots for young drug users, 7 for young MSM and 3 for young STW). Observations included different places such as cafes, streets, parks, flats, juvenile delinquents home, public toilets, parties, (for short description, look at the ANNEX G - MEGA grids). However mapping of hot spots for young drug users in Belgrade as places where they get together could not to be made as such places actually do not exist (except for techno parties and one park near the health care institutions for drug addictions).

3.6 MAPPING

Where it was possible the mapping of hot spots were done (for short description, look at ANNEX G - MEGA grids).

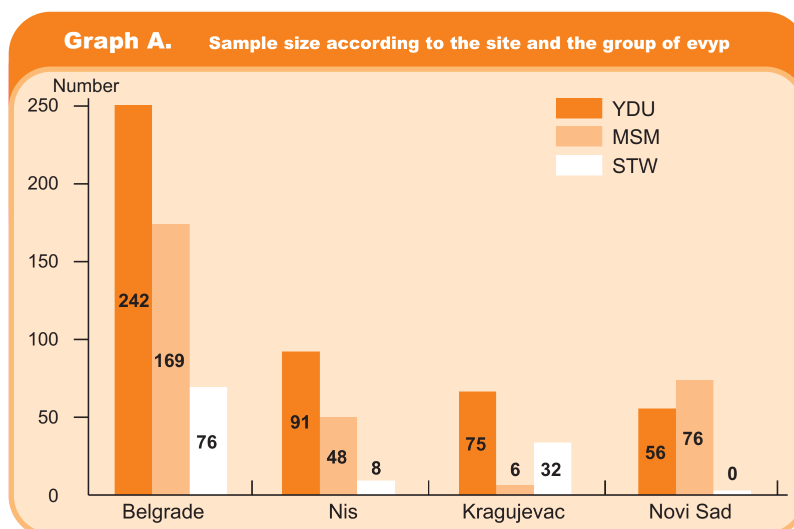
4. SAMPLE

4.1 SAMPLING TECHNIQUE

The selection of samples for the survey was "inductive", new samples were selected on the basis of emerging findings which was necessary before a valid assessment was made. Sampling techniques were mainly based on network samples with snowballs in all sites. Respondents were selected with the help of key informants for each vulnerable group throughout particular social networks, their informal groups and formal organisations (such as NGOs). The findings from different samples were constantly compared and checked through triangulation from the qualitative sources of data. Data gathering was continued to the "point of saturation" when the RAR Team and all Field Teams considered that all sources of potential variation between respondents had been explored and there is no other new information.

4.2 SAMPLE SIZE

The number of respondents in samples overcame approximate estimates of the potential samples size, especially where the group of MSM is under consideration. The total number of EVYP who completed the questionnaires is 879 (and after excluding those who were older then 24), while the numbers of young people in three target groups completing the particular questionnaire is as follows:



- 464 for young drug users (Belgrade: 242, Nis: 91, Kragujevac: 75, Novi Sad: 56),
- 299 for young MSM (Belgrade: 169, Novi Sad: 76, Nis: 48, Kragujevac: 6), and
- 116 for young STW (Belgrade: 76, Kragujevac: 32, Nis: 8)

In the following tables the separate Sample Size for each target group, including all methods for data collection and according to the cities is presented.

4.2.1 Belgrade

Table C 1. Belgrade sample size among young drug users

	Questionnaires*	Interviews	Focus Groups	TOTAL
Target Group	242	34	75 (9)	351
Service Providers		41	50 (6)	91
Policy Makers		4		4
TOTAL:	242	79	125 (15)	446

Plus: 12 observation and secondary sources of data (medical documentation, published papers)

Table C2. Belgrade sample size among young MSM

	Questionnaires*	Interviews	Focus Groups	TOTAL
Target Group	169	13	35 (6)	217
Service Providers		5		5
Policy Makers				
TOTAL:	196	18	18 (6)	222

Plus: 7 observation, 113 interviews at the gay web site (www.gay.serbia.com), mapping of the gay hot spots and secondary sources of data(students published papers)

Table C3. Belgrade sample size among young STW

	Questionnaires*	Interviews	Focus Groups	TOTAL
Target Group	76	13	24 (3)	113
Service Providers				
Policy Makers				
TOTAL:	76	13	24 (3)	113

Plus: 3 observation and mapping

4.2.2 Kragujevac

Table D1. Kragujevac sample size among young drug users

	Questionnaires*	Interviews	Focus Groups	TOTAL
Target Group	75	11	12	98
Service Providers		41	35	76
Policy Makers		11	30	41
Others		38	103	141
TOTAL	75	101	180	356

Others: prisoners, students, journalist, teachers, owners of clubs, parents

Table D2. Kragujevac sample size among young STW

	Questionnaires*	Interviews	Focus Groups	TOTAL
Target Group	32	10	12	54
Service Provider		13	8	21
Policy Makers		1	24	25
Others		9	27	36
TOTAL	32	33	71	136

Others: prisoners, students, journalists, teachers, owners of the clubs, parents, etc

4.2.3 Nis

Table E1. Nis sample size among young MSM

	Questionnaires*	Interviews	Focus Groups	TOTAL
Target Group	91	40	13	
Service Providers		60	8	
Policy Makers		6		
TOTAL	91	106	107	304

Table E2. Nis sample size among young MSM

	Questionnaires*	Interviews	Focus Groups	TOTAL
Target Group	48	40	5 (26)	
Service Providers		41	2 (10)	
Policy Makers				
TOTAL	48	81	36	165

Table E3. **Nis sample size among young STW**

	Questionnaires*	Interviews	Focus Groups	TOTAL
Target Group	8	2		10
Service Providers				
Policy Makers				
TOTAL	8	2		10

4.2.4 Novi Sad

Table F1. **Novi Sad sample size among young drug users**

	Questionnaires*	Interviews	Focus Groups	TOTAL
Target Group	56	57	10 (47)	67
Service Providers		28	3 (14)	31
Policy Makers		3	2 (20)	5
TOTAL	56	88	85	229

Table F2. **Novi Sad sample size among young MSM**

	Questionnaires*	Interviews	Focus Groups	TOTAL
Target Group	76	41	14 (39)	
Service Providers		3		
Policy Makers		1		
TOTAL	76	45	14 (39)	160

5. ETHICAL CONSIDERATIONS

During the process of data collection respondents within the questionnaire survey as well as interviews and focus group discussion, were informed about the purpose of the RAR. Special stress was given to the confidentiality of information and potential use for the improvement of preventive intervention, so that they could make informed decisions about participation in the RAR. Together with data collection basic information about HIV/AIDS was distributed together with written materials. During the RAR process within the whole fieldwork a few good interventions were done upon the requests of target groups. An example is the voluntary HIV testing among 14 young residents of one Belgrade reformatory (the house for correction of criminal behaviour among young people).

6. DATA ANALYSIS

All collected data were validated through triangulation. Missing values were left as blanks in the data entry process.

6.1 QUANTITATIVE DATA

Quantitative data collected from the questionnaire for all 4 sites were entered centrally by two persons into Epi Info version 6 software. In further analysis they were exported in SPSS version 10.0 software for Windows and for the purpose of this preliminary report were analysed only by means of descriptive statistics.

6.2 QUALITATIVE DATA

Qualitative data were analysed through activity and mega grids. For all 3 target groups separate MEGA grids were constructed and filled in by Team members at each 4 cities. MEGA grids contained qualitative information about context, risk and protective behaviour, health and social consequences and intervention. The Core RAR Team and members of Field Teams carefully discussed all MEGA grids. The main reason for that was the wish to highlight the problems more deeply through qualitative data. For example in Belgrade the new observation was written around the New Year holidays when the key informants noticed a serious increase in cocaine consumption, though it has been already concluded by triangulation that heroin is the main intravenous drug among Belgrade young drug users. However, after discussion with Field Team members and validation of their conclusions with sources from drugs distributors and police, it was concluded that this is typical behaviour among young drug users during any important holiday through the year.

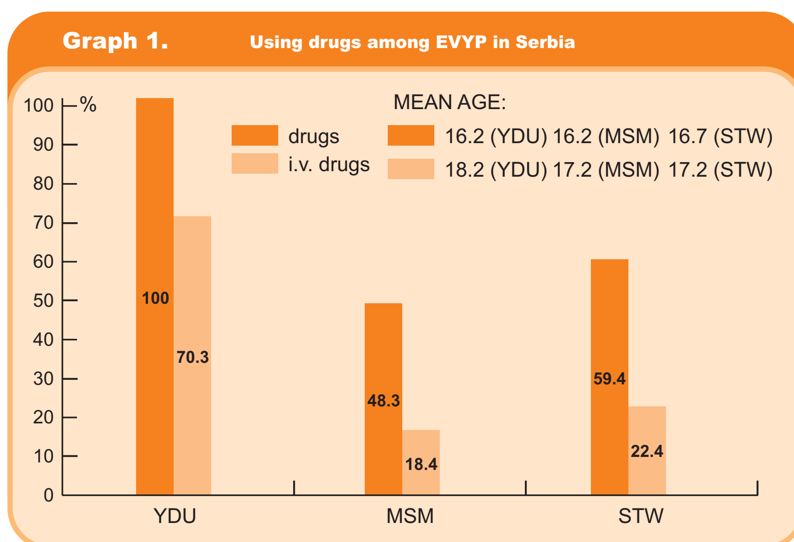
7. FINDINGS

The key findings have shown that quantitative data from the survey corresponds to qualitative findings from mega grids for all three target groups. Hereby the findings from the questionnaire survey are presented separately for each target group.

7.1 YOUNG DRUG USERS

7.1.1 Core Survey Questions

Drug use among all EVYP groups who were interviewed during RAR project is presented in Graph 1.



More then two thirds (74,8%) of respondents belong to the 20-24 age group, without significant differences between 4 sites.

Table 1. Age groups

	Total		City							
	No.	%	Belgrade		Nis		Novi Sad		Kragujevac	
			No.	%	No.	%	No.	%	No.	%
10 - 14	3	.6%	1	.4%	2	2.2%				
15 - 19	114	24.6%	67	27.7%	25	27.5%	12	21.4%	10	13.3%
20 - 24	347	74.8%	174	71.9%	64	70.3%	44	78.6%	65	86.7%
Total	464	100.0%	242	100.0%	91	100.0%	56	100.0%	75	100.0%

The number of male respondents is bigger twice then female (67,9% and 32,1% respectively).

Table 2. Gender

	Total		City							
	No.	%	Belgrade		Nis		Novi Sad		Kragujevac	
			No.	%	No.	%	No.	%	No.	%
Male	315	67.9%	160	66.1%	64	70.3%	39	69.6%	52	69.3%
Female	149	32.1%	82	33.9%	27	29.7%	17	30.4%	23	30.7%
Total	464	100.0%	242	100.0%	91	100.0%	56	100.0%	75	100.0%

7.1.2 Drug Use Behaviour

All of them have used some form of drugs and 70,3% are intravenous drug users (Kragujevac: 93,3% Novi Sad: 75% Nis: 64,8% Belgrade: 64%). According to frequency distributions the biggest No first used drugs in the 15 years old.

Mean age when they first used drugs was 16,2, and according to the cities are very similar:

Table 3. Age when they first used drugs

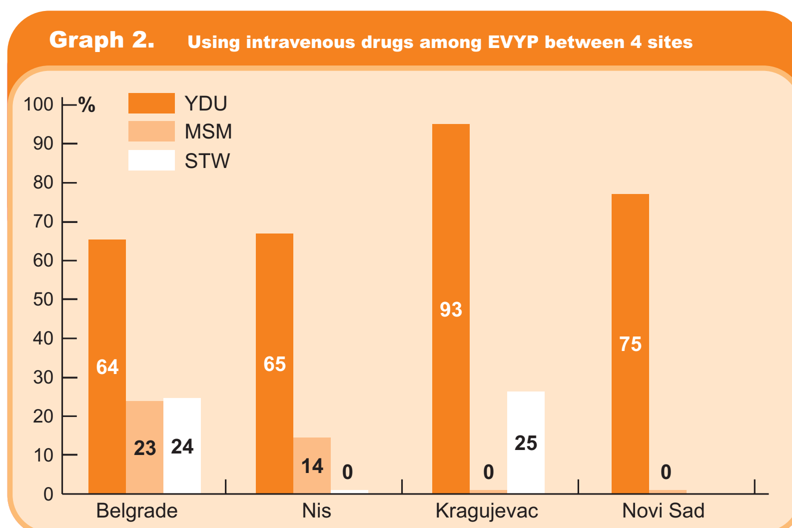
	Total		City							
			Belgrade		Nis		Novi Sad		Kragujevac	
	No.	%	No.	%	No.	%	No.	%	No.	%
10.00	4	.9%	3	1.3%			1	1.9%		
11.00	6	1.3%	5	2.1%			1	1.9%		
12.00	17	3.7%	11	4.6%	3	3.4%	2	3.8%	1	1.3%
13.00	32	7.0%	15	6.3%	9	10.1%	4	7.5%	4	5.3%
14.00	57	12.5%	23	9.6%	12	13.5%	10	18.9%	12	16.0%
15.00	87	19.1%	49	20.5%	14	15.7%	10	18.9%	14	18.7%
16.00	80	17.5%	36	15.1%	16	18.0%	11	20.8%	17	22.7%
17.00	74	16.2%	44	18.4%	13	14.6%	6	11.3%	11	14.7%
18.00	49	10.7%	25	10.5%	12	13.5%	3	5.7%	9	12.0%
19.00	28	6.1%	13	5.4%	9	10.1%	4	7.5%	2	2.7%
20.00	12	2.6%	9	3.8%			1	1.9%	2	2.7%
21.00	3	.7%	2	.8%					1	1.3%
22.00	3	.7%	1	.4%					2	2.7%
23.00	2	.4%	2	.8%						
N.O.	2	.4%	1	.4%	1	1.1%				
Total	456	100.0%	239	100.0%	89	100.0%	53	100.0%	75	100.0%

- Novi Sad: 15,4
- Kragujevac: 16,1
- Belgrade: 16,2
- Nis: 16,8.

The mean age when they first injected drugs is 18,2. Most of them started with cannabis (72,2%), but it is not for neglecting that even 9,5% of them did it first time with heroin.

The distribution of intravenous drug use among all EVYP groups, according to the four sites, is interesting (Graph 2).

Graph 2. Using intravenous drugs among EVYP between 4 sites

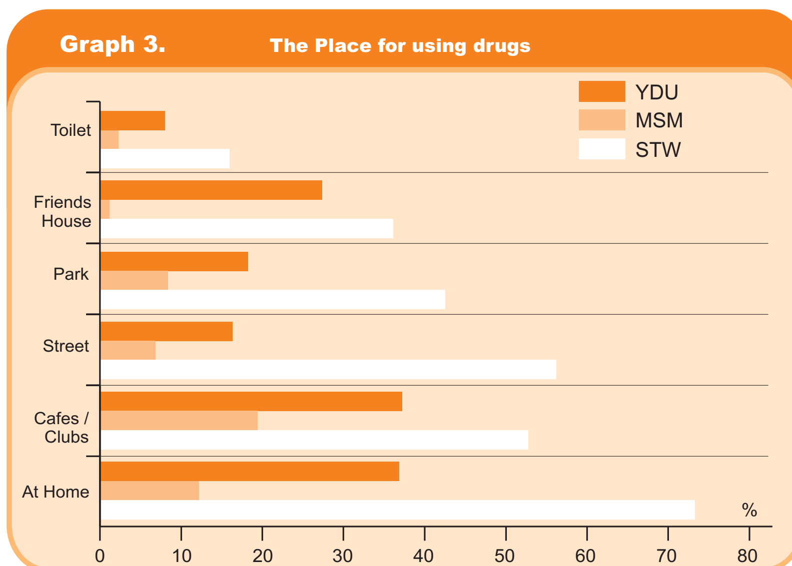


They usually use drugs at home (73,3%) followed by cafes/clubs (53,9%), street (46,3%) and park (43,3%). The place for using drugs does not differ significantly among 4 sites, though it is noted that in Belgrade and Kragujevac home is a much more favourable place for this activity then in Nis and Novi Sad.

Table 4. Areas where usually use drugs

		Total	City			
			Belgrade	Nis	Novi Sad	Kragujevac
Base		N=464	N=242	N=91	N=56	N=75
N.A.	Cases	447	205	99	77	66
	%	96.3%	84.7%	108.8%	137.5%	88.0%
Café/club/	Cases	250	138	53	24	35
	%	53.9%	57.0%	58.2%	42.9%	46.7%
Home	Cases	340	192	52	32	64
	%	73.3%	79.3%	57.1%	57.1%	85.3%
Street	Cases	215	115	42	24	34
	%	46.3%	47.5%	46.2%	42.9%	45.3%
Park	Cases	202	110	46	17	29
	%	43.5%	45.5%	50.5%	30.4%	38.7%
School	Cases	38	22	5	7	4
	%	8.2%	9.1%	5.5%	12.5%	5.3%
Public toilet	Cases	78	46	8	12	12
	%	16.8%	19.0%	8.8%	21.4%	16.0%
Other places	Cases	23	9	7	3	4
	%	5.0%	3.7%	7.7%	5.4%	5.3%
u kuci prijatelja	Cases	167	84	27	16	40
	%	36.0%	34.7%	29.7%	28.6%	53.3%
Party	Cases	96	47	25	12	12
	%	20.7%	19.4%	27.5%	21.4%	16.0%

Taking into consideration all vulnerable groups - young drug users, young men having sex with men, as well as young sex workers, a pattern of distribution could be observed (Graph 3).



Considering the type of drug most used in the last month at the first location is cannabis (81,7%), followed by heroin (65,5%), analgesic (41,6%), diazepam (37,7%), ecstasy (36,9%). These findings are differed among 4 sites. Cannabis is the most frequent in Belgrade (87,2%) followed by Nis (84,6%), while heroin is typical in Kragujevac (even 93,3%) followed by Belgrade (69,4%).

Almost all of them have experience of taking two or more drugs at the same time (88,4%), almost without differences between the four cities.

According to all vulnerable groups which where analysed during the RAR project, the types of drugs are presented in Graph 4.

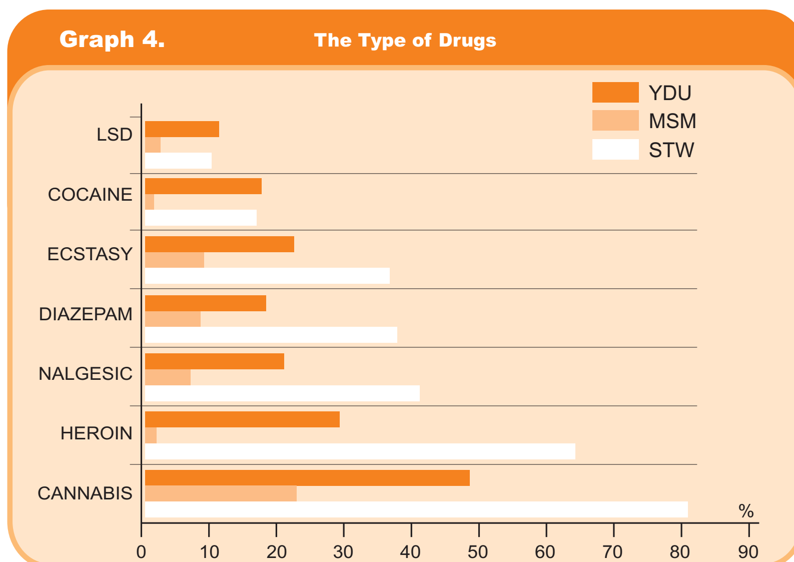


Table 5. Drugs most used in the last 1 month

		City								Total	
		Belgrade		Nis		Novi Sad		Kragujevac		Br	%
		No.	%	No.	%	No.	%	No.	%		
Cigarette	Ne	22	9.1%	5	5.5%	10	17.9%	2	2.7%	39	8.4%
	Yes	220	90.9%	86	94.5%	46	82.1%	73	97.3%	425	91.6%
Alcohol	Ne	70	28.9%	14	15.4%	11	19.6%	16	21.3%	111	23.9%
	Yes	172	71.1%	77	84.6%	45	80.4%	59	78.7%	353	76.1%
Cannabis marihuana	Ne	31	12.8%	14	15.4%	19	33.9%	21	28.0%	85	18.3%
	Yes	211	87.2%	77	84.6%	37	66.1%	54	72.0%	379	81.7%
Diazepam	Ne	140	57.9%	54	59.3%	40	71.4%	55	73.3%	289	62.3%
	Yes	102	42.1%	37	40.7%	16	28.6%	20	26.7%	175	37.7%
Ecstasy	Ne	122	50.4%	68	74.7%	42	75.0%	61	81.3%	293	63.1%
	Yes	120	49.6%	23	25.3%	14	25.0%	14	18.7%	171	36.9%
Glue or inhalator	Ne	228	94.2%	86	94.5%	49	87.5%	74	98.7%	437	94.2%
	Yes	14	5.8%	5	5.5%	7	12.5%	1	1.3%	27	5.8%
Amphetamine	Ne	213	88.0%	87	95.6%	56	100.0%	74	98.7%	430	92.7%
	Yes	29	12.0%	4	4.4%			1	1.3%	34	7.3%
LSD	Ne	205	84.7%	89	97.8%	49	87.5%	73	97.3%	416	89.7%
	Yes	37	15.3%	2	2.2%	7	12.5%	2	2.7%	48	10.3%
Heroin	Ne	74	30.6%	54	59.3%	27	48.2%	5	6.7%	160	34.5%
	Yes	168	69.4%	37	40.7%	29	51.8%	70	93.3%	304	65.5%
Methadone	Ne	205	84.7%	89	97.8%	49	87.5%	60	80.0%	403	86.9%
	Yes	37	15.3%	2	2.2%	7	12.5%	15	20.0%	61	13.1%
Cocaine	Ne	185	76.4%	84	92.3%	51	91.1%	67	89.3%	387	83.4%
	Yes	57	23.6%	7	7.7%	5	8.9%	8	10.7%	77	16.6%
Opium	Ne	230	95.0%	89	97.8%	51	91.1%	73	97.3%	443	95.5%
	Yes	12	5.0%	2	2.2%	5	8.9%	2	2.7%	21	4.5%
Analgesic	Ne	145	59.9%	54	59.3%	35	62.5%	37	49.3%	271	58.4%
	Yes	97	40.1%	37	40.7%	21	37.5%	38	50.7%	193	41.6%
Total		242	100.0%	91	100.0%	56	100.0%	75	100.0%	464	100.0%

Table 6. Those who have ever taken two or more drugs at the same time

	Total		City							
	No.	%	Belgrade		Nis		Novi Sad		Kragujevac	
			No.	%	No.	%	No.	%	No.	%
N. A.	14	3.0%	8	3.3%	3	3.3%	2	3.6%	1	1.3%
Ne	40	8.6%	19	7.9%	9	9.9%	7	12.5%	5	6.7%
Yes	410	88.4%	215	88.8%	79	86.8%	47	83.9%	69	92.0%
Total	464	100.0%	242	100.0%	91	100.0%	56	100.0%	75	100.0%

Even worse is the experience of having sexual intercourse under the influence of drugs (90,7% of respondents has such experience). Though such risk behaviour is most present in Belgrade it is obviously high in all cities, without differences.

Table 7. Those who ever had sexual intercourse under the influence of drugs

	Total		City							
	No.	%	Belgrade		Nis		Novi Sad		Kragujevac	
			No.	%	No.	%	No.	%	No.	%
N.A.	9	1.9%	4	1.7%	2	2.2%	2	3.6%	1	1.3%
No	34	7.3%	13	5.4%	8	8.8%	5	8.9%	8	10.7%
Yes	421	90.7%	225	93.0%	81	89.0%	49	87.5%	66	88.0%
Total	464	100.0%	242	100.0%	91	91	56	100.0%	75	100.0%

It has already been mentioned that many young drug users abuse intravenous drugs, the percentage of those who practice this ranges from 64% in Belgrade to even 93,3% in Kragujevac. However, it is worth mentioning that in Kragujevac the field team made special efforts by obtaining help from key informants to reach intravenous drug abusers.

Table 8. Injected drug users

	Total		City							
	No.	%	Belgrade		Nis		Novi Sad		Kragujevac	
			No.	%	No.	%	No.	%	No.	%
N.A.	11	2.4%	3	1.2%	6	6.6%	2	3.6%		
No	127	27.4%	84	34.7%	26	28.6%	12	21.4%	5	6.7%
Yes	326	70.3%	155	64.0%	59	64.8%	42	75.0%	70	93.3%
Total	464	100.0%	242	100.0%	91	100.0%	56	100.0%	75	100.0%

More then half of them who inject drugs (57,1%) share drug-injecting equipment. Such behaviour is the most frequently present in Kragujevac (70,7%) and the least in Novi Sad (25%), when all participants in the survey are under consideration (see the Table below).

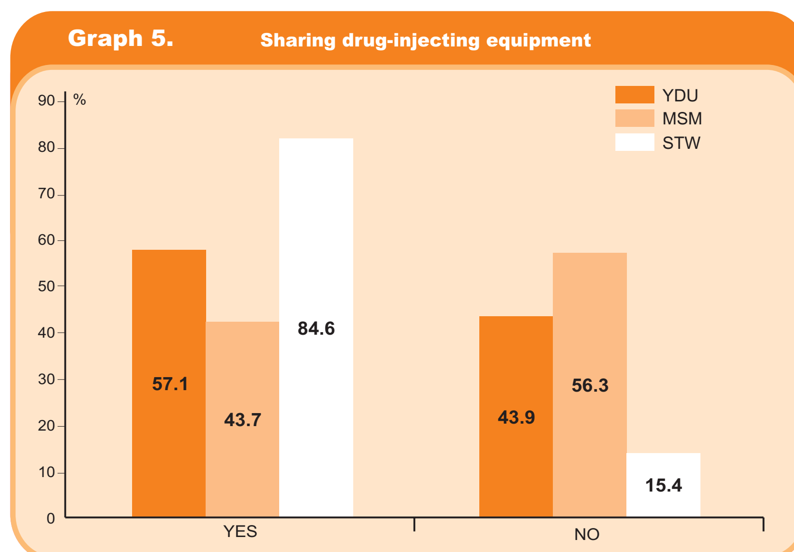
Table 9. Those who shared drug-injecting equipment

	Total		City							
	No.	%	Belgrade		Nis		Novi Sad		Kragujevac	
			No.	%	No.	%	No.	%	No.	%
N.A.	128	27.6%	75	31.0%	35	38.5%	13	23.2%	5	6.7%
No	144	31.0%	76	31.4%	22	24.2%	29	51.8%	17	22.7%
Yes	192	41.4%	91	37.6%	34	37.4%	14	25.0%	53	70.7%
Total	464	100.0%	242	100.0%	91	100.0%	56	100.0%	75	100.0%

However, when we exclude those who did not answer on this question the situation is much worse. The percentage of those sharing drug injecting equipment in the whole national sample in such a way is 57,1%, ranging from 32,5 in Novi Sad, 54,5% in Belgrade, 60,7% in Nis and even 75,7% in Kragujevac.

The sharing of drug-injecting equipment among all three vulnerable groups is presented in Graph 5.

Graph 5. Sharing drug-injecting equipment



7.1.3 Sexual Behaviour

With regards to their sexual behaviour almost all have sexual intercourse (98%) and the mean age of the first sexual intercourse was 15,8 (Belgrade: 15,4%, Kragujevac and Nis: 16,0%, Novi Sad: 16,0). The largest number according to frequency distribution had their first sexual intercourse at 15 years, at national level, but with slight differences between cities.

Table 10. Age at the first sexual intercourse

	Total		City							
	No.	%	Belgrade		Nis		Novi Sad		Kragujevac	
			No.	%	No.	%	No.	%	No.	%
10.00	1	.2%	1	.4%						
11.00	1	.2%	1	.4%						
12.00	12	2.6%	8	3.3%	2	2.2%	1	1.9%	1	1.4%
13.00	25	5.5%	15	6.2%	3	3.4%	2	3.7%	5	6.8%
14.00	48	10.5%	31	12.9%	5	5.6%	6	11.1%	6	8.1%
15.00	118	25.8%	65	27.0%	24	27.0%	16	29.6%	13	17.6%
16.00	109	23.8%	65	27.0%	17	19.1%	8	14.8%	19	25.7%
17.00	63	13.8%	30	12.4%	15	16.9%	6	11.1%	12	16.2%
18.00	45	9.8%	17	7.1%	11	12.4%	10	18.5%	7	9.5%
19.00	19	4.1%	5	2.1%	7	7.9%	2	3.7%	5	6.8%
20.00	8	1.7%	1	.4%	2	2.2%	1	1.9%	4	5.4%
N/O	9	2.0%	2	.8%	3	3.4%	2	3.7%	2	2.7%
Total	458	100.0%	241	100.0%	89	100.0%	54	100.0%	74	100.0%

Table 11. Mean age at the first sexual intercourse

Total	City			
Mean	Belgrade	Nis	Novi Sad	Kragujevac
15.8	15.4	16.2	16.0	16.2

The average number of sexual partners in the last year is 5,2. However, in Belgrade the average is 6,5 while it is much less in the other 3 sites (Kragujevac:3,9 Nis: 3,7 and Novi Sad: 3,0). The small No of those (17%) who have had sexual intercourse during the last year used condoms always. This preventive practice is at the least present in Kragujevac (14,7%), followed by Nis (15,4%), Belgrade (16,1%) and Novi Sad (26,8%).

Table 12. The practice of using condoms during sexual intercourse

	Total		City							
	No.	%	Belgrade		Nis		Novi Sad		Kragujevac	
			No.	%	No.	%	No.	%	No.	%
N.A.	17	3.7%	3	1.2%	7	7.7%	4	7.1%	3	4.0%
Always	79	17.0%	39	16.1%	14	15.4%	15	26.8%	11	14.7%
Sometimes	241	51.9%	130	53.7%	51	56.0%	27	48.2%	33	44.0%
Never	127	27.4%	70	28.9%	19	20.9%	10	17.9%	28	37.3%
Total	464	100.0%	242	100.0%	91	100.0%	56	100.0%	75	100.0%

The main explanation for such risk behaviour is that they do not like sex with condoms (53,4%) and they have trust in their partners (33,6%).

Table 13. The reasons for not "always" using condoms

		Total	City			
			Belgrade	Nis	Novi Sad	Kragujevac
Base		N=464	N=242	N=91	N=56	N=75
N.A.	Cases	1241	605	242	177	217
	%	267.5%	250.0%	265.9%	316.1%	289.3%
Too expensive / cannot afford	Cases	54	41	6	4	3
	%	11.6%	16.9%	6.6%	7.1%	4.0%
Embarrassed to buy	Cases	17	8	6	2	1
	%	3.7%	3.3%	6.6%	3.6%	1.3%
Difficult to use	Cases	42	30	7	1	4
	%	9.1%	12.4%	7.7%	1.8%	5.3%
Not easily available	Cases	48	46	2		
	%	10.3%	19.0%	2.2%		
Don't like sex with condoms	Cases	248	135	45	21	47
	%	53.4%	55.8%	49.5%	37.5%	62.7%
Embarrassed to ask partner to use	Cases	24	10	9	3	2
	%	5.2%	4.1%	9.9%	5.4%	2.7%
I have trust in my partners	Cases	156	82	40	13	21
	%	33.6%	33.9%	44.0%	23.2%	28.0%
No knowledge / awareness about the benefit of using condoms	Cases	5	1	3		1
	%	1.1%	.4%	3.3%		1.3%
Other reason	Cases	21	10	4	3	4
	%	4.5%	4.1%	4.4%	5.4%	5.3%

The percentage of those who had sexual intercourse with someone in return for money, drugs, etc is 13,1%; the biggest is in Kragujevac (17,3%) and the smallest in Novi Sad (8,9%).

Table 14. Those who had sexual intercourse with someone in return for money, drugs, etc.

	Total		City							
	No.	%	Belgrade		Nis		Novi Sad		Kragujevac	
			No.	%	No.	%	No.	%	No.	%
N.A.	14	3.0%	5	2.1%	4	4.4%	2	3.6%	3	4.0%
No	389	83.8%	206	85.1%	75	82.4%	49	87.5%	59	78.7%
Yes	61	13.1%	31	12.8%	12	13.2%	5	8.9%	13	17.3%
Total	464	100.0%	242	100.0%	91	100.0%	56	100.0%	75	100.0%

7.1.4 Health Seeking Behaviour

Regarding the places where they usually get information on HIV or other STIs, at the first instance is the media (75,4%), followed by friends (64,7%) and family (28,2%).

Table 15. The places where to get information on HIV or other STIs

		Total	City			
			Belgrade	Nis	Novi Sad	Kragujevac
Base		N=464	N=242	N=91	N=56	N=75
N.A.	Cases	843	420	162	119	142
	%	181.7%	173.6%	178.0%	212.5%	189.3%
Family	Cases	131	76	18	10	27
	%	28.2%	31.4%	19.8%	17.9%	36.0%
Friends / peers	Cases	300	177	55	27	41
	%	64.7%	73.1%	60.4%	48.2%	54.7%
Media	Cases	350	173	76	33	68
	%	75.4%	71.5%	83.5%	58.9%	90.7%
School	Cases	78	33	27	10	8
	%	16.8%	13.6%	29.7%	17.9%	10.7%
Social / health workers	Cases	68	37	16	8	7
	%	14.7%	15.3%	17.6%	14.3%	9.3%
STI counselling services	Cases	36	20	6	8	2
	%	7.8%	8.3%	6.6%	14.3%	2.7%
Other places	Cases	15	4	2	6	3
	%	3.2%	1.7%	2.2%	10.7%	4.0%
Nowhere NO PLACES !!!!!	Cases	35	28	2	3	2
	%	7.5%	11.6%	2.2%	5.4%	2.7%

Their perception of personal risk for HIV or other STIs is considerably high - even 78,3% (high risk: 22% and moderate risk: 56,3%). Half of them have been tested for HIV/AIDS (50,0%) and much less for Hepatitis B and Hepatitis C (21,8% and 29,1% respectively).

Table 16. Testing practice

		Total		City							
		No.	%	Belgrade		Nis		Novi Sad		Kragujevac	
				No.	%	No.	%	No.	%	No.	%
HIV	NA.	11	2.4%	6	2.5%	5	5.5%				
	No	221	47.6%	109	45.0%	50	54.9%	31	55.4%	31	41.3%
	Yes	232	50.0%	127	52.5%	36	39.6%	25	44.6%	44	58.7%
Total		464	100.0%	242	100.0%	91	100.0%	56	100.0%	75	100.0%

Table 16. **Testing practice**

		Total		City							
		No.	%	Belgrade		Nis		Novi Sad		Kragujevac	
				No.	%	No.	%	No.	%	No.	%
Hepatitis "B"	NA.	11	2.4%	6	2.5%	5	5.5%				
	No	352	75.9%	186	76.9%	64	70.3%	46	82.1%	56	74.7%
	Yes	101	21.8%	50	20.7%	22	24.2%	10	17.9%	19	25.3%
Total		464	100.0%	242	100.0%	91	100.0%	56	100.0%	75	100.0%

		Total		City							
		No.	%	Belgrade		Nis		Novi Sad		Kragujevac	
				No.	%	No.	%	No.	%	No.	%
Hepatitis "C"	NA.	11	2.4%	6	2.5%	5	5.5%				
	No	318	68.5%	174	71.9%	66	72.5%	47	83.9%	31	41.3%
	Yes	135	29.1%	62	25.6%	20	22.0%	9	16.1%	44	58.7%
Total		464	100.0%	242	100.0%	91	100.0%	56	100.0%	75	100.0%

Out of those who have been tested 1,7% are HIV+ (5 in Belgrade, 2 in Novi Sad and 1 in Nis). In the last one year 7,8% has STI plus 17,2% who ever had an STI.

7.1.5 Context

Most of the young drug users who were examined in all 4 sites have not finished higher education. Many of them are unemployed. In Belgrade out of 80 total drug addict interviewees, nine have completed elementary education, and only six are university postgraduates. The others are equally distributed among those who graduated from high schools and those who have begun but never completed university studies. More than three fourths of subjects are unemployed (only 7 employed), two are in sex trafficking, one is family pension beneficiary, a girl lives with a much older drug dealer, and a great number of them (more than two thirds) engages in criminal activities as a means to provide for drugs. In Kragujevac not one of the respondents was a university graduate. Two of the respondents are studying, although both are at a standstill due to their use of heroin. Most of the respondents are secondary school graduates. Mostly this means a vocational school; rarely a high school. The youngest respondents of 16 years of age are dropouts from secondary school, due to drugs. During their schooling they had numerous problems following the lectures, with truancy, conflicts with teachers, and consecutive troubles in the family. Commonly they are unemployed, or get temporary employment. In the situation of general unemployment, it is even more difficult to find one if one is a drug addict. Sometimes they try to get engaged in a in the family business, but with little success. In cases when they used to be employed, most of them had various problems. Drug addicts in the older generation (on heroin for over 15 years), used to be employed by the local economy. Some are retired invalids, due to consequences that ensued after a long-term abuse of psychoactive substances. Now they are living on the brink of the existential and human minimum.

Thirteen Belgrade respondents were growing or are reaching adulthood without their parents (in institutions, at foster homes, with relatives), dozen of them live in incomplete families, and almost all of the rest in a dysfunctional family, in frigid relations, misunderstood by their kin, (only 13 out of about sixty subjects claim their parents understand them and are fighting for them). Most often it is the mother that fights for her child, and they usually take up the role of a guardian in the process of treatment, while fathers most frequently withdraw hastily. In case of about a dozen addicts, parents are unaware of the problem,

whether they live out of town, or the addict is still socially functioning properly, managing to hide the real condition. The families in Kragujevac that the drug addicts originate from have had their share of problems even before the drug addiction. Commonly there were fights, brawls, and bad marriages ending up in divorces. Absence of understanding by parents, bad family communication, lack of quality time with children, and replacement of parental love with money and gifts, these are the commonest descriptions of the conditions of their upbringing. Alcoholism by one or both parents is also often present in these families. There are families with several children who are drug addicts (brother - a dealer, sister - a drug addict, who sells sexual favours for heroin). Families defend themselves by denial as a rule - they refuse to accept the child is an addict even though such behaviour is obvious. Kragujevac respondents come from all social strata - from those very near to the poorest; one interviewee lives in the country. We traced indicators by induction which point to larger quantities of marijuana seized in villages and their vicinity, as it is easily grown and hard to notice (due to lack of information in the community) in the villages, and that a certain number of intravenous drug addicts leave and start living in the country in an attempt to get rid of the old habits. Only three respondents in Kragujevac state that their family was supportive, that the family did not contribute to the development of addiction, and that they feel remorse for their addiction. They did not get any information on drugs or dangers thereof from their parents. Most often they were taught in the street. Most of our respondents in Kragujevac (interviews, focus groups) live with their parents. They mostly have no permanent relationships. 'A heroin addict is asocial, without a partner, all relationships are short-lived as the guiding star is heroin'. In choosing their partners they decide for someone similar to them (a boy is a dealer, a girl a heroin addict). Family and marriage constellations are usually intertwined: one lives in an extramarital relationship with a woman who is not an addict and has a 20-month old daughter, and at the same time provides for his wife, a married woman who also bore him a child. Only one respondent in Kragujevac had never had any contact with the population of drug addicts; neither his partner, nor his friends have nothing to do with drugs.

Psychoactive substances are most often taken out of sense of emptiness and void, or boredom, for feeling that life has no sense, and as one of the main reasons they cited the expected liberation from constant anxiety and tension. Besides, positive group dynamics, the sense of acceptance, and a "common cause" were also added. The same prevailing feeling is largely present today also among the young people, ways of solving the problem, too. There can hardly be any fun or a party with no alcohol or drug abuse. Observations made at Belgrade cafés show high degree of marijuana and alcohol abuse by young people (up to the age of 25) during their everyday outings and weekend fun and games, but quite seldom does one picture him or herself as a person with problems. In Kragujevac the use of psychoactive substances starts by the end of the elementary school. Survey results show the average age at which one starts using psychoactive substances is - 16.1 years. The first drug used is most commonly marijuana/grass (in about 90%). There are exceptions: a man smoked marijuana first when he was 28 years old, then switched to heroin; another one started using heptanone (methadone) intravenously when he was 25. Even though the response in 90% of cases is marijuana, great majority of respondents already used cigarettes and/or alcohol prior to this. Alcohol and cigarettes seem to be taken for granted, these are not recognized as psychoactive substances (?). The transition from marijuana to other drugs is not standardized. In 60,0% of cases there is a gap from 1 to 5 years until one starts to intravenously apply drugs. The transition is caused insufficient marijuana effects. Some respondents start with marijuana, only to switch to heroin in less than one year. At first they use heroin by smoking, sniffing, or administering it to other mucous membranes (often so, but not as a rule). The average age at the start of using drugs intravenously is 18.5 years. The decision to start using it intravenously is explained by a lack of money for the needed dose of heroin. Some respondents cannot explain why they start using the needle. Others yet have never switched to the intravenous use (2 respondents) only for fear from the needle.

In Novi Sad the majority of young drug users are unemployed and consuming drugs at the home and on the streets, where they spend the most of their free time, "loosing time" is their basic activity.

In Nis there are many more risks than protective factors. Young drug adicts are unemployed, their parents cover them with money for living, and very often they are involved in nonlegal and criminal activities. Sometimes they work at "normal" job places. There is a large number of destroyed and incomplete families. Some of respondents live with their grand parents, because their parents are abroad. Usually they belong to the middle class.

Out of 80 total drug addict interviewees, nine have completed elementary education, and only six are university postgraduates. The others are equally distributed among those who graduated from high schools and those who have begun but never completed university studies. More than three quarters of subjects are unemployed (only 7 employed), two are in sex trafficking, one is a family pension beneficiary, a girl lives with

a much older drug dealer, and a great number of them (more than two thirds) engage in criminal activities as a means to provide for drugs. Thirteen respondents were growing or are reaching adulthood without their parents (in institutions, at foster homes, with relatives), dozen of them live in incomplete families, and almost all of the rest in a dysfunctional family, in frigid relations, misunderstood by their kin, (only 13 out of about sixty subjects claim their parents understand them and are fighting for them). Most often it is the mother that fights for her child, and they usually take up the role of a guardian in the process of treatment, while fathers most frequently withdraw hastily. In the case of about a dozen addicts, parents are unaware of the problem, whether they live out of town, or the addict is still socially functioning properly, managing to hide the real condition.

Psychoactive substances are most often taken out of a sense of emptiness and personal void, or boredom, from feeling that life has no sense, and as one of the main reasons they cited the expected liberation from constant anxiety and tension. Besides, positive group dynamics, the sense of acceptance, and a "common cause" were also added. The same prevailing feeling is largely present today among young people, ways of solving the problem, too. There can hardly be any fun or a party with no alcohol or drug abuse. Observations made at Belgrade cafés show a high degree of marijuana and alcohol abuse by young people (up to the age of 25) during their everyday outings and weekend fun and games, but quite seldom does one picture him or herself as a person with problems. For a great majority of them marijuana use is the most common activity there is. Transfer to other and harder drugs than marijuana leads to psychological and physical (or only psychological) addiction, and the main motive for taking the drug is not lack of satisfaction, but fear of "cold turkey withdrawal, entering paranoia" (abstinence crisis, fear of. madness). Usually the whole life cycle and daily rhythm is closely connected with drug abuse. ("I have no alternative to drugs", says one of them.) There is nothing that they perceive in reality as more valuable than drugs, nothing to replace them. The threshold of tolerance to frustration is lowered, pleasure must begin right here and now, not much could be sacrificed, as, according to them, nothing makes any sense, anyhow.

CASE STUDY

Still, a 17 year-old parentless child, protégé of a juvenile home, abandoned i.v. drug abuse and considerably diminished his overall intake of drugs after he had embraced God, was baptized and started going to church. Not attempting to interpret the phenomenon, the therapeutical impact of grasping long-term and higher goals, and of subjugating oneself to them, has to be emphasized.

There are no regular meeting places in Belgrade for young drug users in all cities, no such points where they would gather in larger numbers days on end. There is only the park across from the National Institute for Addiction Diseases, while for all 4 cities: some clubs and cafés, techno and rave parties, the park near trade centres, vicinity of SKC (entrance, cd vendors' stalls, the park to the rear), doorways and vestibules, any secluded place in secondary school yards, these are just a small part of addicts' goings-on. The most important finding is that the largest groups of junkies usually gather in somebody's apartment, waiting for the dealer to bring the stuff, or in the drug dealer's flat, where they buy drugs before they use them. While making the deal on drugs, until they fix themselves. It almost invariably means taking the drug in a group.

There is not a single place in Kragujevac where drug addicts regularly gather. Interviews, focus groups, observations confirm that there is a part of town where there is a larger concentration of psychoactive substances users than in any other town establishment. There are several facilities in that part of the town where traces of drug abuse are apparent (syringes, needles, peaces of ampoule glass, joint butts), and there is lots of graffiti. The trade centre under construction that was observed is situated 10 to 15 metres from an apartment building, about 200 m from an elementary school, and 250 m from a police station. The younger part of the population (those under 18) is mostly in another part of town. A part of the city park where drugs are used was also mapped. This part is rather convenient as it is deserted, secluded, and still close to the town's centre. The Trodon road (once the Valoron road) is a road that connects the observed town establishment with the park, along which the traces of drug abuse are evident, other equipment is also often found there. There are cafés in Kragujevac known to be places where drug deals are made (mediation in purchase, mediation in

offering lawyer's services, mediation in sexual favours sale). Those who are not told beforehand what is to be observed can find it hard to detect what kind of business is dealt in there. There is another café in town where drugs (grass) are used more freely. Other identified and observed spots in Kragujevac are schoolyards, vicinity of apartment buildings, and cellars in some apartment buildings, elite parties. Schoolyards are places where used equipment is found, but no intravenous drug addicts are among pupils (interviews, focus groups with psychologists, pedagogues, school principals, teachers, the police). Dealers who sell grass in front of schools are noted. Used equipment can also be found in the vicinity of apartment buildings, mostly where a dealer lives. There were instances when drug addicts gathered in an apartment building cellar, leaving the equipment on post-boxes at the entrance. Drugs in Kragujevac are commonly taken individually, out of larger groups. Parties at friends' apartments are places to use grass in company. There, at these parties, they use a mix of cigarettes, alcohol, and grass. There is no data on specially organized parties for the use of heroin.

An increase in drug addiction in Novi Sad is observed through triangulation within interviews with psychologists, teachers, and policemen. The street is the most important place in Novi Sad for young drug addicts. Most often marijuana and heroin are used in Novi Sad.

Concerning the situation in Belgrade, almost three quarters were treated at the Institute for Addiction Diseases and they ALL have an extremely bad experience:

- Stern and often unfair rules as to whom to admit or not for treatment, so that many of them are left unassisted
- At the entrance, at the reception desk, the nurses are heavy smokers, which is strictly forbidden to patients
- Communication with doctors and nurses is cold and official, without any traces of human empathy and understanding, without true motivation
- The prevailing mood at the Institute is that of alienation, patients feel like guilty parties, discarded members of society, instead of being treated as persons with problems
- Small number of doctors as compared to the number of patients
- There is no truly multidisciplinary approach to treatment, no real psychotherapy, no work therapy, at the same time getting together is not encouraged, necessary homogeneity of a group is not respected.
- Sexual intercourse at the Institute is frequent, but there are no condoms!!!
- Once caught in the act of drug abuse, the patients are discharged for 6 months to one year, the money deposit is held back, and they are thus pushed even deeper into abuse.
- The methadone programme is available only to those who are addicts for more than 15 years, and to HIV-positive patients
- Methadone dosage is highly suspicious to most of patients, for they do not feel the expected effects
- Methadone is distributed on a daily basis, so that even fifty year-old patients have to make a long journey every day, coming from surrounding towns to Belgrade for their daily doses, no compassion shown by the staff.

At the onset of a crisis they do not know whom to turn to. Ambulances arrive rather late, and then doctors do know not where to take their patient to, particularly if they are HIV-positive. Insulin syringes of the kind drug addicts use can seldom be found in pharmacies.

Not many health facilities would take them in when they come to seek help in a crisis, there are no appropriate protocols for this. The social medical service documentation of the Clinical Centre of Serbia states neither the drug addiction nor the drug types, especially as the diseases and the causes of death certificates do not legally require addiction to be reported. Intravenous addiction is not separated as a diagnosis by the International Classification of Diseases. The admission protocol of the Emergency Centre of Serbia contains no section where addiction could be stated. The files at the Institute for Psychiatry are somewhat more in order (in 2000 - they had 2 cases, and in 2001 - 4 cases of polytoxicomany, 2 without i.v., 1 heroin addict without i.v., and 1 user of LSD).

Most of the interviewees maintain that at the time they started using drugs they were not informed enough of risks and eventual consequences.

The interviewed teachers and pedagogy-psychology staff members at secondary schools emphasise a far better theoretical knowledge among the young people, as opposed to fully conscious, experienced perception of risks concerning substance abuse and unsafe sex.

7.1.6 Risk and Protective Behaviour

The commonest age is 14 to 16, usually together with a small group of close buddies or at a party. Among our respondents the earliest beginning was at the age of 10, the latest at 19. Similar findings were collected through questionnaire survey. The greatest number of respondents started using drugs by smoking marijuana, one started with sniffing glue, and two started directly by inhaling heroin (at the ages of 16 and 17). A move onto hard drugs (stronger substances) is caused by diminishment of marijuana effects, and by an urge to explore other states of consciousness. On average this happens after one to three years from first marijuana use (in our case, it was one month at the earliest, and at the latest it was 6 years after the use of marijuana, when the subject was 22 years old).

The decision to start taking drugs intravenously is often in connection to an idol, a close friend, an acquaintance, someone who initiates the individual into the ritual. At the onset of i.v. drug abuse the activities are more likely to be performed in a group, rarely by oneself. The wish to experince "the flash", a brief state of "oblivion", unattainable if the drug is taken nasally ("sniffing") due to insufficient blood concentration of the substance taken that way

The most commonly used substances in our country are: marijuana (grass), heroin (horse, dope), ecstasy (nails), LSD (trip), amphetamines, cocaine, benzodiazepines (Bensedin mostly; others less frequently), analgesics (Trodon), and also anti-Parkinsonians (Akineton, Artane), opium poppy tea, and sometimes codeine powder or syrup.

Marijuana (Cannabis, Indian hemp) is often domestically grown or imported from Albania ("albanka"). It is dried, minced, and mixed with tobacco, so that it can be rolled into a specific sharp-smelling cigarette (joint). A single dose of marijuana (1g) costs about DM 1,5 - 2. It is very largely used at parties, in cafés, and it has become a household word of every young person's life in the cities.

Heroin is seldom found pure, it is almost invariably mixed with flour or powdered sugar, with the ratio sometimes going up to 50:50 - same quantities of heroin and of added substance(s). The white powder is either swallowed, sniffed, or used intravenously. Sniffing can damage the nasal cartilage, so that improved techniques are introduced - new banknotes are rolled into a pipe and then used to snort the powder. This causes bleeding in the nasal cavity, and as the notes go round this may be a new channel of HIV blood transmission. The price depends on the market, most of all on the quantity taken: 1/4g - DM 15-20, 1/2g - DM 30, 1g - DM 60, 5g - DM 200.

Cocaine, white powder, usually sniffed, infrequently taken orally (rubbed onto gums), smoked, or injected, and the effects are stimulating, as opposed to those of heroin. Unlike heroin, which is rather widely used among larger groups of show biz people (rock musicians use it together with grass and alcohol), cocaine is consumed by upper class rich people, nouveaux riches (so called businessmen), those on the other side of the law, turbo-folk stars, and some politicians are also prone to use it at weekends on rare occasions. The price per 1g is DM 70-120 and higher, depending on total quantity purchased. Cocaine is not used in this country as widely as in the States, becoming a scene among a larger number of consumers only on weekends or at anniversaries and celebrations, such as New Year, when it is usually somewhat cheaper and more readily obtainable.

Ecstasy - psycho stimulant synthetic (out of amphetamine), amply distributed at rave parties, but also widely used in general. It comes in the form of spiky powder or tablets with an impressed logo.

One tablet is DM 10-15 (DM 7 and higher).

Opium poppy tea is extremely popular with heroin addicts as an additional compensation for lack of heroin, but also as a complete substitution for heroin for a period of time. A small bag is DM 10-15, and 1dl of very strong tea is enough to replace a dose.

Methadone (Heptanon) is a synthetic drug, substitute for heroin. It is used in substitutional therapy, distributed as liquid (drops) or tablets. A box of 20 tablets is DM 70-90, covering 2 to 5 days, depending on addiction status. All mentioned drugs are supplied by a drug dealer, but meeting points differ: addict's flat, the dealer's apartment, doorway or a café, street booth or a schoolyard. In case a larger quantity is bought, the price goes down considerably so junkies often pool their money.

Unlike the above mentioned drugs, benzodiazepins, Trodon, anti-Parkinsonians are sold freely in private drugstores, (state-owned pharmacies follow the instructions on prescribed drugs), and what makes it worse is that they are not on the double-recipe list. As the sale is not regulated at the feder-

al level by the Law on Psychoactive Drugs Trafficking, the private pharmacies use this loop to sell these potentially dangerous drugs unprescribed. These drugs are often consumed together with marijuana and alcohol.

In Kragujevac Heroin is procured from Turkey via Bulgaria, local distribution is town-based. Prices in Sofia, Bulgaria, are DM 20-25.000 per kilogram; in Turkey it is DM 15-17.000 per/1 kg. Street costs in our country: DM 40 - 60/gr. There has never been so much heroin about, of such low quality, and so cheap than today. As a comparison, the heroin in the town is purer than in Belgrade, and of worse quality than the one in Niš. There are numerous ways of supplying drugs in Kragujevac, but presently the most common is to supply it without a mediator: after a telephone contact is established with a dealer, a meeting is set, money is given to the dealer, and drugs are finally left at a third spot, thus avoiding police. It is conspicuous that all respondents in Kragujevac reluctantly speak about dealers, or refuse to talk about it at all. 'If a dealer is nicked, you got no drugs, you got to get it in another town, it all just makes the situation more complicated', says one of the participants in a focus group; for the older addicts squealing is a code which is unbreakable. There are instances of a dealer fawning to someone who is already charged with some crime to accept the dealer's charge as well and thus be provided for free with heroin while in jail. Drug addicts cannot be persuaded that a dealer uses the same drug as s/he does. Some dealers do not use drugs.

Out of 62 i.v. drug users only four of them have never used somebody else's syringe or given their own to others. A great majority of them have more often than not exchanged their needles and syringes in the past, and although they do it quite rarely now, it still happens with those they feel "secure" with. (An addict unwillingly infected her own sister with HIV this way and both are now deceased, as was reported in the focus group of Dec.18, 2001). Frequency of use depends on one's financial means, degree of addiction, and similar. It ranges in our survey from 4-5 times a day (a female respondent living with a drug dealer) to several times a week, and four of our respondents made a six-month to one-year break trying to come off the drug and get "clean".

CASE STUDY

Preparation ritual and use of hard drugs is ALARMINGLY unhygienic and risky: Heroin is boiled with tap water in a common spoon (boiling of the drug in a dirty bottle cap was observed across the Narco-Centre) wherefrom it is filtered through cotton with a shared needle, into a shared gun, and only then is it shot into other syringes the cotton balls are not wasted, they are routinely put aside in a box and stored for a time when there is no drug available around, when these are boiled over again in an attempt to drain the last droplets out of them. Only slightly over one quarter of respondents use a single-use kit; most often the equipment is previously used, boiled in water afterwards or rinsed in alcohol, a bleacher, or even dishwashing liquids. Attempts at pointing the needle to the blood vein can sometimes last up to 45 minutes, with different types of blood all over the place. Addicts are utterly mindless (the bloody cotton balls, if thrown away, are just thrown into a trash bin).

In Kragujevac not a single respondent claimed s/he ALWAYS uses a clean and new kit - syringe and needle! Not a single respondent claimed that during his/her addiction (short or long) s/he USED ONLY HIS/HER EQUIPMENT! There are some who clean their kits regularly, but only at first; later on, it ceases to be important.

7.1.7 Health and Social Consequences

Almost all respondents feel more or less stigmatised and rejected by society, family and friends, and to a large extent by the health system expected to offer them adequate help. Customarily, they are understood only by members of their own sub-group, and the plight is even worse with the HIV-positive persons.

Depression, ever present anxiety, lack of concentration, impaired physiology of the nervous system by substance abuse combined with constant fear, makes these people strung-out in permanent craving for drugs, scrounging for money, living in anguishing loneliness, without support and with every-

day living problems creating a vicious circle to live in. A dozen of them have flashback recurrent experiences of formerly used LSD, and the same number had gone through an epileptic fit (caused by Trodon). Almost one third of them feel a necessity to take strong antidepressants and anxiolytics due to severe attacks of depression.

More than one third had gone through an overdose experience, and more than one half of these were in that state twice or several times.

One half tested for HIV, in Belgrade 15 are HIV-positive. A dozen of them have hepatitis B, the same number hepatitis C, which is considered only to be the tip of the iceberg (many have never tested themselves for hepatotropic viruses). One respondent has diabetes.

Over one half of heroin addicts in Belgrade of long standing rank have a permanent sexual partner, having sex without protection. It seems that those who are not in permanent relationships do not have a considerable number of sexual contacts, most probably attributable to decreased sexual urge due to depression. More than one half out of the latter group use condoms sometimes or always. On the other hand, teenage users of psychoactive substances, rave party goers, as well as those addicts whose mental health is not seriously damaged, have more frequent sexual intercourse, often rather uncritically, in a state of altered consciousness, and unfortunately, under such circumstances, safe-sex is the last thing they would think of. Less than one half of respondents in this group always or sometimes use condoms. The youngest drug abusers use condoms only on a few occasions, the most common two reasons given are, "I'm looking for innocent girls to have sex with", recklessly heedless of the possibility to transmit a disease to the girl, and the second is, "I don't like condoms, and what's the point anyway, since they burst so often.".

No less than three girls in Belgrade had aborted unwanted pregnancies.

As already stated, very few respondents are permanently employed.

Over a half of them, some rarely, others more often, engage in crime in order to gain money for drugs.

Seven of Belgrade respondents were taken to prison for selling drugs, and once incarcerated they were beaten to blood (without a prior check-up of their HIV status, even though one of them is HIV-positive), three of them went though the abstinence crisis with no help provided, the crisis itself being turned against them as means of securing confession.

Five Belgrade female respondents had sexual intercourse for money used to buy drugs.

Observations made at a Home for Juvenile Delinquents in Belgrade suggests that these institutions are in fact places where young people, left without proper work in poorly organized establishments, gain extra craft and skills in criminal enterprises, and rarely does anyone leave an institution like that truly or at least partly rehabilitated. Thefts and burglaries in neighbouring apartments and the vicinity, drug abuse, risky sex contacts, unwanted pregnancies, those make up the common background of these institutions.

Belgrade In-patient clinics (where correctional work begins) is not separated form the admission facility (with a constant inflow of new wards), and together with pedagogically unjustified mixing of different types of personalities and of their delinquencies due to lack of space, these contribute unfavourably to addiction Out of 70 inmates at Home, 50-60 use drugs constantly, 2 of them are i.v. addicts. In the last two months there were two ODs and two abortions.

In Kragujevac, in all interviews and focus groups among target groups a group of drug addicts report that the topic of infection is hardly discussed among them. Even when they suspect someone is infected, it is not mentioned out loud. It is only alluded once one dies. As perpetrators, or while in investigation prison, they often claim to be HIV+, though it cannot be ascertained, because they think it could alleviate the punishment. Work with family is particularly troublesome if there are one or more members who are HIV+.

7.1.8 Existing Interventions

All our respondents were unanimous in assessing that the past measures undertaken in AIDS prevention are insufficient, one-sided, and sporadic. Ambulances arrive late, health care institutions are entirely uncoordinated, and patients' admission protocols are incomplete, leaving no possibility for adequate statistical follow-up of patients who come with problems related to drugs.

In case of onset of an abstinence crisis late in the evening or overnight the subjects do not know whom to ask or where to go for help. Psychiatrists, who privately practice and apply different psychotherapies, methods and programmes of re-socialisation in the treatment of drug abusers, charge minimally DM 30 per session, thus remaining unavailable to most of the addict sub-population.

Addicts are often mistreated by the medical staff as crooks and law offenders, having only themselves to blame for their own predicament, and not as persons with problems.

A lot of rock musicians ruined their careers because of heroin addiction, some of them died, many are rather interested in joining the prevention activities, but do not know how, so that some method of organising them is evidently needed.

The assessments made by psychology-pedagogy staff at secondary schools show a presence of marked aggressiveness among young people, intolerance to everything that differs, use of marijuana is growing enormously, sexual activities start at a decreasingly lower age and almost never with protection, cooperation between parents and teachers is almost nonexistent, as are organized measures of prevention. Besides the St. Sava High School where they developed a project "Talking Makes Us Happy", and the 13th Gymnasium where the Group 484, in the form of workshops, conducts addiction prevention programme "Escape To Dead-End Street", all other prevention measures (education of teachers by Ministry of Interior officers, various forms of peer education, occasional lectures by JAZAS Youth of), are sporadic, incoordinated, and most often initiated by teachers and school services themselves.

Secluded and dimly lit corners of a school yard may often turnout to be a meeting point of local addicts, and sometimes of school children, and elementary school pupils are lately used by drug dealers as means of getting through to high-school students.

There is not a single organized prevention programme at the Ministry of Education level, Ministries of Interior, Health, Education, and the Ministry of Work and Social Issues have their coordination teams set up to follow the health situation in the country, and the Institute for Addiction Diseases and the Institute for Mental Health (the Serbian Government is founder of both institutions) are undertaking a juvenile addicts programme.

There are several NGOs dealing with issues of addiction and sexuality:

GOD - Generation Response To Drugs (Generacijski odgovor drogama), with goals set to offer support to young people in getting themselves out of their addiction problem

ALEXO - struggle for social justice and medical protection of HIV-positive people and those affected with AIDS

HIV/AID - in January 2001 a concert of classical music was organized at the Kolarac University for the benefit of AIDS affected people, and the amount of money collected was used to buy reagents for counting CD4 lymphocytes.

JAZAS,

JAZAS Youth of (Omladina JAZAS-a) - with the aim of preventing HIV/AIDS and addiction diseases, as well as the programme of psychosocial support to affectedpersons

Group 484 - programmes of addiction prevention ("Escape To Dead-End Street"), educational-prevention programmes

Sexology Studies Centre (Centar za seksološke studije) www.geocities.com/cssbeograd,

Belgrade Open Club (Beogradski otvoreni klub) with an Internet counselling service (www.savetovaliste.org.yu), but their actions are incoordinated and few. There is no coordination betwen the Government of Serbia, so that their drives (except in the case of JAZAS) often pass unnoticed, while young people hardly know they exist, let alone know about the possibilities of work.

Not a single research participant was satisfied with what has been done in Kragujevac concerning drug addiction and risk behaviour. Dissatisfaction is directed to what has (not) been done at a wider state level. Different groups perceive the causes and consequences differently. In Kragujevac a City Assembly's drive to prevent drug addiction named "Think About It" is underway. The drive is continual, encompassing several subjects: Psychiatric Clinic, **NGO 3D (Don't do drugs)**, all town schools, media. The town is also participating in the "Play for Life, No to Drugs" drive. According to drug addicts' statements in Kragujevac there is not a single NGO in town dealing in risk behaviour and problems relating to HIV infection, or working with these groups; extreme dissatisfaction with the psy-

chiatric service or other health services' work; prison services are also assessed as inadequate for the purpose (for example, the only physician-consultant at the Prison is a gynaecologist!). There are more drugs in prison than out; it is purely a drug addiction environment. A respondent sentenced to compulsory treatment for drug abuse or HIV+ would rather choose the prison, not the hospital, as there he could find other inmates besides drug addicts. The law was assessed as inefficient, police procedure as brutal.

There is no coordination betwen the Government of Serbia, so that their drives (except in case of JAZAS) often pass unnoticed, while the young people hardly know they exist,

7.1.9 Recommendations for Interventions

The level of PRIMARY PREVENTION:

- Organized, coordinated, continuous, and expert action of the social community aimed at target groups: population under risk (preadolescents and adolescents), parents and teachers, the police, as well as drug abusers themselves
- Education of adolescents has to comprise a complex, specific approach to personality as a whole, and should enable them to cope with social pressures in a constructive and not a defensive way. Education of educators is to be completed beforehand.
- Education of adolescents is to respect in full the progressive and modern methods, renouncing the preachings ex cathedra
- Education of parents - learning of constructive communication with their children
- Programmes of peer education
- Education of teachers and psychology-pedagogy staff in recognizing the problem, in constructive conversation, in giving example of positive use of social skills
- Lighting of school yards with improved supervision
- Propaganda of programmes and projects of different institutions, NGOs, individuals and services, whose work may be useful to young people
- Education of journalists in television and newspaper houses, in constructive approach to addiction problems, not the provocative way and sensationalism which make false heroes
- AntiAIDS campaigns organized continuously and well proportioned, not only on the occasion of the Anti-AIDS Day, which turns the initial intention into a frivolous one
- Coordinated action of the ministries of health, education, and the interior, on the one hand, and schools, on the other, the object of which is to devise a long-term and continual prevention programmes
- Inclusion of ever growing number of ex-addicts, as well as HIV-positive persons, which can prove to have multiple positive effects
- Strict control of admittance age at techno and rave happenings (so far, those younger than 18 were also admitted)
- Improvement of police actions in disclosing and suppressing the drug spreading routes
- Continuous education of young addicts, informing them of consequences, protective measures, and preservation and improvement of health
- Making the health protection system accessible to this sub-population, controlling the health situation and early discovery of illnesses
- Placement of condom slot machines at several places downtown
- Establishment of coordinated activities of NGOs dealing with the same or similar issues, attempts at uniting forces in joint ventures, establishment of coordination between the NGOs, the Government, and the relevant minitries, and foundation of adequate health services
- Introduction of centralized control of drug distribution, and more severe fines for pharmacists who supply unprescribed drugs (establishment of special inspections for this purpose).

The level of SECONDARY PREVENTION:

- Education of selected personnel at key positions in health protection institutions in good management and appropriate policy realization
- Introduction of standardized therapy protocols in the whole of Yugoslavia, thereby avoiding arbitrariness of doctors and uncontrolled application of treatment
- Adoption of multidisciplinary approach to addictions: medical, social, and rehabilitation programmmes

- Serious application of psycho-social and family therapies, alongside medical treatment for addiction
- In addition to hospital treatment, determined introduction of partial hospitalization (day and night hospitals where addicts could come for help day and night), and establishment of adequate clinics with counselling services for addicts and their families
- Work at a more humane, highly emphatic approach to people with a problem
- Standardization of admission protocols for easier statistical follow-up of the phenomenon

The level of TERTIARY PREVENTION:

- Programme of comprehensive long-term (1-5 years) resocialization of individuals
- Establishment of rehabilitation centres for drug addicts
- Coordinated action of the police, the Narco-Centre services, and of the Social Work Centre
- Efforts in introducing former addicts into everyday activies, finding them jobs, etc.
- Education on healthy life styles, precaution measures, safe sex contacts, and use of i.v. kit (in case no treatment is saught for)
- Programme of needle exchange decreases the risk of transmitting virus infections, and helps the society in creating a more realistic picture on number of i.v. addicts, and in realizing certain action measures and education of this group ofpeople (opportunity for direct contact)
- Day-and-night availability of single-use needles and syringes in all pharmacies, diminishing to a certain degree the necessity to use one needle in a group.

7.2 YOUNG MEN WHO HAVE SEX WITH MEN

7.2.1 Core Survey Questions

More then two thirds (73,9%) of young MSM in this assessment belong to the 20-24 age group with slight differences between 3 sites (Novi Sad: 59,2% Belgrade: 73,9% Nis: 77,1).

7.2.2 Sexual Behaviour

The mean age at their first sexual intercourse was 16,5 without differences among sites:

- Belgrade: 16,5
- Nis: 16,1
- Novi Sad: 16,4.

Distribution of frequency also pointed that at the national level most of young MSM has sexual inter-

Table 17. **Age groups**

	Total		City							
	No.	%	Belgrade		Nis		Novi Sad		Kragujevac	
			No.	%	No.	%	No.	%	No.	%
10 - 14	4	1.3%	1	.6%			3	3.9%		
15 - 19	74	24.7%	35	20.7%	11	22.9%	28	36.8%		
20 - 24	221	73.9%	133	78.7%	37	77.1%	45	59.2%	6	100.0%
Total	299	100.0%	169	100.0%	48	100.0%	76	100.0%	6	100.0%

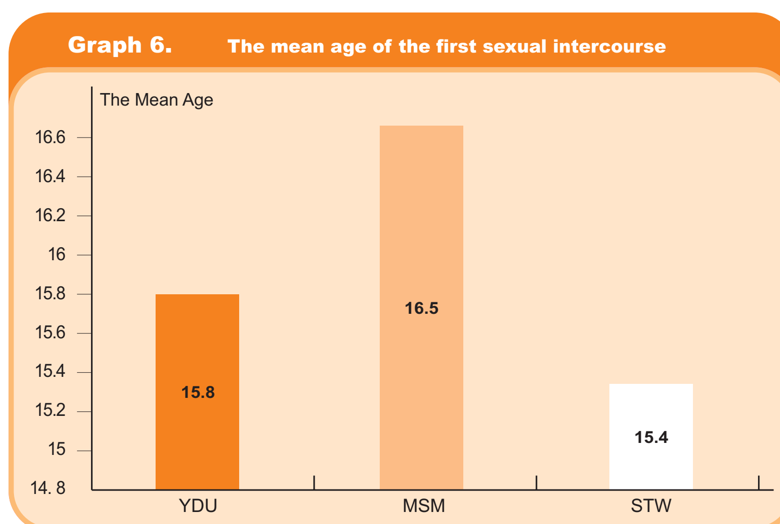
course at 15 and 16 years. A difference is noticed in Novi Sad where the biggest number according to frequency distribution had their first sexual experience at 17 years.

Table 18. Most frequent age at the first sexual intercourse

	Total		City							
			Belgrade		Nis		Novi Sad		Kragujevac	
	No.	%	No.	%	No.	%	No.	%	No.	%
N.A.	96	32.1%	45	26.6%	35	72.9%	10	13.2%	6	100.0%
10	1	.3%	1	.6%						
11	1	.3%			1	2.1%				
12	12	4.0%	11	6.5%			1	1.3%		
13	9	3.0%	5	3.0%	1	2.1%	3	3.9%		
14	18	6.0%	9	5.3%	2	4.2%	7	9.2%		
15	28	9.4%	17	10.1%	1	2.1%	10	13.2%		
16	34	11.4%	19	11.2%	2	4.2%	13	17.1%		
17	35	11.7%	18	10.7%	1	2.1%	16	21.1%		
18	24	8.0%	15	8.9%	3	6.3%	6	7.9%		
19	20	6.7%	13	7.7%	1	2.1%	6	7.9%		
20	9	3.0%	5	3.0%	1	2.1%	3	3.9%		
21	9	3.0%	8	4.7%			1	1.3%		
22	1	.3%	1	.6%						
23	1	.3%	1	.6%						
24	1	.3%	1	.6%						
Total	299	100.0%	169	100.0%	48	100.0%	76	100.0%	6	100.0%

The average year of having the first sexual intercourse is presented in Graph 6.

Graph 6. The mean age of the first sexual intercourse



In general less then half of them (in average 41,1%) have permanent sexual partners except the group from Novi Sad (61,8%).

For this target group the average number of sexual partners in the last year is 10,3, according to the cities the average number of partners is the following:

- Belgrade: 12,9
- Novi Sad: 5,7
- Nis: 5,2.

Table 19. Presence of permanent partner

	Total		City							
	No.	%	Belgrade		Nis		Novi Sad		Kragujevac	
			No.	%	No.	%	No.	%	No.	%
N.A.	2	.7%	2	1.2%						
no	174	58.2%	109	64.5%	30	62.5%	29	38.2%	6	100.0%
yes	123	41.1%	58	34.3%	18	37.5%	47	61.8%		
Total	299	100.0%	169	100.0%	48	100.0%	76	100.0%	6	100.0%

The maximum is even 60 partners. However 59,2% of them have no more then 5 partners in the same period

Table 20. Frequency distribution of the numbers of partners is presented in the table bellow: The number of partners during the last year

	Total		City							
	No.	%	Belgrade		Nis		Novi Sad		Kragujevac	
			No.	%	No.	%	No.	%	No.	%
.00	7	3.8%	1	.8%	4	12.1%	2	6.5%		
1.00	26	14.0%	11	9.3%	8	24.2%	7	22.6%		
2.00	25	13.4%	18	15.3%	1	3.0%	6	19.4%		
3.00	19	10.2%	12	10.2%	2	6.1%	4	12.9%	1	25.0%
4.00	18	9.7%	13	11.0%	4	12.1%	1	3.2%		
5.00	15	8.1%	7	5.9%	4	12.1%	4	12.9%		
6.00	11	5.9%	6	5.1%	4	12.1%	1	3.2%		
7.00	9	4.8%	6	5.1%	1	3.0%	1	3.2%	1	25.0%
8.00	4	2.2%	4	3.4%						
9.00	1	.5%					1	3.2%		
10.00	13	7.0%	10	8.5%	1	3.0%	1	3.2%	1	25.0%
12.00	4	2.2%	4	3.4%						
13.00	1	.5%	1	.8%						
14.00	1	.5%	1	.8%						
15.00	7	3.8%	5	4.2%	2	6.1%				
17.00	3	1.6%	2	1.7%					1	25.0%
20.00	10	5.4%	8	6.8%	1	3.0%	1	3.2%		
24.00	1	.5%	1	.8%						
28.00	1	.5%	1	.8%						
30.00	4	2.2%	2	1.7%	1	3.0%	1	3.2%		
40.00	3	1.6%	2	1.7%			1	3.2%		
50.00	1	.5%	1	.8%						
60.00	1	.5%	1	.8%						
500.00	1	.5%	1	.8%						
Total	186	100.0%	118	100.0%	33	100.0%	31	100.0%	4	100.0%

Less then half (41,5%) always use condoms during sexual intercourse, but this preventive practice is almost completely missed during the oral sex (only 10% reported permanent use of condom in this type of sex). Though the differences among cities is small it has been noticed that the general care about the preventive practice of using condoms is most often present in Nis.

Table 21. **The practice of condom use**

	Total		City							
	No.	%	Belgrade		Nis		Novi Sad		Kragujevac	
			No.	%	No.	%	No.	%	No.	%
Always	124	41.5%	70	41.4%	22	45.8%	32	42.1%		
Sometimes	141	47.2%	78	46.2%	18	37.5%	39	51.3%	6	100.0%
Never	34	11.4%	21	12.4%	8	16.7%	5	6.6%		
Total	299	100.0%	169	100.0%	48	100.0%	76	100.0%	6	100.0%

Table 22. **Condom using during the oral sex**

	Total		City							
	No.	%	Belgrade		Nis		Novi Sad		Kragujevac	
			No.	%	No.	%	No.	%	No.	%
N.A.	1	.3%			1	2.1%				
yes	30	10.0%	13	7.7%	4	8.3%	13	17.1%		
Sometimes	52	17.4%	17	10.1%	8	16.7%	26	34.2%	1	16.7%
No	216	72.2%	139	82.2%	35	72.9%	37	48.7%	5	83.3%
Total	299	100.0%	169	100.0%	48	100.0%	76	100.0%	6	100.0%

Table 23. **Condom using during the anal sex**

	Total		City							
	No.	%	Belgrade		Nis		Novi Sad		Kragujevac	
			No.	%	No.	%	No.	%	No.	%
N.A.	3	1.0%			1	2.1%	2	2.6%		
yes	152	50.8%	85	50.3%	26	54.2%	38	50.0%	3	50.0%
Sometimes	100	33.4%	56	33.1%	12	25.0%	31	40.8%	1	16.7%
No	44	14.7%	28	16.6%	9	18.8%	5	6.6%	2	33.3%
Total	299	100.0%	169	100.0%	48	100.0%	76	100.0%	6	100.0%

During anal sex the situation is much better but still unsatisfactory (only 50,8% using condom in such occasion). The reported reasons for not "always" using condoms are the following: do not like sex with condom (25,8%), having trust in partner (23,7%), condoms are too expensive (9,0%), condoms are not easily available (7,7%), difficult to use (6,7%), etc.

The reasons slightly differ according to cities. For example the main reason for young MSM from Novi Sad is "having trust in partner", followed by "do not like sex with condoms".

Table 24. Reasons for not using condoms

		Total	City			
			Belgrade	Nis	Novi Sad	Kragujevac
Base		N=299	N=169	N=48	N=76	N=6
Too expensive / cannot afford	Cases	27	13	2	12	
	%	9.0%	7.7%	4.2%	15.8%	
Embarrassed to buy	Cases	8	3	4	1	
	%	2.7%	1.8%	8.3%	1.3%	
Difficult to use	Cases	20	6	2	12	
	%	6.7%	3.6%	4.2%	15.8%	
Not easily available	Cases	23	3	2	18	
	%	7.7%	1.8%	4.2%	23.7%	
Don't like sex with condoms	Cases	77	30	15	29	3
	%	25.8%	17.8%	31.3%	38.2%	50.0%
Embarrassed to ask partner to use	Cases	9	4	4	1	
	%	3.0%	2.4%	8.3%	1.3%	
I have trust in my partners	Cases	71	24	13	32	2
	%	23.7%	14.2%	27.1%	42.1%	33.3%
No knowledge / awareness about the benefits of using condoms	Cases	2	2			
	%	.7%	1.2%			
Other reasons	Cases	5	2	1	2	
	%	1.7%	1.2%	2.1%	2.6%	

Those who had sexual intercourse with someone in return for money, drugs etc comprise 13% out of all respondents.

Table 25. Those who had sexual intercourse in return for money, drugs, etc

	Total		City							
	No.	%	Belgrade		Nis		Novi Sad		Kragujevac	
			No.	%	No.	%	No.	%	No.	%
No	260	87.0%	142	84.0%	41	85.4%	73	96.1%	4	66.7%
Yes	39	13.0%	27	16.0%	7	14.6%	3	3.9%	2	33.3%
Total	299	100.0%	169	100.0%	48	100.0%	76	100.0%	6	100.0%

They usually meet their sexual partners at gay hot spots (41,5%) and by searching the Internet (34,1%).

7.2.3 Health Seeking Behaviour

The places where they get information about HIV or other STIs are usually the media (69,6%) followed by friends (58,5%).

Table 26. The places where they get information on HIV or other STIs

		Total	City			
			Belgrade	Nis	Novi Sad	Kragujevac
Base		N=299	N=169	N=48	N=76	N=6
Family	Cases	43	23	6	13	1
	%	14.4%	13.6%	12.5%	17.1%	16.7%
Friends / peers	Cases	175	91	23	58	3
	%	58.5%	53.8%	47.9%	76.3%	50.0%
Media	Cases	208	123	41	39	5
	%	69.6%	72.8%	85.4%	51.3%	83.3%
School	Cases	72	31	12	29	
	%	24.1%	18.3%	25.0%	38.2%	
Social / health workers	Cases	44	26	8	8	2
	%	14.7%	15.4%	16.7%	10.5%	33.3%
STI counselling services	Cases	33	14	9	9	1
	%	11.0%	8.3%	18.8%	11.8%	16.7%
Other places	Cases	25	16	5	3	1
	%	8.4%	9.5%	10.4%	3.9%	16.7%
Nowhere NO PLACES	Cases	10	8	2		
	%	3.3%	4.7%	4.2%		

Even 85,2% assess that they have a high or moderate risk of HIV or other STIs. The least perception of risk is Novi Sad, while the highest is in Belgrade.

Table 27. The risk for HIV or other STIs

	Total		City							
	No.	%	Belgrade		Nis		Novi Sad		Kragujevac	
			No.	%	No.	%	No.	%	No.	%
N.A.	2	.7%	1	.6%			1	1.3%		
high	42	14.0%	30	17.8%	9	18.8%	3	3.9%		
moderate	184	61.5%	112	66.3%	23	47.9%	43	56.6%	6	100.0%
no risk	71	23.7%	26	15.4%	16	33.3%	29	38.2%		
Total	299	100.0%	169	100.0%	48	100.0%	76	100.0%	6	100.0%

Out of total 40,8% have been ever tested for HIV/AIDS, but only 13,4% for Hepatitis B and 12% for Hepatitis C. From those who have been tested 2,3% are HIV positive (Belgrade: 6, Novi Sad: 7).

Table 28. Testing practice

		Total		City							
		No.	%	Belgrade		Nis		Novi Sad		Kragujevac	
				No.	%	No.	%	No.	%	No.	%
HIV	NA.	92	30.8%	20	11.8%	13	27.1%	59	77.6%		
	No	85	28.4%	66	39.1%	16	33.3%			3	50.0%
	Yes	122	40.8%	83	49.1%	19	39.6%	17	22.4%	3	50.0%
Total		299	100.0%	169	100.0%	48	100.0%	76	100.0%	6	100.0%

		Total		City							
		No.	%	Belgrade		Nis		Novi Sad		Kragujevac	
				No.	%	No.	%	No.	%	No.	%
Hepatitis "B"	NA.	92	30.8%	20	11.8%	13	27.1%	59	77.6%		
	No	167	55.9%	123	72.8%	31	64.6%	8	10.5%	5	83.3%
	Yes	40	13.4%	26	15.4%	4	8.3%	9	11.8%	1	16.7%
Total		299	100.0%	169	100.0%	48	100.0%	76	100.0%	6	100.0%

		Total		City							
		No.	%	Belgrade		Nis		Novi Sad		Kragujevac	
				No.	%	No.	%	No.	%	No.	%
Hepatitis "C"	NA.	92	30.8%	20	11.8%	13	27.1%	59	77.6%		
	No	171	57.2%	129	76.3%	29	60.4%	8	10.5%	5	83.3%
	Yes	36	12.0%	20	11.8%	6	12.5%	9	11.8%	1	16.7%
Total		299	100.0%	169	100.0%	48	100.0%	76	100.0%	6	100.0%

Their knowledge about HIV is almost complete (above 92% for all questions assessing the knowledge).

Table 29. HIV positive out of those who were tested

	Total		City							
	No.	%	Belgrade		Nis		Novi Sad		Kragujevac	
			No.	%	No.	%	No.	%	No.	%
N.A.	202	67.6%	107	63.3%	44	91.7%	45	59.2%	6	100.0%
No	90	30.1%	56	33.1%	4	8.3%	30	39.5%		
Yes	7	2.3%	6	3.6%			1	1.3%		
Total	299	100.0%	169	100.0%	48	100.0%	76	100.0%	6	100.0%

In the last year 19% has had some type of STIs plus 5% ever in the past.

7.2.4 Drug Use Behaviour

Concerning drug abusing behaviour, less then half (48,3%) use drugs with average start at 16,2 years and 18,4% has experience of drug injecting with average start in 17,2. There are almost no differences between cities:

- Belgrade: 16,1
- Nis: 16
- Novi Sad: 16,9.

Table 30. Age when first use drugs

	Total		City					
	No.	%	Belgrade		Nis		Novi Sad	
			No.	%	No.	%	No.	%
10.00	1	.5%			1	7.7%		
12.00	4	2.0%	3	2.4%			1	1.6%
13.00	6	3.0%	5	4.0%			1	1.6%
14.00	8	4.0%	7	5.6%			1	1.6%
15.00	12	6.0%	9	7.3%	1	7.7%	2	3.1%
16.00	22	10.9%	18	14.5%			4	6.3%
17.00	14	7.0%	7	5.6%	3	23.1%	4	6.3%
18.00	16	8.0%	10	8.1%	2	15.4%	4	6.3%
19.00	3	1.5%	2	1.6%			1	1.6%
20.00	2	1.0%	1	.8%			1	1.6%
21.00	3	1.5%	1	.8%			2	3.1%
22.00	2	1.0%	2	1.6%				
N.A.	108	53.7%	59	47.6%	6	46.2%	43	67.2%
Total.	201	100.0%	124	100.0%	13	100.0%	64	100.0%

They usually use drugs in clubs/cafes and at home, with very small differences between cities, as could be seen from the table:

Table 31. Areas where usually use drugs

		Total	City			
			Belgrade	Nis	Novi Sad	Kragujevac
Base		N=299	N=169	N=48	N=76	N=6
Bars / café / clubs	Cases	56	36	3	17	
	%	18.7%	21.3%	6.3%	22.4%	
Home	Cases	39	28	4	7	
	%	13.0%	16.6%	8.3%	9.2%	
Streets	Cases	20	12	4	4	
	%	6.7%	7.1%	8.3%	5.3%	
Parks	Cases	25	17	4	4	
	%	8.4%	10.1%	8.3%	5.3%	
Schools	Cases	13	11	1	1	
	%	4.3%	6.5%	2.1%	1.3%	
Toilets	Cases	5	4	1		
	%	1.7%	2.4%	2.1%		
Other places	Cases	2	2			
	%	.7%	1.2%			
Friends house	Cases	24	24			
	%	8.0%	14.2%			
Party	Cases	33	33			
	%	11.0%	19.5%			

Only 23,4% of them use cannabis, while other types of drugs are presented with less then 10% (ecstasy - 9% followed by analgesic - 4,7% heroin - 2,3% and LSD - 2,3%).

Table 32. **Drugs most used in the last 1 month**

		Total		City							
		No.	%	Belgrade		Nis		Novi Sad		Kragujevac	
				No.	%	No.	%	No.	%	No.	%
Cigarette	N.A.	105	62.1%	41	85.4%	55	72.4%	6	100.0%	207	669.2%
	No	5	3.0%			4	5.3%			9	3.0%
	Yes	59	34.9%	7	14.6%	17	22.4%			83	27.8%
Alcohol	N.A.	105	62.1%	41	85.4%	55	72.4%	6	100.0%	207	69.2%
	No	11	6.5%			2	2.6%			13	4.3%
	Yes	53	31.4%	7	14.6%	19	25.0%			79	26.4%
Cannabis / marijuana	N.A.	105	62.1%	41	85.4%	55	72.4%	6	100.0%	207	69.2%
	No	13	7.7%			9	11.8%			22	7.4%
	Yes	51	30.2%	7	14.6%	12	15.8%			70	23.4%
Diazepam	N.A.	105	62.1%	41	85.4%	55	72.4%	6	100.0%	207	69.2%
	No	54	32.0%	7	14.6%	18	23.7%			79	26.4%
	Yes	10	5.9%			3	3.9%			13	4.3%
Ecstasy	N.A.	105	62.1%	41	85.4%	55	72.4%	6	100.0%	207	69.2%
	No	43	25.4%	4	8.3%	18	23.7%			65	21.7%
	Yes	21	12.4%	3	6.3%	3	3.9%			27	9.0%
Glue or inhalant	N.A.	105	62.1%	41	85.4%	55	72.4%	6	100.0%	207	69.2%
	No	63	37.3%	7	14.6%	21	27.6%			91	30.4%
	Yes	1	.6%							1	.3%
Amphetamines	N.A.	105	62.1%	41	85.4%	55	72.4%	6	100.0%	207	69.2%
	No	64	37.9%	7	14.6%	21	27.6%			92	30.8%
LSD	N.A.	105	62.1%	41	85.4%	55	72.4%	6	100.0%	207	69.2%
	No	58	34.3%	7	14.6%	20	26.3%			85	28.4%
	Yes	6	3.6%			1	1.3%			7	2.3%
Heroin	N.A.	105	62.1%	41	85.4%	55	72.4%	6	100.0%	207	69.2%
	No	57	33.7%	7	14.6%	21	27.6%			85	28.4%
	Yes	7	4.1%							7	2.3%
Methadone	N.A.	105	62.1%	41	85.4%	55	72.4%	6	100.0%	207	69.2%
	No	62	36.7%	7	14.6%	21	27.6%			90	30.1%
	Yes	2	1.2%							2	.7%
Cocaine	N.A.	105	62.1%	41	85.4%	55	72.4%	6	100.0%	207	69.2%
	No	62	36.7%	7	14.6%	21	27.6%			90	30.1%
	Yes	2	1.2%							2	.7%
Opium	N.A.	105	62.1%	41	85.4%	55	72.4%	6	100.0%	207	69.2%
	No	64	37.9%	7	14.6%	21	27.6%			92	30.8%
Analgesics	N.A.	105	62.1%	41	85.4%	55	72.4%	6	100.0%	207	69.2%
	No	54	32.0%	5	10.4%	19	25.0%			78	26.1%
	Yes	10	5.9%	2	4.2%	2	2.6%			14	4.7%
Total		169	100.0%	48	100.0%	76	100.0%	6	100.0%	299	100.0%

The small number (18,7%) ever taking two or more drugs at the same time. Practice of sharing drug-injecting equipment is far less present among this population then within young drug users previously presented. However it is worth mentioning that much more of them did not reply to this answer!

Table 33. The practice of sharing drug-injecting equipment

		Total		City							
				Belgrade		Nis		Novi Sad		Kragujevac	
		No.	%	No.	%	No.	%	No.	%	No.	%
	N.A.	283	94.6%	154	91.1%	47	97.9%	76	100.0%	6	100.0%
	Ne	9	3.0%	8	4.7%	1	2.1%				
	Yes	7	2.3%	7	4.1%						
Total		299	100.0%	169	100.0%	48	100.0%	76	100.0%	6	100.0%

Out of total, 19,4% ever had sexual intercourse under the influence of drugs. The most such behaviour is present in Belgrade, while the least in Novi Sad.

Table 34. Those who ever had sexual intercourse under the influence of drugs

	Total		City							
			Belgrade		Nis		Novi Sad		Kragujevac	
	No.	%	No.	%	No.	%	No.	%	No.	%
N.A.	209	69.9%	107	63.3%	41	85.4%	55	72.4%	6	100.0%
No	32	10.7%	18	10.7%	1	2.1%	13	17.1%		
Yes	58	19.4%	44	26.0%	6	12.5%	8	10.5%		
Total	299	100.0%	169	100.0%	48	100.0%	76	100.0%	6	100.0%

7.2.5 Context

Almost two thirds are still closeted to their parents, and most of them are apprehensive about a parental potentially very aggressive reaction. Almost all subjects who are out to their parents claim that acceptance on their part is merely verbal, reporting on morose silence about the matter, and lack of communication in general.

CASE STUDY

A 20 year-old respondent (commendable student of philosophy) was taken by his parents, upon telling them of his sexual orientation, to the re-known sexologist Dr Zoran Rakic of the Dragiša Mišovic Clinic, only to be retorted by the expert that they are the ones in need of therapy and treatment. The guy left home eventually.

A subject's parents take such precautions as to keep his toilet kit separately, fearing HIV infection, for, "If he's gay, he's likely to have AIDS."

The mother is commonly described as directly or indirectly a dominant person, and the father is usually a negative or an utterly passive figure.

One third of subjects are out to their straight friends who accept them in a fairly friendly way (particularly girls), while some of the others go to the greatest lengths in order to hide their sexuality. Heterosexual girls accept their friends' sexuality far more easily then their male counterparts, considering it cool to have a gay friend, as opposed to heterosexual boys who find it hard to receive them with approval. This is confirmed by other studies.

In case one has to turn for help to a health service one fears his/her sexuality might be exposed and stigmatised. They tend to seek help with private doctors, particularly the gay friendly ones, as they expect their anonymity to be better protected that way. If they need treatment for a condition that directly points to homosexual intercourse it takes them a long time to reach for help, even in case of highly educated interviewed gay persons.

7.2.6 Risk and Protective Behaviour

Mostly between 16 and 19 years of age, some later, with first partner being of the same age or slightly older, usually a neighbour or an Internet acquaintance. Condom was rarely used in the first sexual intercourse, unless the partner insisted

One third of subjects in permanent relationships, others have no permanent sexual partner. More than a half of subjects who have permanent relationships had 5-7 partners last year beside the regular one, apparently endorsing an open relationship. Others had about 20-30 partners each in one year.

The main channel of making acquaintances is the Internet chat (www.gay-serbia.com), and Internet personals (www.gay-serbia.com, www.oglasi.org.yu), the "X" Club is rated next, then follow friends' recommendations, parks, and other gay localities.

It seems that people who frequent parks, public lavatories are from lower educational and material strata, and they have a greater number of sexual intercourses with different partners (3-5 per week) than those who use other means of communication. Presumably, the parks, toilets, or the theatre, are for them more than just places to meet other gay people (like the "X" Club), but also the places where they can heedlessly and quickly indulge in sexual contacts. ("The reasoning goes blank in those joints", says one subject).

Commonly both anal and oral sexual acts are performed, few are those who engage in oral sex solely. Approximately each third oral sexual act ends with ejaculation in the partner's mouth. Two thirds of subjects use condoms always or sometimes in anal intercourse, the rest use protection rarely or never.

Out of those who use protection always or sometimes the number of those using condoms irregularly is by far larger than those who use them always (22 as opposed to 8), considered not to be a favourable figure. All HIV-positive subjects use condoms for anal intercourse. Almost none of them uses condoms in oral sex acts. One bisexual always uses condoms with males ("It's more likely to get AIDS"), and almost never with females.

The commonest reason given for not using any protection was the trust in one's partner, and the thought of diminishing the mutual trust by insisting on the use of condoms. Most often the confidence is not grounded in reality, as the partner is not tested and has no proof of his HIV status. The second reason not to use condoms is their dislike for safe sex, problems with the use of condoms (they often burst)

Most of the interviews could not make a difference between kinds of condoms and their purpose, they often buy the cheaper but thinner ones (price for a Durex extra safe is 95 to 105 dinars, thinner Romed condoms are 28 dinars), and confusion is added to by use of inadequate oil and greasy lubricants instead of water-based ones which cannot be obtained here.

A person may a show total absence of critical opinion, if aroused sexually at the moment he or she meets a physically very attractive partner, or if the partner is well endowed and one is horny. It is not an uncommon stance that AIDS happens no matter what precautions one takes, so that protection is not a priority. There is a remarkable disproportion between real knowledge on transmission and protection from STIs (and AIDS) and its application (TOTALLY UNAWARE).

Safe-sex campaigns reach only a few, and then partially, as subjects do not perceive them as realistic at all or true to life (the irrational notion of it all happening to someone else is still strong)

CASE STUDY

A statement of considerable significance was given by a subject who claimed he started using protection regularly ever since he had an unprotected intimate encounter with an HIV-positive person and was in great risk of getting infected. He deems it valuable to include as many HIV-positive persons as possible in a preventive campaign.

About 20 out of 35 subjects use some drugs, the most common is an occasional smoke of marijuana at parties, with only two subjects using other drugs: one sniffs heroin regularly, the other abuses Trodon and benzodiazepines. No incident of IV use was found in Belgrade.

In Nis young homosexuals usually have a low level or secondary education, are usually unemployed. It is typical that in Nis they don't use drugs and also it was noted during the RAR project that they do not sell their sexual services.

In Novi Sad there are still no gay places, though there are NGOs that involve young men sex having sex with men. The Internet has a great role in their everyday life. Also, in Novi Sad the gay monthly magazine is published. However, young MSM doesn't recognize their risk for HIV infection during unsafe sex.

7.2.7 Health and Social Consequences

Almost each subject considers himself to be more or less stigmatised by society and can sense certain degrees of homophobia, which causes anxiety and depression. This was also shown by the site's poll, where almost 80% of 'pollees' stated that there is a dominant feeling of homophobia in our society. One third of subjects are out to their parents (similarly, in the site's poll - 27,9%), but the point at issue is seldom talked about, in spite of their willingness to open up.

Stemming from the above mentioned - depression, fear, a feeling of rejection are not uncommonly found. Several interviewed persons have a sense of guilt, ego dystonia, and one even thought himself to be the only gay in town!

- 2 subjects seriously contemplated suicide
- 3 of them had hepatitis B in the last two years
- 3 HIV-positive persons with accompanying symptomatology
- 7 had venereal warts; one of them refused to see the doctor as the warts were localized at the anus

More than one third were tested for HIV and hepatoviruses; out of these, 6 are HIV-positive, and each subject seriously doubts the anonymity of testing. Barely a very small number subjects use only Durex extra safe condoms for anal intercourse, specially hardened for the purpose, while a great majority of subjects do not distinguish between condoms, despite noticing some often burst during anal intercourse, and they admit to becoming aware of ejaculation in corpore too late.

Only a few of them were offering sexual services for a fee (DM 70 p/h) two years ago, mostly involving unsafe sex.

7.2.8 Interventions

All subjects are in complete agreement in their estimation that the present AIDS prevention methods, as well as society's stance towards gay people and their problems, are at least insufficient and one-sided:

Consequentli, it is necessary:

- Adoption of laws on indiscrimination of minorities, penal retribution against any discrimination based on faith, ethnicity, sexual preferences, and so on.
- Politicians, intellectuals, artists, medical professionals, they should all come out in public against discrimination of any kind (after the Gay Pride Day incident only the Prime Minister spoke out rather prudently)
- All categorizations of homosexuality in a derogatory or negative sense are to be eliminated from text-books and mass media, supported by the fact that homosexuality is no longer a sexual disorder or disease, according to the 10th Revision of the International Classification of Diseases.
- Continuous and well-proportioned anti-AIDS media campaign throughout the year, and not only on Anti-AIDS Drive Day, as it thus creates a feeling of insincerity that prevents the message from getting through
- A directed and well proportioned media campaign calling for tolerance and appreciation of diversities, inviting parents to accept their children as they are, to understand and to love them.
- Establish counselling services for young homosexuals, with teams of experts who can provide them with help in psychosocial getting of age and in accepting themselves
- Also, setting up better and more encompassing family advisory services where parents of gay children could get help and support.
- Establishment of "hot lines", S.O.S. phone service network, for giving support to those in crises, legal advice, and information
- Organising preventive work in schools and other spots according to the principles of modern approach (work with small groups, creative workshops, and similar), and abandonment of lecturing ex cathedra.
- Greater number of HIV-positive persons included in preventive work, thus making the drive more effective and authentic.
- Placing slot machines for condoms at several places downtown, particularly near hot spots, where there is a greater frequency of sexual intercourses.
- Placing billboards at the same spots, which will remind cruisers of safe sex measures.
- Anti-AIDS leaflets distributed in public toilets along with entrance tokens
- Secure genuine anonymity for HIV test subjects
- Carry out a continuous anti-AIDS campaign adapted to gay population needs (for example, not only the condom itself, but the kind of condom for certain types of sex), using the most frequented media by gays (most of all the Internet sites dealing with gay issues)
- Better organisation of and improved connections between the non-governmental organisations (NGOs) with the purpose of promoting and developing sexual minorities' rights, giving them support and aid, educating professionals and individuals in the work with certain problems and requirements of the LGBT population, lobbying and informing the social, scientific, cultural, and health institutions on actual demands of the LGBT population.

Some of these are:

- Labris (www.womenngo.org.yu/labris, labris@Eunet.yu), tel: 063/851-3170
- Gayten-LGBT- Centar za promociju prava seksualnih manjina (gayten_lgbt@yahoo.com),
- Queer Studies / Istopolne studije (prefect@tehnicom.net)
- GALEA (www.galea.org.yu, galea_yu@yahoo.com)
- Deve Centric (hot line network, peer education, education of educators, cooperation with the Danish Association for Family)
- Campaign Against Homophobia / Kampanja protiv homofobije - the joint project of the Humanitarian Law Fund, Arkadija, and the European Youth Association (www.gay-serbia.com/srb/campaign.shtml, dusan@gay-serbia.com)

7.3 YOUNG SEX TRADE WORKERS

7.3.1 Core Survey Questions

Predominantly the age group among these respondents is the 20-24 and with regards to the gender they are predominantly female (female: 89,7% and male: 10,3%).

Table 35. Age groups

	Total		City					
	No.	%	Belgrade		Nis		Kragujevac	
			No.	%	No.	%	No.	%
15 - 19	28	24.1%	21	27.6%	2	25.0%	5	15.6%
20 - 24	88	75.9%	55	72.4%	6	75.0%	27	84.4%
Total	116	100.0%	76	100.0%	8	100.0%	32	100.0%

According to gender, as expected they are predominantly female, but in Belgrade 11 of male were interviewed by questionnaire.

Table 36. Gender

	Total		City					
	No.	%	Belgrade		Nis		Kragujevac	
			No.	%	No.	%	No.	%
male	12	10.3%	11	14.5%			1	3.1%
female	104	89.7%	65	85.5%	8	100.0%	31	96.9%
Total	116	100.0%	76	100.0%	8	100.0%	32	100.0%

7.3.2 Sexual Behaviour

They started with sex trade work on average at 18,7 years, however before their 18th year almost one third of them (30,2%, with the minimum age of 13). Average year by sites are the following:

- Ni{: 17,6
- Kragujevac: 18,3 i
- Beograd: 18,5.

Table 37. Mean age at first sexual intercourse

Total	City		
	Belgrade	Nis	Kragujevac
15.4	15.3	15.4	15.5

In general, the mean age at the first sexual intercourse was 15,4 without differences between cities. A slightly different situation was noticed when the distribution of frequencies was analysed (table below). In this case the biggest number had their first sexual intercourse in their 16th year at national level, in Nis and Kragujevac, while in Belgrade the starting time is one year before.

Table 38. Age at the first sexual intercourse

	Total		City					
	No.	%	Belgrade		Nis		Kragujevac	
			No.	%	No.	%	No.	%
12.00	6	5.2%	6	8.0%				
13.00	13	11.3%	12	16.0%			1	3.1%
14.00	13	11.3%	8	10.7%	1	12.5%	4	12.5%
15.00	28	24.3%	15	20.0%	3	37.5%	10	31.3%
16.00	30	26.1%	14	18.7%	4	50.0%	12	37.5%
17.00	13	11.3%	9	12.0%			4	12.5%
18.00	8	7.0%	7	9.3%			1	3.1%
19.00	2	1.7%	2	2.7%				
20.00	1	.9%	1	1.3%				
21.00	1	.9%	1	1.3%				
Total	115	100.0%	75	100.0%	8	100.0%	32	100.0%

In order to find clients at the first place (37,1%) they work with macro, then alone (27,6%) and with friends (19%), without differences among cities.

Table 39. The type of work in order to find client

	Total		City					
	No.	%	Belgrade		Nis		Kragujevac	
			No.	%	No.	%	No.	%
N.A.	2	1.7%	2	2.6%				
alone	32	27.6%	20	26.3%	1	12.5%	11	34.4%
With friends	22	19.0%	13	17.1%	4	50.0%	5	15.6%
With macro	43	37.1%	24	31.6%	3	37.5%	16	50.0%
Other	17	14.7%	17	22.4%				
Total	116	100.0%	76	100.0%	8	100.0%	32	100.0%

Most frequently they find their clients at bars/cafes (44%), streets (41,4%) and private parties (25%). However, this mode is different among sites. For example the most frequent place for sex trade work in Kragujevac is a street (84,4%).

Table 40. **The place for meeting client**

		Total	City		
			Belgrade	Nis	Kragujevac
Base		N=116	N=76	N=8	N=32
Bars / café / clubs	Cases	51	30	8	13
	%	44.0%	39.5%	100.0%	40.6%
party	Cases	29	20	5	4
	%	25.0%	26.3%	62.5%	12.5%
parks	Cases	23	22		1
	%	19.8%	28.9%		3.1%
street	Cases	48	21		27
	%	41.4%	27.6%		84.4%
schools	Cases	8	4		4
	%	6.9%	5.3%		12.5%
In salon for massage	Cases	12	9	2	1
	%	10.3%	11.8%	25.0%	3.1%
Other	Cases	41	40	1	
	%	35.3%	52.6%	12.5%	

The average number of clients during the last month is 38 with significant differences among sites (Belgrade: 46 Kragujevac: 28 and Nis: 8). Taking the whole of last year into consideration the number of different partners is much higher, in average: 193, but mostly because of Belgrade (Belgrade: 262, Nis: 55 and Kragujevac: 14).

Table 41. The number of clients during the last month

	Total		City					
			Belgrade		Nis		Kragujevac	
	No.	%	No.	%	No.	%	No.	%
1.00	1	1.0%	1	1.5%				
2.00	1	1.0%			1	12.5%		
3.00	2	2.0%			2	25.0%		
5.00	3	3.0%	2	3.0%			1	4.0%
6.00	2	2.0%			2	25.0%		
8.00	2	2.0%	1	1.5%			1	4.0%
10.00	7	7.1%	5	7.6%			2	8.0%
11.00	1	1.0%			1	12.5%		
12.00	2	2.0%	2	3.0%				
14.00	1	1.0%	1	1.5%				
15.00	5	5.1%	2	3.0%	1	12.5%	2	8.0%
16.00	1	1.0%	1	1.5%				
18.00	1	1.0%					1	4.0%
20.00	15	15.2%	9	13.6%	1	12.5%	5	20.0%
26.00	1	1.0%	1	1.5%				
30.00	21	21.2%	11	16.7%			10	40.0%
35.00	1	1.0%					1	4.0%
40.00	3	3.0%	2	3.0%			1	4.0%
50.00	10	10.1%	10	15.2%				
60.00	7	7.1%	7	10.6%				
70.00	1	1.0%	1	1.5%				
80.00	3	3.0%	3	4.5%				
90.00	2	2.0%	2	3.0%				
100.00	1	1.0%	1	1.5%				
150.00	2	2.0%	1	1.5%			1	4.0%
160.00	1	1.0%	1	1.5%				
170.00	1	1.0%	1	1.5%				
250.00	1	1.0%	1	1.5%				
Total	99	100.0%	66	100.0%	8	100.0%	25	100.0%

Table 42. **Mean number of clients in the last month**

Total	City		
Mean	Belgrade	Nis	Kragujevac
38.2	45.6	8.3	28.2

The average number of sexual partners is remarkably different between three target groups, which were interviewed during the RAR project; this was expected (Graph 7)

Graph 7. **The average number of sexual partners in the last year**

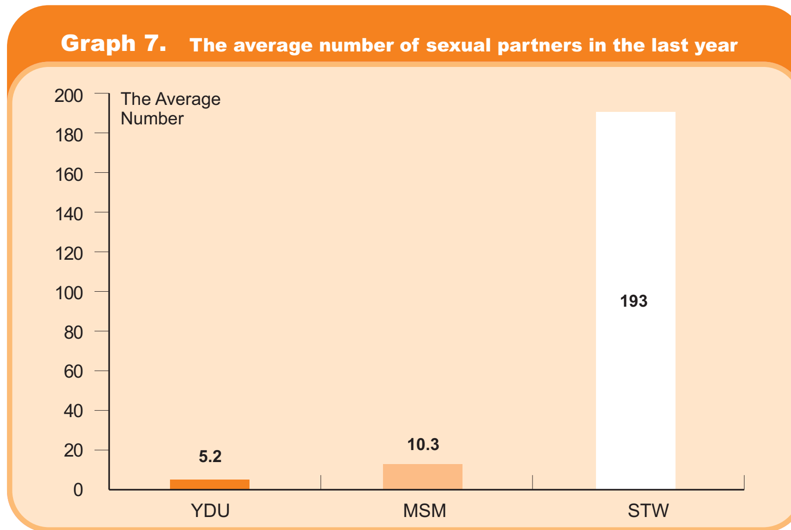


Table 43. **The mean number of partners during the last year**

Prosek	City		
Mean	Belgrade	Nis	Kragujevac
192.7	262.3	55.2	13.9

Almost one third (29,3%) of them has a permanent partner; this percentage is the least in Belgrade (19,7%) and the highest in Kragujevac (53,1%).

Table 44. **Presence of permanent partner**

	Total		City					
			Belgrade		Nis		Kragujevac	
	No.	%	No.	%	No.	%	No.	%
No	82	70.7%	61	80.3%	6	75.0%	15	46.9%
Yes	34	29.3%	15	19.7%	2	25.0%	17	53.1%
Total	116	100.0%	76	100.0%	8	100.0%	32	100.0%

Taking into consideration that only a small number of young STW has a permanent sexual partner, the practice of using condoms is very important. However this protective behaviour is very low in all cities, though little more present than between young drug users and young MSM.

Table 45. **Use of condoms during sexual intercourse**

	Total		City					
			Belgrade		Nis		Kragujevac	
	No.	%	No.	%	No.	%	No.	%
always	70	60.3%	44	57.9%	4	50.0%	22	68.8%
sometimes	41	35.3%	28	36.8%	3	37.5%	10	31.3%
Never	5	4.3%	4	5.3%	1	12.5%		
Total	116	100.0%	76	100.0%	8	100.0%	32	100.0%

The main reason for not having sex with condoms usually comes from their partners, after that because of feeling embarrassed, without differences between cities.

Table 46. **The reasons for not "always" using condoms**

		Total	City		
			Belgrade	Nis	Kragujevac
Base		N=116	N=76	N=8	N=32
Client paying more for sex without condom	Cases	17	13		4
	%	14.7%	17.1%		12.5%
Too expensive / cannot afford	Cases	2	2		
	%	1.7%	2.6%		
Embarrassed to buy	Cases	2	2		
	%	1.7%	2.6%		
Difficult to use	Cases	1	1		
	%	.9%	1.3%		
Not easily available	Cases	5	4		1
	%	4.3%	5.3%		3.1%
Don't like sex with condoms	Cases	9	4	4	1
	%	7.8%	5.3%	50.0%	3.1%
Embarrassed to ask partner to use	Cases	11	5	2	4
	%	9.5%	6.6%	25.0%	12.5%
I have trust in my partners	Cases	1			1
	%	.9%			3.1%
No knowledge / awareness about the benefits of using condoms	Cases	3	1	1	1
	%	2.6%	1.3%	12.5%	3.1%
Other reasons	Cases	18	18		
	%	15.5%	23.7%		

7.3.3 Health Seeking Behaviour

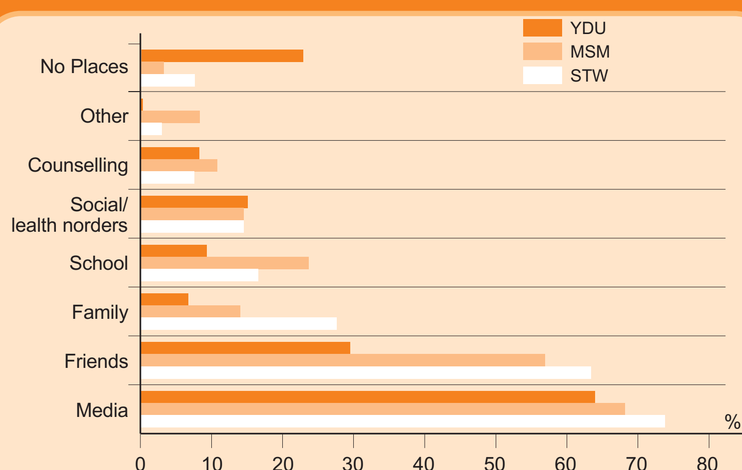
The main sources of their information about HIV and other STIs are the media (65,5%), friends (30,2%) and social / health workers (15,5%) but those last only in Belgrade and Nis.

Table 47. Places where to get information on HIV and other STIs

		Total	City		
			Belgrade	Nis	Kragujevac
Base		N=116	N=76	N=8	N=32
Family	Cases	8	2	1	5
	%	6.9%	2.6%	12.5%	15.6%
Friends / peers	Cases	35	21	6	8
	%	30.2%	27.6%	75.0%	25.0%
Media	Cases	76	51	7	18
	%	65.5%	67.1%	87.5%	56.3%
School	Cases	11	10		1
	%	9.5%	13.2%		3.1%
Social / health workers	Cases	18	17	1	
	%	15.5%	22.4%	12.5%	
STI counselling services	Cases	10	9		1
	%	8.6%	11.8%		3.1%
Nowhere - NO PLACE !!!	Cases	27	15		12
	%	23.3%	19.7%		37.5%

The location for information about HIV/AIDS and other STIs could be also highlighted according to three vulnerable groups, which were interviewed during the RAR project (Graph 8).

Graph 8. The places for information about HIV/AIDS and other STIs



At the same time they consider their risk for HIV/STIs as high in 32,8% and moderate in 43,1%.

Table 48. Perception of risk for HIV or other STIs

	Total		City					
			Belgrade		Nis		Kragujevac	
	No.	%	No.	%	No.	%	No.	%
high	38	32.8%	33	43.4%			5	15.6%
moderate	50	43.1%	34	44.7%	7	87.5%	9	28.1%
no risk	28	24.1%	9	11.8%	1	12.5%	18	56.3%
Total	116	100.0%	76	100.0%	8	100.0%	32	100.0%

Out of a total, 50,9% have been tested for HIV/AIDS, 12,9% for Hepatitis B and 13,8% for Hepatitis C. The biggest number of those tested for HIV/AIDS is in Belgrade, while for Hepatitis B and Hepatitis C this number is largest in Nis, though still very small.

Table 49. Testing practice

		Total		City					
				Belgrade		Nis		Kragujevac	
		No.	%	No.	%	No.	%	No.	%
HIV	NA.	24	20.7%	14	18.4%			10	31.3%
	No	33	28.4%	15	19.7%	4	50.0%	14	43.8%
	Yes	59	50.9%	47	61.8%	4	50.0%	8	25.0%
Total		116	100.0%	76	100.0%	8	100.0%	32	100.0%

		Total		City					
				Belgrade		Nis		Kragujevac	
		No.	%	No.	%	No.	%	No.	%
Hepatitis "B"	NA.	24	20.7%	14	18.4%			10	31.3%
	No	77	66.4%	52	68.4%	5	62.5%	20	62.5%
	Yes	15	12.9%	10	13.2%	3	37.5%	2	6.3%
Total		116	100.0%	76	100.0%	8	100.0%	32	100.0%

		Total		City					
				Belgrade		Nis		Kragujevac	
		No.	%	No.	%	No.	%	No.	%
Hepatitis "C"	NA.	24	20.7%	14	18.4%			10	31.3%
	NO	76	65.5%	53	69.7%	6	75.0%	17	53.1%
	Yes	16	13.8%	9	11.8%	2	25.0%	5	15.6%
Total		116	100.0%	76	100.0%	8	100.0%	32	100.0%

Their knowledge about HIV/AIDS is rather high, the percentage of correct answers on this group of questions in more than 85%. However a pretty high percentage had experiences with some STIs during the last year.

It is important to compare experiences with testing between three vulnerable groups (Graph 9).

Graph 9. Testing

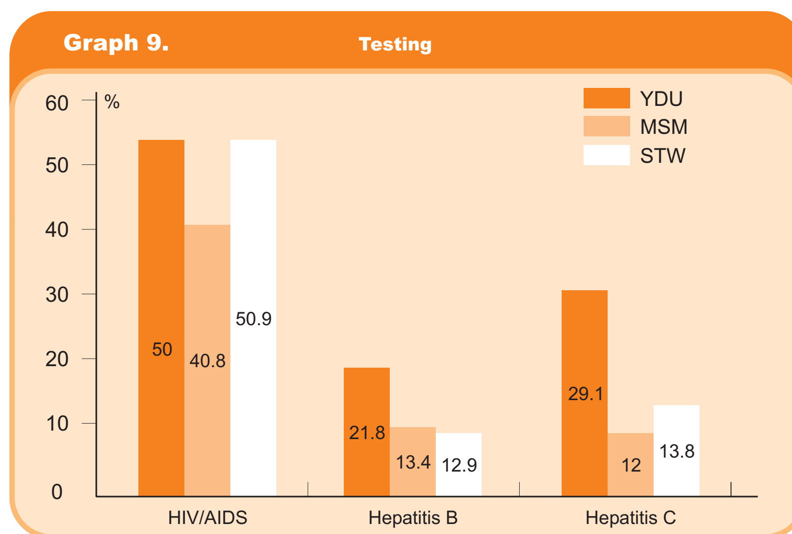
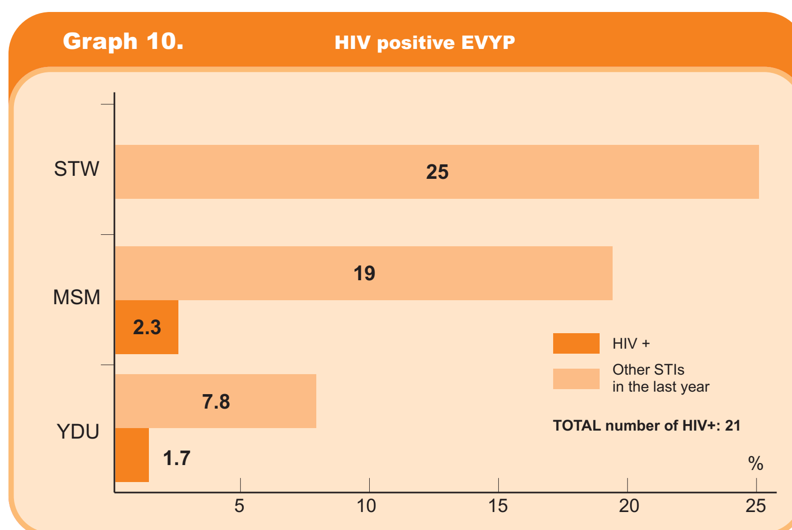


Table 50. Having Sexually Transmitted Infection

	Total		City					
			Belgrade		Nis		Kragujevac	
	No.	%	No.	%	No.	%	No.	%
N.A.	2	1.7%	2	2.6%				
In the last 1 year	14	12.1%	10	13.2%	2	25.0%	2	6.3%
In the last 6 months	10	8.6%	8	10.5%			2	6.3%
In the last 1 month	5	4.3%	3	3.9%			2	6.3%
Ever in the past	28	24.1%	16	21.1%	2	25.0%	10	31.3%
Never	57	49.1%	37	48.7%	4	50.0%	16	50.0%
Total	116	100.0%	76	100.0%	8	100.0%	32	100.0%

Regarding HIV status the group of young sexual workers was not examined, however the important results were obtained from the other two groups (Graph 10).



7.3.4 Drug Use Behaviour

Regarding drug using behaviour - 59,4% have such experience and started at the mean age of 16,7. The differences between cities is recorded as follows:

- Belgrade: 17,0
- Nis: 16,7
- Kragujevac: 15,5.

Table 51. Most frequent age when first use drugs

	Total		City					
			Belgrade		Nis		Kragujevac	
	No.	%	No.	%	No.	%	No.	%
12.00	1	.9%	1	1.3%				
13.00	3	2.7%	2	2.6%			1	3.4%
14.00	4	3.5%	3	3.9%			1	3.4%
15.00	14	12.4%	10	13.2%			4	13.8%
16.00	11	9.7%	5	6.6%	50.0%	50.0%	2	6.9%
17.00	10	8.8%	8	10.5%	12.5%	12.5%	1	3.4%
18.00	8	7.1%	8	10.5%				
19.00	8	7.1%	6	7.9%	12.5%	12.5%	1	3.4%
20.00	4	3.5%	4	5.3%				
22.00	3	2.7%	3	3.9%				
N.O.	47	41.6%	26	34.2%	25.0%	25.0%	19	65.5%
Total	113	100.0%	76	100.0%	100.0%	100.0%	29	100.0%

Intravenous drugs are used by 22.4% and started with this at 17.2 years. In 19% of cases they share their drug-injecting equipment. The risk behaviour of sharing drug-injecting equipment is most frequently present in Kragujevac.

Table 52. Practice of sharing drug-injecting equipment

	Total		City					
			Belgrade		Nis		Kragujevac	
	No.	%	No.	%	No.	%	No.	%
N.A.	90	77.6%	58	76.3%	8	100.0%	24	75.0%
No	4	3.4%	3	3.9%			1	3.1%
Yes	22	19.0%	15	19.7%			7	21.9%
Total	116	100.0%	76	100.0%	8	100.0%	32	100.0%

The young STW usually uses drugs in bar/cafes (38,8%), at home (37,9%) and friends' home (29,3%). Differences among cities exists, especially in Nis where the second place for drug abuse is a friend's home.

Table 53. Areas where usually use drugs

		Total	City		
			Belgrade	Nis	Kragujevac
Base		N=116	N=76	N=8	N=32
Bars / cafes / clubs	Cases	45	35	5	5
	%	38.8%	46.1%	62.5%	15.6%
Home	Cases	44	35	3	6
	%	37.9%	46.1%	37.5%	18.8%
Street	Cases	19	14	1	4
	%	16.4%	18.4%	12.5%	12.5%
Parks	Cases	21	17	1	3
	%	18.1%	22.4%	12.5%	9.4%
Schools	Cases	4	3		1
	%	3.4%	3.9%		3.1%
Toilets	Cases	9	7		2
	%	7.8%	9.2%		6.3%
Other places	Cases	15	11		4
	%	12.9%	14.5%		12.5%
Friend's house	Cases	34	25	4	5
	%	29.3%	32.9%	50.0%	15.6%
Party	Cases	24	19	5	
	%	20.7%	25.0%	62.5%	

The types of most frequent drugs are the following: cannabis - 49,1%, heroin - 29,3%, ecstasy - 23,3%, analgesic - 21,6%, cocaine - 17,2%, diazepam - 17,2% and LSD - 11,2%.

Table 54. **Drugs most used in the last month**

		Total		City					
				Belgrade		Nis		Kragujevac	
		No.	%	No.	%	No.	%	No.	%
Tobacco	N.A.	50	43.1%	26	34.2%	2	25.0%	22	68.8%
	No	2	1.7%	2	2.6%				
	Yes	64	55.2%	48	63.2%	6	75.0%	10	31.3%
Alcohol	N.A.	50	43.1%	26	34.2%	2	25.0%	22	68.8%
	No	7	6.0%	6	7.9%			1	3.1%
	Yes	59	50.9%	44	57.9%	6	75.0%	9	28.1%
Cannabis / marijuana	N.A.	50	43.1%	26	34.2%	2	25.0%	22	68.8%
	No	9	7.8%	4	5.3%			5	15.6%
	Yes	57	49.1%	46	60.5%	6	75.0%	5	15.6%
Diazepam	N.A.	50	43.1%	26	34.2%	2	25.0%	22	68.8%
	No	46	39.7%	31	40.8%	6	75.0%	9	28.1%
	Yes	20	17.2%	19	25.0%			1	3.1%
Ecstasy	N.A.	50	43.1%	26	34.2%	2	25.0%	22	68.8%
	No	39	33.6%	26	34.2%	3	37.5%	10	31.3%
	Yes	27	23.3%	24	31.6%	3	37.5%		
Glue or inhalant	N.A.	50	43.1%	26	34.2%	2	25.0%	22	68.8%
	No	64	55.2%	48	63.2%	6	75.0%	10	31.3%
	Yes	2	1.7%	2	2.6%				
Ampheta-mines	N.A.	50	43.1%	26	34.2%	2	25.0%	22	68.8%
	No	61	52.6%	45	59.2%	6	75.0%	10	31.3%
	Yes	5	4.3%	5	6.6%				
LSD	N.A.	50	43.1%	26	34.2%	2	25.0%	22	68.8%
	No	53	45.7%	38	50.0%	5	62.5%	10	31.3%
	Yes	13	11.2%	12	15.8%	1	12.5%		
Heroin	N.A.	50	43.1%	26	34.2%	2	25.0%	22	68.8%
	No	32	27.6%	25	32.9%	5	62.5%	2	6.3%
	Yes	34	29.3%	25	32.9%	1	12.5%	8	25.0%
Methadone	N.A.	50	43.1%	26	34.2%	2	25.0%	22	68.8%
	No	54	46.6%	40	52.6%	6	75.0%	8	25.0%
	Yes	12	10.3%	10	13.2%			2	6.3%
Cocaine	N.A.	50	43.1%	26	34.2%	2	25.0%	22	68.8%
	No	46	39.7%	36	47.4%	3	37.5%	7	21.9%
	Yes	20	17.2%	14	18.4%	3	37.5%	3	9.4%
Poppy tea	N.A.	50	43.1%	26	34.2%	2	25.0%	22	68.8%
	No	64	55.2%	49	64.5%	6	75.0%	9	28.1%
	Yes	2	1.7%	1	1.3%			1	3.1%
Analgesics	N.A.	51	44.0%	26	34.2%	2	25.0%	23	71.9%
	No	40	34.5%	29	38.2%	6	75.0%	5	15.6%
	Yes	25	21.6%	21	27.6%			4	12.5%
Total		116	100.0%	76	100.0%	8	100.0%	32	100.0%

7.3.5 Context

Most of the female young STW live independently, in rented apartments, only several of them still live with their parents who are unaware of their profession. Only one male respondent claims that all of his family and friends know about his business, which is the reason, he asserts, for the stigmatisation that he suffers from.

All respondents (both sexes) support themselves, as sex trade makes a sufficient source of income (a guy gave up all his side dealings when he started prostituting himself).

Mainly they stay out of marriage, except for two respondents who are divorced, but with legitimate children (according to them, children are the principal motive for them to continue with this trade).

They are in the sexual trade individually, from 1 to 4 years. The main reason to start prostituting oneself is money (a subject also pointed out desire for adventure), and the decision to go into this kind of business was chiefly triggered by a friend, a buddy (especially with boys in the trade), and former steady partners. A girl working independently is rarely encountered (men are more likely to decide to work on their own), they usually work under the protection of pimps (if working the streets) or escort agencies' owners, i.e. their security thugs (if working for an agency), and they have to deduce 40 to 60 % off of their earnings and give it to their pimp or owner of the agency, for safety, advertising, and sometimes accommodation is provided. Three levels of prostitution can be distinguished:

- The lowest level comprises girls and young transsexuals (transgenders), and transvestites, who bunch together at certain hot spots around town, standing there for long hours (alone, or under close watch of their pimps and his thugs) waiting for a trick. They start appearing around 5 or 6 in the evening (later in the summer) and stay there until the wee hours of the morning. Their clients are of inferior education and not well-to-do (workers, people coming from around the country, highway truckers, and similar). Their prices are lower than in the agencies, going up to around DM 50 per hour. The sexual service is performed in a park, a car, or at somebody's place. The usual meeting points are: the park across from the Faculty of Economics, the whole area covered by the Main Railway and the Bus stations, part of the highway near the Dušanovac Bridge (there the greatest number of workers are transvestites and young Romas from Marinkova bara), the bridge leading to Medakovic suburb, and the spot on the highway to Bezanijska kosa.
- The middle level refers to those working for escort agencies. No certificate, no medical proof of health, is asked either by the agency owners or by the clients. The agencies advertise in Novosti Oglasi, Pan Erotica, and on www.tripod.co.yu, www.oglasi.org.yu. They operate from rented apartments in the city centre, where they can usually provide accommodation for their clients. For advertising, lodging, and for furnished protection the agencies' protégés get a cut on their income by 40-60% (1h - DM 100, 2h - DM 150).
- Higher level is comprised of people engaged by certain agencies, in plush hotels and similar, where sexual services go along with the actual business of escorting. Clients are usually businessmen, prices are considerably higher.

7.3.6 Risk Behaviour

The number of sexual contacts varies from a dozen per one week up to 5-10 in a day, and it is about 20 per week on average. Female respondents have regular contacts with both sexes if required, but male respondents are clearly separated, they make distinctions as to whether they work with the same or opposite sex, or both. Kissing is rare in their contacts. According to HIV risk, and their sexual behaviour, the sex trade workers can be divided into several groups:

- (Female) workers using psychoactive substances and/or alcohol who indulge in sex incontrollably, often without any protection, whether unaware of the risk or being in a tight corner for money due to addiction.
- Uneducated and uninformed of risk behaviour, the Roma prostitutes who agree to have bare sex (without a condom) if the client insists or offers to pay more.
- Those prostitutes that are not fully aware of the risk, nor do they have a clear position on the use of condoms, so they use it on and off.
- Homosexuals and bisexuals who use condoms habitually, but not always, and it is worth noting that those referred to as active (top) guys in the division of sex roles pay far more attention to it than the passive (bottom) ones.

- Prostitutes who are well aware of the risk, those who are professionals for financial gain (family support, and similar), and who use condoms invariably.

More than one half of respondents often smoke marijuana, and only two of them (unless the others are not willing to admit) sniff heroin now and then, most likely provided by the agency's boss, rarely by a local dealer. Not a single respondent (of both sexes) uses drugs intravenously, although it is allegedly not a rare habit among sex trade workers, in particular with inexperienced prostitutes as it is supposed to relax and make them lively and spirited, as well as among highly educated girls who are unable to work unless they take a psychoactive substance. The girls who are addicts, they claim, always use drugs in a group and are almost totally unaware of risk behaviour, exchanging equipment quite often (a respondent's room-mate couldn't even remember she has ever exchanged her kit for somebody else's, let alone could she recall any details of sexual contacts she has had while being in a state of altered consciousness). Money to obtain heroin is no trouble for them, as they can earn up to DM 1,000 in a week.

In Kragujevac this group comprises two distinctly separate groups of prostitutes: a mixed group of girls and women from the local neighbourhood (one third up to one half of them are Romas), and a second group composed of girls who are intravenous drug abusers (IV DUs/STWs). Agencies are not present in Kragujevac. Our key informants were users of those services in Belgrade. There were hints pointing to a possibility that modelling agencies are involved in this prostitution trade as well. During the summer one of these agencies was repeatedly mentioned, but data were not confirmed by triangulation. Several sources in Kragujevac pointed to female students who act as prostitutes. Triangulation proved this form of sale of sexual favours to exist. A few sporadic cases in prison show there are foreign citizens who deal in prostitution in surrounding villages (Romanians). They were incarcerated for irregular stay permits.

A (large) group of prostitutes in Kragujevac works exclusively with a pimp. 31.2% of prostitutes use psychoactive substances, 25.0% use drugs intravenously. 15% of the group is comprised of students and persons who independently sell sexual favours at hotels and élite restaurants.

7.3.7 Health and Social Consequences

Most of the girls take good care of their health and appearance, and the boys keep their bodies fit (gym halls, active in sports, etc.) so that in general they do not complain of serious ailments. Four prostitutes in Belgrade had repeated infections of the genital tract, one had an abortion. They all claim to be well informed about STDs, but point to their co-workers as ignorant of the dangers (never including themselves).

Most of them show signs of impatience, leaving the impression of anxious and scared persons. Several were under the influence of alcohol during the interview. Three of them stated they use antidepressants, sometimes mixing them with alcohol ("To get high faster", as they say). Less than a half were incarcerated overnight by the City Police and then released after paying the mandatory fine. No less than five of them claim they were sexually abused by the police while in jail, and two of them say they had more than one policeman as clients who not only refused to pay for the service, but also made threats with 30 days of prison.

7.3.8 Interventions

There are no organised interventions dealing with young sexual trade workers. The most important is to find ways to reach this population with the purpose of educating them (lectures on health to bring about a hightened awareness of risk behaviour), being aware that prostitution cannot be eradicated, it has to be decriminalized first, and then legalized, thus obliging the escort and sexual services agencies to register, and introducing as well numerous legal decrees that would regulate their business. This would enable strict health control of the prostitutes (regular monthly STD tests), prohibition of work to those who use psychoactive substances, and high penalties and prison sentences for offenders. Control of the police, who up to now have not only refused to punish those who, disguised as an escort agency, instigate crime, prostitution, and abuse of psychoactive substances (agency owners are the main procurers of narcotics to prostitutes), but have been their clients under threat and free of charge.

In Kragujevac there is not a single intervention program targeting this vulnerable population.

8. DISCUSSION

1. Information collected by RAR in each of the three studied vulnerable groups relate for the most part to the age span from 20 to 24. As this was not "targeted" by the sample choice method, it could be surmised that these were groups easier to access for research. In that age span which is, as the results point out, several years distant from the onset of risk behaviour, the social restraints and barriers are expected to diminish, that certain "defence" mechanisms were learnt, so the subjects were more readily cooperative and able to verbalize their problems. The uncertainty remains as to whether the problems of young people in those obviously "hard to reach" groups were approached successfully. One of the remaining tasks in further activities is to reach them through additional research coupled with offered interventions.

2. Although the research focused on three different vulnerable groups, when it comes to HIV specific risks all the groups show many similarities and confirm the co-variance of risk behaviour

   - Discrimination, stigmatisation, and life on social margins, as well as connectedness with "law", characterize all these groups, thus making them hard to reach in all preventive activities and programmes. Their communication with health and social sectors is rather limited and occurs only in great need. A great number of respondents were not able to name a single spot in the system where one can get information on HIV/AIDS and other STIs, while the participation of the health sector in counselling and distributing information is quite low.
   - Commercial sex, just like unsafe and promiscuous sex, and drugs - these are communication "bridges" in between all three groups, as well as with the rest of the general population.
   - High-risk sexual behaviour is a distinctive characteristic of young sex trade workers, but it is present in all three groups, albeit with somewhat lower frequency. It is manifested in the great number of sex partners, rare use of condoms, and in commercial sex. The last mentioned, according to the existing information, is present in the general population as well, and is not marked as prostitution.
   - Drugs are a distinctive characteristic of young drug users, but are also present in other two groups. All other forms of behaviour connected with drug abuse are also present, such as the use of common equipment and unsafe sex.
   - The general level of information is relatively high in all three groups, even though it is in complete discordance with actual behaviour. Media take the largest part in informing all three groups.
   - Perception of one's own risk for HIV/AIDS is relatively high in all three groups, but it is inconsistent with actual behaviour. According to the health belief model, one expects the high-risk perception should result in a readiness to change, which is not the case in this group. It remains to be further investigated what happens with other factors that cause behavioural changes, such as availability of preventive measures, trust in preventive measures undertaken, quality of these preventive measures and their influence upon the life styles of the observed groups.
   - Prevalence of STI, even though it is well known this refers to sub-registration and inadequate recognition, is rather high and bears evidence to sex risk.
   - There are data on HIV tests for all three groups, and on a relatively low sero-positivity. These data must be scrutinized with utmost reserve. Test data refer to a single test, followed by the same form of risk behaviour. There is a serious probability that sero-prevalence is somewhat higher, so additional motivation is needed in order to check it concomitantly with efforts to correct that behaviour.
   - All three groups share the same contextual factors which facilitate the risk behaviour - lack of needle exchange and other harm reduction programmes, insufficient market supply of condoms, scarcity of special condoms and lubricants, high prices, deficiency of reagents for testing, test prices, insecurity in professional secrecy in regards to results, inaccessibility of counselling forms of work, insufficient availability and accessibility of health services and inadequacy of their response.

- Existing communal programmes are mostly targeted at the general population and they do not "recognize" the mentioned groups. The programmes, too, are mainly designed and implemented for the large part by professionals, while people who have experience with the problem involved do not participate at all, although they have great potentials.
- Self-organizing and capacity for advocacy are small in all three groups, inadequately supported by few. It cannot be claimed that any of the NGOs took the advocacy role in full for any of these groups.

3. Experiences gained through the RAR Project point, on the one hand, to unsatisfactory application of the existing legal norms and regulations, and on the other, to shortcomings concerning the absence of certain regulations.

When the international legal aspect is reviewed, the starting point should be the basic document which protects human rights, the Universal Declaration on Human Rights (the Declaration was signed by the FRY), and in Europe it is the European Convention on Human Rights, the Convention on Children's Rights, the Declaration on Non-Discrimination of Women, and similar. These documents guarantee human rights in a general way, among them prohibition of discrimination and the right to health protection in the broadest sense. The international community in the UN has also adopted conventions in direct or indirect connexion to HIV/AIDS prevention, such as the Convention on Narcotics (the Single Convention on Narcotic Drugs) and the attached Protocol, the Convention on Psychotropic Substances, the Convention on Prohibition of Narcotics and Psychotropic Substances Trade, and so on. Although a detailed analysis of application of these regulations has not been made, the practice shows these are not applied adequately.

The internal legal system of a country is founded on the Constitution as the basic and supreme legal act of the country, and in that way the SRY Constitution and the Constitution of the Republic of Serbia also cite the general stipulations on banishment of discrimination (of persons affected with HIV/AIDS), and on the right to health protection. Further elaboration of these principles was developed by federal and republic laws, but with a new added aspect, which is prohibition of certain forms of behaviour by the penal code and misdemeanour regulations. The laws regulating this sphere are the Federal Law on Protection of Inhabitants from Infectious Diseases Threatening to the Whole Country, the Penal Code of the Republic of Serbia (art. 111, p. 3 - procuring and enabling lechery, art. 122 - transmission of an infectious disease, art. 124 - transmission of venereal disease, art. 125 - employment of persons affected with an infectious disease, art. 126 - treatment of patients with negligence, art. 127 - denial of medical help, and qualified forms of these criminal acts), the Penal Code of the SRY (production and market distribution of narcotic drugs), and the Law and Order Act which directly prescribes short prison terms for persons who deal in prostitution, let premises for prostitution, or do it to a minor. The application of each of these regulations is met with numerous problems with all the consequent outcomes.

The FRY is signatory to all relevant conventions which treat human rights and freedoms, together with the protection of basic values, including health. Formally and legally, the SRY and Republic of Serbia have embraced the legal norms that treat health protection and sanction criminal acts referring to the use and distribution of narcotics, protection of health, and prostitution. The problem is of a different nature, concerning the application of all the existing norms that treat the mentioned issues, and their concrete implementation in the health protection domain and prohibition of certain forms of behaviour.

The social changes, including the introduction of the school subject Civic Education, can improve the situation at general population level and may contribute to the decrease in discrimination, but the necessity to apply the existing regulations remains.

Shortcomings of the legal regulations may refer to the following matters:

- Prostitution - and enabling the business of prostitution are considered as misdemeanours and the penalty fine prescribed for this offence is 30, which is 60 days. There are no legal measures whatsoever for clients. It is also worth noting that the category of persons who deal in organized prostitution (most frequently in hotels and restaurants) is filled with foreign citizens, from Moldavia, Rumania, or Ukraine. These persons are exiled from our country due to expiration dates of their allowed stay, not for prostitution, thus preventing keeping records on that category. They stand before misdemeanour courts for violating expiration date, not for prostitution.

Domestic legislation, insufficiently regulating the field of shop opening and dealing in certain registered trades, leaves ample space for persons who wish to start a prostitution business, as they can enter the business by applying for an escort agency, or a match-making agency. In that way the business of "cover-up" prostitution was actually legalized. The mentioned collision between the prohibition of prostitution and permission to open an establishment that deals in this very business can be resolved by harmonizing the regulations in this field.

- Health - There is insufficient control of physicians and their prescription practice, and violation of laws regulating prescription of certain drugs. This is particularly important for private pharmacies where a large number of psychoactive substances can be purchased without a prescription.

9. RECOMMENDATIONS

The RAR Project has clearly indicated that the studied group of highly vulnerable young people differs considerably from other young people in regards to risks, proven to be related to transmission of the HIV epidemic.

The "continuum of risk" is known to exist, so that some young people put themselves in hightened HIV risk periodically, some do it more often, and some maintain the risk behaviour as an established way of life. Among them there are young people who are in contact with a great number of sexual partners every day, practicing unsafe sex, or young people who use common equipment for drug abuse, or, rather often, young people who pursue behaviour which includes several risks, the most frequent of which are: use of a common syringe when taking drugs, a great number of sexual partners combined with unsafe sex (homo, bi, heterosexual), and sex for money. Those people represent "bridges" between persons with risk behaviour and the rest of the population.

There is a tendency in professional circles to regard the members of risk behaviour groups separately, as isolated and well defined entities. The RAR Project demonstrates clearly that "cross-risk approach" should be involved, and that specific strategies have to be planned.

The RAR Project has also refuted the well-known delusion that preventive strategies designed for general population can be applied successfully onto particular vulnerable groups. Studies reveal that the delusion must be transcended by particularly designed strategies for these groups.

The RAR Project resulted in a number of strategies that will only be indicated here.

It is proposed for each recommendation to be followed, through special agreement, by an elaborated practical implementation mechanism.

RECOMMENDATION

RECOMMENDATION 1

Preventive strategies designed according to the "concept of targeting" - which means focusing the preventive efforts onto the part of the population which is under a hightened risk.

RECOMMENDATION 2

Creation of conditions for the application of the so-called "PLACE" method (Priorities for Local AIDS Control Efforts) which offers quick and simple possibilities of identifying points (cities, situations, groups, and similar), where intervention is supposed to be focused, and where special programmes are to be implemented. The RAR Project pointed out, described and defined such points, thus representing a good basis for further work.

RECOMMENDATION

RECOMMENDATION 3

Stigmatisation and discrimination are basic impediments to preventive efforts and their realization. Anything that causes these factors to be diminished is a highly cost-effective preventive effort. It is necessary to make an analysis, and then revise the laws and formulate a precisely defined non-discriminative approach in all institutions and among all supporting professions for all persons with risk behaviour or with HIV; "The Guide for HIV Positive Persons' Rights" should be translated, distributed, and promoted, while certain measures and consequences are to be defined in case of deviations from the Guide's instructions.

Activities covered by UNAIDS campaign on December 1st 2002/2003 are to be also directed towards particularly vulnerable young people.

RECOMMENDATION 4

The RAR Project did not deal specifically with vulnerability associated to the membership of minority groups, uneducated or poor ones, and similar, but by analysing the contextual factors it indicated that these groups tend to couple their high vulnerability to HIV/AIDS with basic deprivation. Diminishing stigmatisation and discrimination is an important preventive measure in avoiding to link the basic risk with HIV.

RECOMMENDATION 5

Awareness of one's own HIV status is a starting point in prevention of further epidemic dissemination among particularly vulnerable young people. If HIV tests are easily available, combined with counselling before and after the testing, it would be a highly significant preventive measure that is to be applied with great respect to the "informed consent" principle.

The tests enable:

- Initiation of behavioural changes directed at preventing further dissemination of the epidemic,
- Availability of HIV specific care and protection,
- Accessibility of intervention that blocks the vertical transmission,
- Psychosocial support.

RECOMMENDATION 6

Capacities of the existing health institutions must be enlarged so that they can offer a comprehensive protection in the fields of:

- Prevention of sexually transmittable diseases,
- Drug addiction,
- HIV infection.

This encompasses:

- Education of health workers for the work with particularly vulnerable young people,
- Inclusion of a large number of health workers, such as social workers, psychologists, work therapists, and others, in the work with particularly vulnerable young people,
- Development of programmes out of a health institution - "out reach programmes" in the field, based on the PLACE model principle,
- Establishment of several preventive, therapeutic, and rehabilitative options.

RECOMMENDATION

RECOMMENDATION 7

Development and implementation of harm reduction programmes for:

- Drug addicts,
- Homosexuals,
- Sex trade workers,
- People in prison.

These programmes offer a gamut of interventions, either isolated or combined. All these, if based upon the fundamental principle -reduction of harm in occurring circumstances - can be easily adapted for any of the cited environments, i.e. groups. The most frequently mentioned segments of such programmes are:

- Expansion of a net of experts for field work at "high concentration points",
- Syringe and needle exchange,
- Methadone programme,
- Medical, legal, and psychosocial help,
- Condom distribution,
- Referring to other levels of protection.

RECOMMENDATION 8

Creation of mutual trust between professionals and particularly vulnerable young people, with participatory approach to these youngsters. This recommendation is closely tied to a number of those relating to stigmatisation and discrimination prevention, as well as to an improved service by all assisting services, particularly the health services and staff education.

Exceptional efforts are to be made in:

- Engaging (actual and former) members of these groups of particularly vulnerable young people in peer education, researches, field work, and similar.

RECOMMENDATION 9

Intensified cooperation of state sectors, through the National AIDS Committee and other forms of communication, and increased cooperation between the state and civil sectors in the realization of programmes aimed at particularly vulnerable young people.

RECOMMENDATION 10

Development of programmes for parents, instructors, and teachers based on local experiences and problems (the PLACE approach), for work with particularly vulnerable young people.

RECOMMENDATION 11

Analysis of legal regulations referring to prescription and circulation of drugs and other substances to young people, coupled with recommended changes, as well as letting premises to be used by young people for various purposes.

RECOMMENDATION 12

Integration of issues and problems relating to especially vulnerable young people into plans and programmes of health protection of children and youth.

BIBLIOGRAFY

1. *Brenner H (1991)* AIDS among drug abusers in Europe. Review of recent development, WHO, Regional Office for Europe
2. *Boras T, Petrovic Z, Nenadovic M.* (1995) Socijalno medicinski aspekti metadonskog odrzavanja u " Narkomanija i alkoholizam ", Beograd 1995, pp 93-100
3. *Cucuc V, Savin K, Korac V* (1996) Drug Addiction between the old and new stigma. III International Conference, Warsaw
4. *Cucic V, Bjegovic V, Vukovic D* (2002): Monitoring AIDS preventive Indicators - first evaluation, UNICEF, Belgrade, 2002
5. "Droga -otisak bliske smrti" (dodatak Zdravlje) - dnevni list "Danas " - 31 januar 2002
6. *Djokic D* (1995) Prevencija zavisnosti od droga - Kognitivno bihevioralni pristup. "Narkomanija i alkoholizam" , Beograd 1995 , pp 93-100
7. *Korac V* (1992) Social reaction to AIDS - persons depending on narcotics in "AIDS and social reaction" (Savin, Korac, Hiber, Cucic , Belgrade 1992)
8. *Jankovic Z, Ilic D, Paunic M* (2000): Zdravstveno ponasanje srednjeskolske omladine. Zbornik radova, Zlatibor 2000
9. *Nenadovic M, Vesel J* (1995): "Heptadon - lek ili zabluda" u " Narkomanija i alkoholizam", Beograd 1995, pp 71-91
10. *Nenadovic M* (1995): Razmere narkomanije medju mladima Beograda, Srbije i Jugoslavije danas. U "Narkomanija i alkoholizam", Beograd 1995, pp 19-27
11. *Paunic M* (2000): Pusenje, alkoholizam i druge narkomanjie kao i nasilnicko ponasanje medju studentima Beogradskog univerziteta. Zbornik radova, Zlatibor 2000
12. *Paunic M* (2001): Epidemiologija HIV/AIDS bolesti. U "Ja volim zivot a ti", Jugoslovenski Crveni krst, Beograd 2001
13. *Radulovic D* (1986). Prostitucija u Jugoslaviji, "Filip Višnjic", Beograd 1986
14. *Savin K.* i saradnici (1992) Sida i drustvena reakcija, Beograd, 1992
15. *Vujovic S* (1999): Mladi i sida, Equilibrijum, Beograd, 1999
16. *Vukovic B, Seguljev Z* (1999): Epidemiološka situacija HIV infekcije u svetu i kod nas. Konferencija "Slusaj - uci, zivi", Beograd, 1999
17. *Zakula N, Djerkovic V* (1999): Sida, epidemiološke karakteristike na podrucju Beograda. Konferencija "Slusaj - uci, zivi", Beograd, 1999
18. *Suvakovic V* (1998) Sirenje sindroma stecene imunodeficijencije u Beogradu, Medju osobama koje koriste drogu intravenskim putem. Srpski arhiv 126; 11-12: 437

ANNEXES

ANNEX A - Workshop

A-1 TRAINING OF TEAM MEMBERS FOR THE PROJECT OF RAPID ASSESSMENT AND RESPONSE (RAR) ON HIV/AIDS IN YOUNG POPULATION

The RAR workshop was organized from November 15 to 17, 2001, at the Institute for Social Medicine, Statistics, and Research of the Medical Faculty facilities, Belgrade.

The objective of the workshop was to train the field team members in knowledge and skills necessary for the implementation of the RAR project.

The purpose of the workshop:

- to acquaint the field team members with the RAR principles and practices
- to make sure the field team members are indeed acquainted with the RAR principles and practices
- to build up or improve the field team members' skills so as to enable them to:
  - assist at meetings of focus groups
  - take key information interviews
  - carry out polls
  - perform observations and mapping
  - keep exact evidence and manage data
  - analyse data using grids of activities

Workshop **participants:**

- Ms. Elsie Wong, UNICEF representative
- Dr Jelena Zajeganovic, UNICEF expert
- Prof. Dr Viktorija Cucic, National Coordinator of the project
- local coordinators with their teams:
  - **Belgrade: Prof. Dr Vesna Bjegovic,** social medicine consultant

    Andrej Ilankovic
    Sasa Nikolic
    Boris Misovic
    Branislav Miskovic
    Tatjana Stamatovic
    Daniel Meškovic
    Vladimir Veljkovic
    Isein Fetoski
    Miloš Loncarevic
    Dragan Protulipac

  - **Novi Sad: Mr. Vladan Beara,** clinical psychology consultant

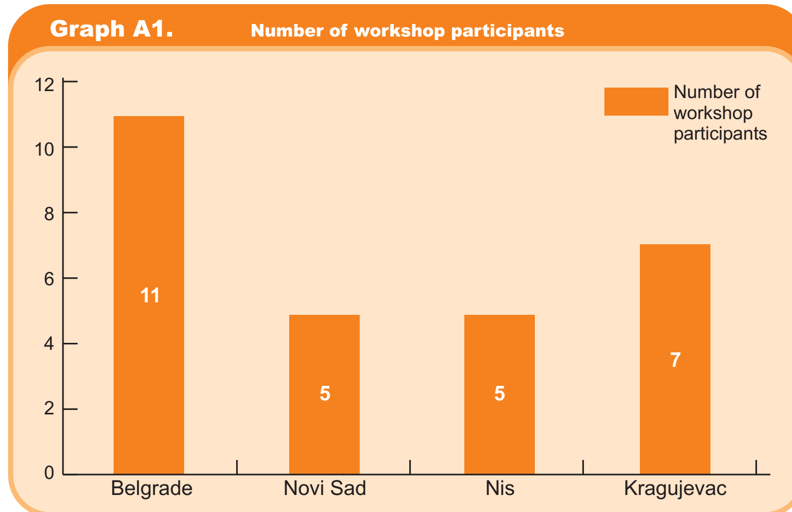
    Boris Popov
    Slavoljub Zaric
    Atila Kovac
    Vlatko Salaj

  - **Nis: Asoc. Prof. Dr Bojana Ilic,** clinical psychology consultant

    Marko Stefanovic
    Gordana Nikolic
    Miodrag Djordjevic
    Lidija Djurdjic

- **Kragujevac: Asoc. Prof. Dr Dragana Ristic, neropsychiatry consultant**
  - Andrea Markovic
  - Mirjana Rikanovic
  - Zoran Rastovic
  - Vesna Andrejevic
  - Mirjana Jovanovic
  - Sandra Nikolic-Labovic

- Apart from those listed above, the workshop was also attended by some who wanted to get further education in this field, as well as by the experts who contributed to the expert level of the workshop by their very presence (such as Dr Vesna Fridman, neuropsychiatry consultant)



Programme of the workshop

15.11.2001 Thursday

9:00 to 10:00	Opening, role of the UNICEF, definition of workshop goals, introduction of participants
10:00 to 10:45	Group work: What makes the young people particularly sensitive - vulnerable
10:45 to 11:00	Plenary session: Group reports
11:00 to 11:30	Coffee break
11:30 to 12:00	V. Cucic: HIV/AIDS (Lecture)
12:00 to 12:45	V. Bjegovic: RAR as a method (Lecture)
12:45 to 14:00	Lunch break
14:00 to 14:45	Group work: Factors contributing to AIDS spreading out in our country
14:45 to 15:00	Plenary session: Group reports
15:00 to 15:15	B. Ilic: Contextual factors (Lecture)
15:15 to 15:30	V. Beara : Risk and protection factors (Lecture)
15:30 to 16:00	Coffee break
16:00 to 16:15	Instructions for field work - observation (V. Beara)
16:15 to 16:30	D. Risti}: Health and social consequences (Lecture)
16:30 to 16:45	J. Zajeganovic: Intervention (Lecture)
16:45 to 17:30	Discussion
18:00	Dinner

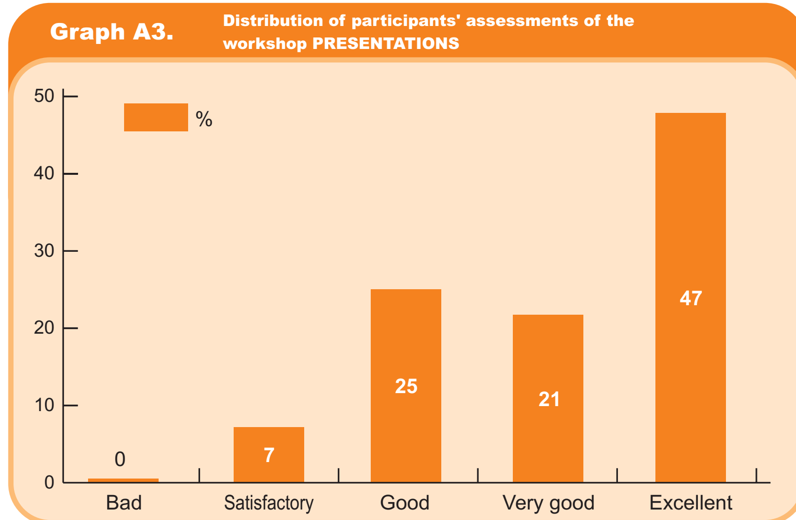
16.11.2001 Friday

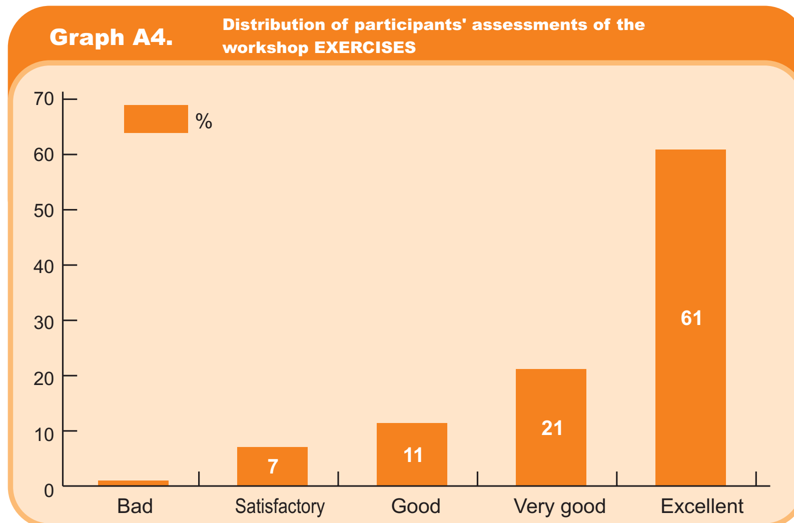
9:00 to 9:30	V.Cucic: Drug addiction as risk (Lecture)
9:30 to 10:30	V. Beara: Active listening (Lecture and practice)
10:30 to 11:00	D. Ristic: Risk of sexual transmission, sex trade workers (Lecture)
11:00 to 11:30	Coffee break
11:30 to 12:00	V. Beara: Homosexualism as choice and possible risk (Lecture)
12:00 to 12:45	Group work : Role playing and interview
12:45 to 13:15	B. Ilic: Interview as a method (Lecture)
13:15 to 13:45	V. Beara: Open questions in interviews (Lecture)
13:45 to 15:00	Lunch break
15:00 to 15:45	Exercise: Questionnaire - filling in (in pairs)
15:45 to 16:15	V. Bjegovic: Questionnaire as a method (Lecture)
16:15 to 16:30	Coffee break
16:30 to 17:30	Exercise: Secondary data
17:30 to 18:00	D.Ristic: Relevance of secondary data (Lecture)
18:00 to 18:30	Discussion
20:00	Dinner at "Skadarlija"

17.11.2001. Saturday

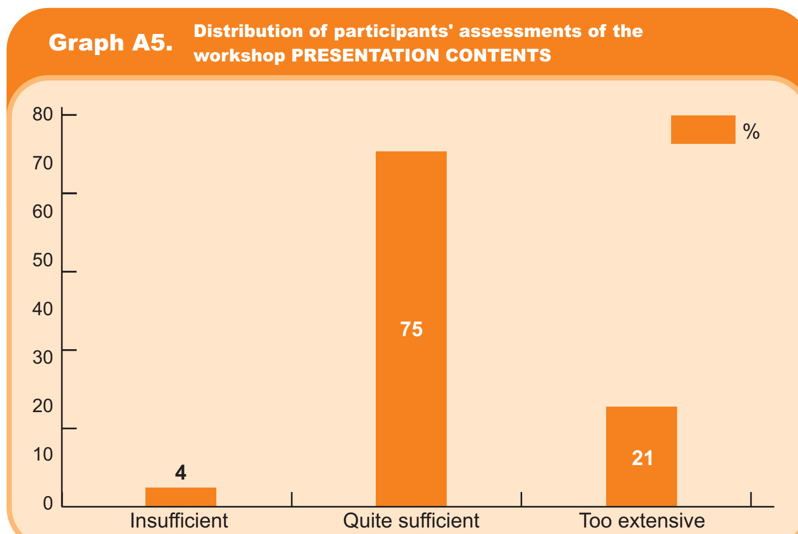
9:00 to 9:45	Plenary session: Report on field observation
9:45 to 10:15	J. Zajeganovic: Observation as a method (Lecture)
10:15 to 11:15	Focus group: Is AIDS a risk for me?
11:15 to 11:30	Coffee break
11:30 to 12:00	V. Bjegovic: Focus group as a method (Lecture)
12:00 to 12:30	V. Cucic: Ethical issues, safety of the pollers
12:30 to 13:30	V. Bjegovic: Preparations for onset of work, instructions, evaluation
13:30 to 14:00	Workshop closing up. Lunch

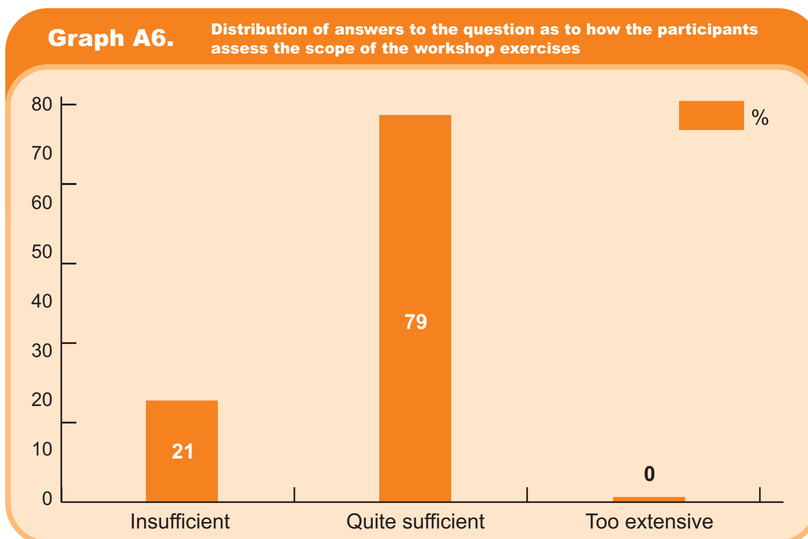
The results stated above show that the RAR workshop participants graded the presentations excellent, and the contents of these presentations were quite good.





Also, the exercises were assessed as excellent, and their contents as quite sufficient, with a recommendation to allow for more space for these exercises at similar workshops.





A-3 WORKSHOP EVALUATION ACCORDING TO WORKSHOP PARTICIPANTS' DISPOSITION EVALUATION FORM

Workshop Participants' Disposition Evaluation Form:

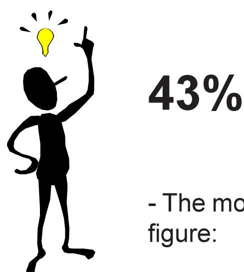
MY DISPOSITION AT THE WORKSHOP

Mood	Day 1	Day 2

Most of the time I felt
(chose the figure that best corresponds to your mood during the first and the second day of the Workshop, by marking it with a plus (+) sign for each day separately)

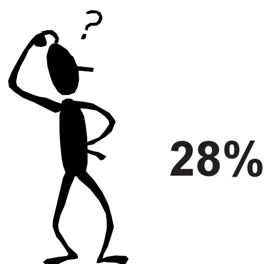
MY DISPOSITION AT THE WORKSHOP

- **DAY ONE** - the workshop participants' disposition was best described by this figure:



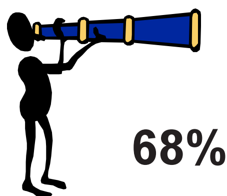
43%

- The mood during the first day of the workshop is also described by this figure:



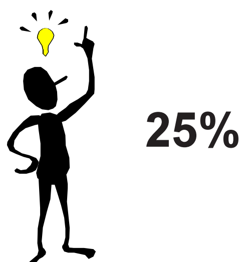
28%

- **DAY TWO** - the workshop participants gave the highest vote to this figure describing their disposition:



68%

- Quite a fewer number of votes was given to this figure:



25%

CONCLUSION

It can be inferred from all gathered results that the participants at the workshop for training the team members in the project of rapid assessment and response to HIV/SIDA (RAR) among the young population have taken an active participation in all elements of education, gave the workshop an EXCELLENT grade, and perceived the problem, the problem of HIV, in a new light which presents the problem that can be grasped and solved by the RAR project.

ANNEX B - Questionnaires

B-1 YOUNG DRUG USERS

UNICEF
MEDICAL FACULTY

Institute for Social Medicine,
Statistics and Research in Health

Q U E S T I O N N A I R E

Questionnaire Identification Number: ☐☐☐☐

City: ____________________

Place of interview: ____________________

Date Questionnaire Completed: ☐☐ ☐☐ ☐☐☐☐ (dd / mm / yyyy)

Field Team Member - Completed by: (initials only): ____________________

Checked by: (initials only): ____________________

"Hello, My name is ………………… I am helping UNICEF with a research study that focuses on issues that affect young people and their health in ……………………….. (name of entity/ country/city). The objective of the study is to find out about the health issues facing young people today and to develop responses to deal with these issues. As part of this study, we are interviewing a large number of vulnerable young people across the region. I would like to ask you a few questions to assist us with this study. It will take about 20 minutes. We are not taking down any names or addresses and all information is completely confidential.

(NOTE for Interviewer: At this stage respond to any queries that the interviewee has. If he/she agrees, record their age to ensure they meet study criterion. IF they do not, thank the respondent and terminate interview.)

AGE: ☐☐ (years old)

Offer the option to the respondent to complete the questionnaire himself/herself.

Instructions for completing the questionnaire:

1. Please put a cross in the box provided. DO NOT TICK.
2. Please answer all questions as honestly as possible.

1. Where are you completing this questionnaire?

   a) ☐ bar / café / club
   b) ☐ school
   c) ☐ street
   d) ☐ park
   e) ☐ at home
   f) ☐ needle exchange (a place or a program where you can take old/used needles and syringes and get new ones in exchange)
   g) ☐ other place (please specify) ____________________

2. Are you:

   a) ☐ male
   b) ☐ female

3. What level of school do you attend?

   a) ☐ primary school

b) ☐ secondary school
c) ☐ higher school
d) ☐ faculty
e) ☐ other: ______________________
f) ☐ I don't attend the school

We would like to ask you some questions related to the use of drugs. Please be assured that your confidentiality is fully maintained as we do not know your name. Remember that we are asking every-body these questions and have not singled you out especially for them.

4. How old were you when you FIRST used drugs? ______________________ years old

5. Which drug? ______________________

6. Do you use intravenous drugs by injecting

a) ☐ yes
b) ☐ no

If you have never used drugs please write "99" then go to Question 10.

7. Before you started with intravenous using of drug, how long did you smoke, sniff or swallow drugs?

a) ☐ less then one year
b) ☐ from 1 to 5 years
c) ☐ from 6 to 10 years
d) ☐ more then 10 years
e) ☐ from the beginning I used IV drugs

8. Where do you usually use drugs? Please put a cross in each box that applies.

a) ☐ bars / cafés / clubs
b) ☐ home
c) ☐ friends' house
d) ☐ party
e) ☐ street
f) ☐ parks
g) ☐ schools
h) ☐ toilets
i) ☐ other place (please specify) ______________________

9. During the week how often do you use intravenous drugs?

a) ☐ each day
b) ☐ only during the weekend
c) ☐ jednom nedeljno
d) ☐ 2-5 times
e) ☐ 5-10 times
f) ☐ more then 10 times
g) ☐ several times per day

10. In the last 1 month, did you use any of the following drugs? Please put a cross in each box that applies.

a) ☐ tobacco
b) ☐ alcohol
c) ☐ cannabis / marijuana
d) ☐ diazepam or other benzodiazepines (local name) ______________________
e) ☐ ecstasy
f) ☐ glue or inhalant
g) ☐ amphetamines
h) ☐ LSD
i) ☐ heroin
j) ☐ methadone
k) ☐ cocaine
l) ☐ poppy tea
lj) ☐ analgesics (local name) ______________________
m) ☐ other drugs (please specify) ______________________

11. Have you ever taken two or more drugs (including alcohol) at the same time?

a) ☐ yes
b) ☐ no

In Question 12, we define "sexual intercourse" as oral, vaginal and anal penetrative sex.

12. 12. Have you ever had sexual intercourse under the influence of any of the drugs mentioned in Question 10, except tobacco?

a) ☐ yes
b) ☐ no

13. Where do you buy drugs?

a) ☐ bars / cafés / clubs
b) ☐ party
c) ☐ parks
d) ☐ street
e) ☐ street
f) ☐ schools
g) ☐ pharmacy
h) ☐ other place (please specify): ________________________

14. How much one doze of the heroin cost? (in DM)

15. 15. From where do you take the money for buying drugs?

a) ☐ from my own salary
b) ☐ from parents/relatives
c) ☐ from friends
d) ☐ from selling sex
e) ☐ from selling drugs
f) ☐ from theft
e) ☐ other (please specify) ________________________

16. How old were you when you FIRST injected drugs? ________________________
Godine

If you have never injected drugs, please write "99" then go to Question 24.

Question 17 is about drug injecting equipment and how it may be used. We define "drug-injecting equipment" as needles and syringes. We define "sharing" as using a needle or syringe for injecting drugs when you knew or suspected that someone else (including your sexual partner) had used it before.

17. Have you ever shared drug-injecting equipment?

a) ☐ yes
b) ☐ no

18. Where do you usually get your equipment for injecting drugs?

a) ☐ sharing equipment with others
b) ☐ from pharmacy
c) ☐ from friends
d) ☐ from health institutions
e) ☐ from drug distributor
f) ☐ other (please specify) ________________________

19. Do you clean equipment before you use it?

a) ☐ yes, always
b) ☐ sometimes
c) ☐ never

20. If yes, or sometimes, how do you clean? ____

____

21. During the last year did you have any problems with skin (blush, pain, infection) at the place where you inject drugs?

a) ☐ yes
b) ☐ no

22. During the last year did you visit the doctor because of drug injecting?

a) ☐ yes
b) ☐ no

23. If yes, please explain why?

a) ☐ An order to quit using drugs
b) ☐ due to overdose
c) ☐ due to skin infection
d) ☐ due to other infection
e) ☐ other (please indicate) ______________________

We define "Sexually Transmitted Infections" as gonorrhea, chlamydia, syphilis, genital herpes, genital or anal warts, trichomoniasis, Hepatitis B, and Hepatitis C.

24. Where do you get information on HIV or other Sexually Transmitted Infections (STI)? Please put a cross in each box that applies.

a) ☐ family
b) ☐ friends / peers
c) ☐ media
d) ☐ school
e) ☐ social / health workers
f) ☐ STI counseling services
g) ☐ other place (please specify) ______________________
h) ☐ no place - I don't get information on HIV or STI

25. What is your risk for HIV or other Sexually Transmitted Infections?

a) ☐ high
b) ☐ moderate
c) ☐ without any risk

26. Have you ever been tested for the following? Please put a cross in each box that applies..

a) ☐ HIV / AIDS
b) ☐ Hepatitis B
c) ☐ Hepatitis C

27. Please, answer on the following statements with "TRUE" or "FALSE"

Statement	TRUE	FALSE
Using condoms during the vaginal, anal or oral sex is decreasing the risk for the HIV transmission.		
Sharing the same glass for drink can transmit the HIV.		
Pregnant woman can transmit the HIV to her unborn child.		
Sharing the needles during intravenous drug injections is increasing the risk for the HIV transmission		

28. Have you ever had problems with police related to intravenous drug using?

a) ☐ yes
b) ☐ no

29. If yes, please explain what problems you have? ______________________________________

____

____

____

30. Have you been persecuted by criminal law because of intravenous drug using?

a) ☐ yes
b) ☐ no

We are asking some questions about sexual behaviour. We realize the personal nature of these questions but would like to remind you that your confidentiality is fully protected and we are asking everybody the same questions. Again, we define "sexual intercourse" as oral, vaginal and anal penetrative sex.

31. At what age did you have your FIRST sexual intercourse? ______________________ years old

If you have never had sexual intercourse please write "99" and thank the respondent then terminate the interview. Give out information if appropriate and answer any questions that the respondent asks. Then go to the last page.

32. Are your sexual partners usually:

a) ☐ male
b) ☐ female
c) ☐ both male and female

33. In the last 1 year, how many sexual partners have you had? ______________________

34. In the last 1 year, how frequently have you used condoms during sexual intercourse?

a) ☐ always
b) ☐ sometimes
c) ☐ never

If you "always" use condoms during sexual intercourse then go to Question 36.

35. What are your reasons for not always using condoms? Please put a cross in each box that applies.

a) ☐ too expensive / cannot afford
b) ☐ embarrassed to buy
c) ☐ difficult to use
d) ☐ not easily available
e) ☐ don't like sex with condoms
f) ☐ embarrassed to ask partner to use
g) ☐ I have trust in my partners
h) ☐ no knowledge / awareness about the benefits of using condoms
i) ☐ other reason (please specify) ______________________

36. Have you ever had sexual intercourse with someone in return for money, drugs, employment, etc?

a) ☐ yes
b) ☐ no

37. Have you had a Sexually Transmitted Infection?

a) ☐ in the last 1 year
b) ☐ in the last 6 months
c) ☐ in the last 1 month
d) ☐ ever in the past
e) ☐ never

38. Which organization do you know which offer help to people living with HIV?

___

___

___

___

39. According to you what is lacking to stop the spread of HIV infection?

Thank the respondent and terminate interview. Give out information leaflets if appropriate and answer any questions that the respondent asks. Also, check that the questionnaire is fully and accurately completed.

Please state how you think the interview went

a) ☐ very well
b) ☐ moderately well
c) ☐ not very well.

If "not very well" please state why. Add any other comments you might have

___

___

___

___

___

___

___

___

___

___

___

___

___

___

___

___

___

B-2 YOUNG MEN WHO HAVE SEX WITH MEN

UNICEF
MEDICAL FACULTY

Institute for Social Medicine,
Statistics and Research in Health

QUESTIONNAIRE

Questionnaire Identification Number: ☐☐☐☐

City: ____________________

Place of interview: ____________________

Date Questionnaire Completed: ☐☐ ☐☐ ☐☐☐☐ (dd / mm / yyyy)

Field Team Member - Completed by: (initials only): ____________________

Checked by: (initials only): ______________________

"Hello, My name is ………………… I am helping UNICEF with a research study that focuses on issues that affect young people and their health in ………………………. (name of entity/ country/city). The objective of the study is to find out about the health issues facing young people today and to develop responses to deal with these issues. As part of this study, we are interviewing a large number of vulnerable young people across the region. I would like to ask you a few questions to assist us with this study. It will take about 20 minutes. We are not taking down any names or addresses and all information is completely confidential.

(NOTE for Interviewer: At this stage respond to any queries that the interviewee has. If he/she agrees, record their age to ensure they meet study criterion. IF they do not, thank the respondent and terminate interview.)

AGE: ☐☐ (years old)

Offer the option to the respondent to complete the questionnaire himself/herself.

Instructions for completing the questionnaire:

1. Please put a cross in the box provided. DO NOT TICK.
2. Please answer all questions as honestly as possible.

1. Where are you completing this questionnaire?

a) ☐ bar / café / club
b) ☐ school
c) ☐ street
d) ☐ park
e) ☐ at home
f) ☐ needle exchange (a place or a program where you can take old/used needles and syringes and get new ones in exchange)
f) ☐ other place (please specify) ___________________________

3. What level of school do you attend?

a) ☐ primary school
b) ☐ secondary school
c) ☐ higher school
d) ☐ faculty
e) ☐ other: ______________________
f) ☐ I don't attend the school

3. What is your age? ____

4. Where do you live?

   a) ☐ village
   b) ☐ small city
   c) ☐ city
   d) ☐ big city

5. With whom do you live? ____

6. Are you married?

   a) ☐ yes
   b) ☐ no

7. Do you have children?

   a) ☐ yes
   b) ☐ no

8. How do you earn money for life? ____

9. Are you satisfied with your job?

   a) ☐ yes

   b) ☐ no

10. Do you use the Internet on the computer?

    a) ☐ yes

    b) ☐ no

11. If yes, how often do you use the Internet? ______________________________________

In Question 12, we define "sexual intercourse" as oral, vaginal and anal penetrative sex.

12. How old was your FIRST male sexual partner?

    a) ☐ similar age as me
    b) ☐ a little younger then me
    c) ☐ a little older than me
    d) ☐ a lot younger than me
    e) ☐ a lot older than me

13. Do you have a just regular partner?

    a) ☐ yes
    b) ☐ no

14. If yes, how long have you been with this just regular partner?___________________________

15. If you have no just regular partner, in the last year, how many different partners have you had sex with?

____

16. Do you take care about using condoms?

    a) ☐ always
    b) ☐ sometimes
    c) ☐ never

17. Do you use condoms for oral sex?

    a) ☐ always
    b) ☐ sometimes
    c) ☐ never

18. Do you use condoms for anal sex?

    a) ☐ always
    b) ☐ sometimes
    c) ☐ never

19. What type of condoms do you use?

a) ☐ for anal sex
b) ☐ any kind
c) ☐ for oral sex
d) ☐ I don't use condoms

20. What are your reasons for not always using condoms? Please put a cross in each box that applies.

a) ☐ too expensive / cannot afford
b) ☐ embarrassed to buy
c) ☐ difficult to use
d) ☐ not easily available
e) ☐ don't like sex with condoms
f) ☐ embarrassed to ask partner to use
g) ☐ I have trust in my partners
h) ☐ no knowledge / awareness about the benefits of using condoms
i) ☐ other reason (please specify)

21. Do you think about having unsafe sex, without condoms?

a) ☐ always
b) ☐ sometimes
c) ☐ never

22. Do you use lubricants?

a) ☐ yes
b) ☐ no

23. If yes, what types of lubricants do you use?

a) ☐ water based
b) ☐ any type (cream or other oil based)
c) ☐ I don't use lubricants

24. Where do you find your partners?

a) ☐ advertisement
b) ☐ Internet
c) ☐ gay places
d) ☐ parks
e) ☐ other (please specify) ____

25. In the last year how many different partners for a night do you have sex with? ________________
years old

26. What are you looking for in a partner?____

____

27. Did you ever had bad experiences with a sexual partners?

a) ☐ yes
b) ☐ no

We define "Sexually Transmitted Infections" as gonorrhea, chlamydia, syphilis, genital herpes, genital or anal warts, trichomoniasis, Hepatitis B, and Hepatitis C.

28. Where do you get information on HIV or other Sexually Transmitted Infections (STI)? Please put a cross in each box that applies.

a) ☐ family
b) ☐ friends / peers
c) ☐ media
d) ☐ school
e) ☐ social / health workers
f) ☐ STI counseling services
g) ☐ other place (please specify)
h) ☐ no place - I don't get information on HIV or STI

29. What is your risk for HIV or other Sexually Transmitted Infections?

a) ☐ high
b) ☐ moderate
c) ☐ without any risk

30. Have you ever been tested for the following? Please put a cross in each box that applies.

a) ☐ HIV / AIDS
b) ☐ Hepatitis B
c) ☐ Hepatitis C

31. Please, answer on the following statements with "TRUE" or "FALSE"

Statement	TRUE	FALSE
Using condoms during the vaginal, anal or oral sex is decreasing the risk for the HIV transmission.		
Sharing the same glass for drink can transmit the HIV.		
Pregnant woman can transmit the HIV to her unborn child.		
Sharing the needles during intravenous drug injections is increasing the risk for the HIV transmission		

32. Have you had a Sexually Transmitted Infection?

a) ☐ yes
b) ☐ no

33. Have you ever had sexual intercourse with someone in return for money, drugs, employment, etc?

a) ☐ yes
b) ☐ no

34. Have you ever had any problem because of your sexual orientation?

a) ☐ yes
b) ☐ no

35. If HIV testing was anonymous would you get an HIV test?

a) ☐ yes
b) ☐ no
c) ☐ I don't know

36. What organizations do you know of that provide HIV help? ______________________________

____

37. Are you satisfied with the work of that organization?

a) ☐ completely
b) ☐ not bad
c) ☐ not completely satisfied
d) ☐ not satisfied at all

38. If you needed HIV help, who would you go to? ______________________________

____

39. What kind of services are missing for young gay population? ______________________________

____

Thank the respondent and terminate interview. Give out information leaflets if appropriate and answer any questions that the respondent asks. Also, check that the questionnaire is fully and accurately completed.

Please state how you think the interview went:

a) ☐ very well
b) ☐ moderately well
c) ☐ not very well.

If "not very well" please state why. Add any other comments you might have.

____
____
____
____
____
____
____
____
____
____
____
____
____
____

B-3 YOUNG SEX WORKERS

UNICEF
MEDICAL FACULTY

Institute for Social Medicine,
Statistics and Research in Health

QUESTIONNAIRE

Questionnaire Identification Number: ☐☐☐☐

City: ____________________

Place of interview: ____________________

Date Questionnaire Completed: ☐☐ ☐☐ ☐☐☐☐ (dd / mm / yyyy)

Field Team Member - Completed by: (initials only): ____________________

Checked by: (initials only): ____________________

"Hello, My name is .... I am helping UNICEF with a research study that focuses on issues that affect young people and their health in .... (name of entity/ country/city). The objective of the study is to find out about the health issues facing young people today and to develop responses to deal with these issues. As part of this study, we are interviewing a large number of vulnerable young people across the region. I would like to ask you a few questions to assist us with this study. It will take about 20 minutes. We are not taking down any names or addresses and all information is completely confidential.

(NOTE for Interviewer: At this stage respond to any queries that the interviewee has. If he/she agrees, record their age to ensure they meet study criterion. IF they do not, thank the respondent and terminate interview.)

AGE: ☐☐ (years old)

Offer the option to the respondent to complete the questionnaire himself/herself.

Instructions for completing the questionnaire:

1. Please put a cross in the box provided. DO NOT TICK.
2. Please answer all questions as honestly as possible.

1. Where are you completing this questionnaire?

a) ☐ bar / café / club
b) ☐ school
c) ☐ street
d) ☐ park
e) ☐ at home
f) ☐ needle exchange (a place or a program where you can take old/used needles and syringes and get new ones in exchange)
f) ☐ other place (please specify) ____________________

2. Are you:

a) ☐ male
b) ☐ female

3. What level of school do you attend?

a) ☐ primary school
b) ☐ secondary school
c) ☐ higher school
d) ☐ faculty
e) ☐ other: ____________________
f) ☐ I don't attend the school

We would like to ask you some questions related to the use of drugs. Please be assured that your confidentiality is fully maintained as we do not know your name. Remember that we are asking everybody these questions and have not singled you out especially for them

4. How old were you when you FIRST used drugs? ______________________
godine

If you don't use drugs please write "99" and then go to question 24.

5. Which drug? ______________________

6. 6. Do you use intravenous drugs by injecting

a) yes ☐
b) no ☐

If your answer is NO, please go to Question 16.

7. How old were you when you FIRST injected drugs? ______________________
godine

8. Before you started with intravenous using of drug, how long did you smoke, sniff or swallow drugs?

a) ☐ less then one year
b) ☐ from 1 to 5 years
c) ☐ from 6 to 10 years
d) ☐ more then 10 years
e) ☐ from the beginning I used IV drugs

Question 9 is about drug injecting equipment and how it may be used. We define "drug-injecting equipment" as needles and syringes. We define "sharing" as using a needle or syringe for injecting drugs when you knew or suspected that someone else (including your sexual partner) had used it before.

9. Where do you usually get your equipment for injecting drugs?

a) ☐ sharing equipment with others
b) ☐ from pharmacy
c) ☐ from friends
d) ☐ from health institutions
e) ☐ from drug distributor
f) ☐ other (please specify) ______________________

10. Have you ever shared drug-injecting equipment?

a) ☐ yes
b) ☐ no

11. Do you clean equipment before you use it?

a) ☐ yes, always
b) ☐ sometimes
c) ☐ never

12. If yes, or sometimes, how do you clean? ______________________

13. During the last year did you have any problems with skin (blush, pain, infection) at the place where you inject drugs?

a) ☐ yes
b) ☐ no

14. During the last year did you visit the doctor because of drug injecting?

a) ☐ yes
b) ☐ no

15. If yes, please explain why? ______________________ ______________________

16. Where do you usually use drugs? Please put a cross in each box that appliesz

a) ☐ bars / cafés / clubs
b) ☐ home
c) ☐ street
d) ☐ parks
e) ☐ schools
f) ☐ toilets
g) ☐ other places (please specify) ______________________________`
h) ☐ friend's house
g) ☐ party

17. During the week how often do you use intravenous drugs?

a) ☐ each day
b) ☐ only during the weekend
c) ☐ once per week
d) ☐ 2 - 5 times
e) ☐ 5 - 10 times
f) ☐ more than 10 times

18. In the last 1 month, did you use any of the following drugs? Please put a cross in each box that applies.

a) ☐ tobacco
b) ☐ alcohol
c) ☐ cannabis / marijuana
d) ☐ diazepam or other benzodiazepines (local name) ____________________
e) ☐ ecstasy
f) ☐ glue or inhalant
g) ☐ amphetamines
h) ☐ LSD
i) ☐ heroin
j) ☐ methadone
k) ☐ cocaine
l) ☐ poppy tea
lj) ☐ analgesics (local name) ____________________________________
m) ☐ other drugs (please specify) _________________________________

19. Have you ever taken two or more drugs (including alcohol) at the same time?

a) ☐ yes
b) ☐ no

In Question 20, we define "sexual intercourse" as oral, vaginal and anal penetrative sex.

20. Have you ever had sexual intercourse under the influence of any of the drugs mentioned in Question 10, except tobacco?

a) ☐ da
b) ☐ ne

21. Where do you buy drugs?

a) ☐ bars / cafés / clubs
b) ☐ party
c) ☐ parks
d) ☐ street
e) ☐ schools
f) ☐ pharmacy
h) ☐ other place (please specify) _____________________

22. How much one doze of the heroin cost?_____________________(in DM)

23. From where do you take the money for buying drugs?

a) ☐ from my own salary
b) ☐ from parents/relatives
c) ☐ from friends

d) ☐ from selling sex
e) ☐ from selling drugs
f) ☐ from theft
g) ☐ other (please specify) ________________________

We are asking some questions about sexual behaviour. We realize the personal nature of these questions but would like to remind you that your confidentiality is fully protected and we are asking everybody the same questions. Again, we define "sexual intercourse" as oral, vaginal and anal penetrative sex.

24. At what age did you start with selling sex? ________________________
Years old

25. At what age did you have your FIRST sexual intercourse? ________________________
Years old

26. How long have you been selling sex? ________________________
Duration in years

27. In order to find clients, do you work:

a) ☐ alone
b) ☐ with friends
c) ☐ with macro
d) ☐ other (please specify) ________________________

28. Where do you usually find clients?

a) ☐ bars / cafés / clubs
b) ☐ party
c) ☐ parks
d) ☐ street
e) ☐ schools
f) ☐ in salon for massage
g) ☐ other place (please specify) ________________________

29. Are your clients usually

a) ☐ apposite sex
b) ☐ same sex
c) ☐ both sexes

30. Are your male clients usually:

a) ☐ from this place
b) ☐ foreigners work here
c) ☐ other (please specify) ________________________

31. In the last month, how many clients have you had? ________________________

32. In the last 1 year, how many sexual partners have you had? ________________________

33. Have you had the permanent (regular) sexual partner?

a) ☐ yes
b) ☐ no

Seksualno prenosive infekcije su gonoreja (triper, kapavac), hlamidija, sifilis, genitalni herpes, trihomonijaza, bradavice ili ~irevi na intimnim mestima, Hepatitic B I Hepatitis C.

34. Gde dobijate informacije o seksualno prenosivim infekcijama (SPI) / HIV? Molimo vas da precrtate kvadrati} za svaki odgovor koji je tacan.

a) ☐ family
b) ☐ friends / peers
c) ☐ media
d) ☐ school
e) ☐ social / health workers
f) ☐ STI counseling services
g) ☐ other place (please specify)
h) ☐ no place - I don't get information on HIV or STI ________________________

35. What is your risk for HIV or other Sexually Transmitted Infections?

a) ☐ high
b) ☐ moderate
c) ☐ without any risk

36. Have you ever been tested for the following? Please put a cross in each box that applies.

a) ☐ HIV / AIDS
b) ☐ Hepatitis B
c) ☐ Hepatitis C

37. Please, answer on the following statements with "TRUE" or "FALSE"

Statement	TRUE	FALSE
Using condoms during the vaginal, anal or oral sex is decreasing the risk for the HIV transmission.		
Sharing the same glass for drink can transmit the HIV.		
Pregnant woman can transmit the HIV to her unborn child.		
Sharing the needles during intravenous drug injections is increasing the risk for the HIV transmission		

38. Have you ever had problems with police related to selling sex?

a) ☐ yes
b) ☐ no

39. If yes, please explain what problems you have? ____

____

____

40. Have you been persecuted by criminal law because of selling sex?

a) ☐ yes
b) ☐ no

41. Do you keep the whole money for you?

a) ☐ da
b) ☐ ne

42. If your answer is NO, please fill in the table.

	You give the part of the money	You give the whole money
To macro		
To boy friend		
To friend		
To family / relatives		
Other (please specify)		

43. What do you do with the money earned?

a) ☐ buying drugs
b) ☐ buying new clothes, shoes, perfumes
c) ☐ saving money for paying the school
d) ☐ saving money
e) ☐ social / health workers
g) ☐ other place (please specify) ____________________

44. In the last 1 year, how frequently have you used condoms during sexual intercourse?

a) ☐ always
b) ☐ sometimes
c) ☐ never

If you "always" use condoms during sexual intercourse then go to Question 46.

45. What are your reasons for not always using condoms? Please put a cross in each box that applies.

a) ☐ too expensive / cannot afford
b) ☐ embarrassed to buy
c) ☐ difficult to use
d) ☐ not easily available
e) ☐ don't like sex with condoms
f) ☐ embarrassed to ask partner to use
g) ☐ I have trust in my partners
h) ☐ no knowledge / awareness about the benefits of using condoms
i) ☐ other reason (please specify) ________________________

46. Have you ever had sexual intercourse with someone in return for money, drugs, employment, etc?

a) ☐ yes
b) ☐ no

47. Have you had a Sexually Transmitted Infection?

a) ☐ in the last 1 year
b) ☐ in the last 6 months
c) ☐ in the last 1 month
d) ☐ ever in the past
e) ☐ never

48. Which organization do you know which offer help to people living with HIV?

a) ☐ JAZAS
b) ☐ Youth of JAZAS
c) ☐ HIV / AID
d) ☐ ALEXO
e) ☐ GOD
f) ☐ Other (please specify) ________________________

49. According to you what is lacking to stop the spread of HIV infection? ________________________

____

Thank the respondent and terminate interview. Give out information leaflets if appropriate and answer any questions that the respondent asks. Also, check that the questionnaire is fully and accurately completed.

Please state how you think the interview went:

a) ☐ very well
b) ☐ moderately well
c) ☐ not very well.

If "not very well" please state why. Add any other comments you might have.

____

____

____

____

____

ANNEX C - Interview with health workers in institutions where drug addicts get treatment

C-1 MANAGERS

Managers in health institutions where drug addicts get treatment
Heads (chiefs-of-staff), Service chiefs in out-patient protection

Name of institution ______________________________

Name of ward ____________________________

Name of service _______________________________

Interview structure

- Would you, according to your institution's data, assess drug addiction in our country as going up?
- What other changes do you find based on your institution's morbidity figures?
- Is intravenous addiction on the rise?
- What are the biggest problems that you encounter during your demanding work?
- If things at your institution depended solely on you, if you were to make decisions exclusively, what changes would you introduce?
- Do you follow forms of risk behaviour related to HIV transmission of your patients?
- Are any measures undertaken to prevent such behaviour? Which?
- What therapeutical programmes applied are the most effective?
- How can you confirm it?
- What do you deem inefficient and in need of change? What would you eliminate?
- What therapy efficiency indicators do you use?
- How much is a patient followed?
- After discharge, are rhere any planned controls?
- Are there problems with personnel at your institution, and what?
- Where and how do you inform the staff on work specifics, therapy options, methods, and similar?
- Could you enumerate all activities that your institution deals with?
- What out-of-institution activities and programmes is your institution involved with?
- What is your opinion on needle and syringe exchange programme for intravenous drug addicts?
- What preventive activities do you propose?
- Anything to add, not included in this interview?

C-1 PHYSICIANS

Managers in health institutions where drug addicts get treatment
Heads (chiefs-of-staff), Service chiefs in out-patient protection

Name of institution ____________________________

Name of ward ___________________________

Name of service _____________________________

Interview structure

- Would you, according to your institution's data, assess drug addiction in our country as going up?
- What other changes do you find based on your institution's morbidity figures?
- Is intravenous addiction on the rise?
- What are the biggest problems that you encounter during your demanding work?
- If things at your institution depended solely on you, if you were to make decisions exclusively, what changes would you introduce?
- Do you follow forms of risk behaviour related to HIV transmission of your patients?
- Are any measures undertaken to prevent such behaviour? Which?
- What therapeutical programmes applied are the most effective?
- How can you confirm it?
- What do you deem inefficient and in need of change? What would you eliminate?
- What therapy efficiency indicators do you use?
- How much is a patient followed?
- After discharge, are rhere any planned controls?
- Are there problems with personnel at your institution, and what?
- Where and how do you inform the staff on work specifics, therapy options, methods, and similar?
- Could you enumerate all activities that your institution deals with?
- What out-of-institution activities and programmes is your institution involved with?
- What is your opinion on needle and syringe exchange programme for intravenous drug addicts?
- What preventive activities do you propose?
- Anything to add, not included in this interview?

ANNEX D - Interview in schools

School Principals

School (elementary or secondary) ______________________________

Interview structure

- Many information sources point to an increase in young people's risk behaviour. What is your opinion?
- How would you describe such behaviour (i.e., according to you, what are the most serious health threatening risks for the young)?
- How is that behaviour perceived and manifested at your school?
- Could you make an approximate estimation as to the number of children at school who manifest a form of risk behaviour?
- Drug addiction, no doubt, is per se a very serious phenomenon among young people, and coupled with HIV infection threat it gets a new dimension. What is your opinion?
- Besides the mentioned risks, would you care to add any others, specific for drug addiction?
- How do you assess situation at your school in regards to drug addiction?
- Is behaviour of the young, drug addiction in particular, ever spoken of at meetings with parents, at class assemblies, parents' councils (only in elementary schools), school board metings?
- How many children, according to your opinion, use drugs at your school?
- Are there any intravenous addicts?
- They say children take drugs at school. Any such experience?
- How do you react in such a situation?
- What do you think causes such behaviour?
- Have any concrete measures been undertaken at school? Which?
- Was school involved in any action organized by others? Which? Organized by whom?
- Anything planned for the future?
- Anything to add (not included above)?

ANNEX E - Questionnaire for identifying interventions

QUESTIONNAIRE "I"

Title of institution (organization) ____________________

1. Is your institution carrying out an activity (programme) aimed at YOUNG , related to HIV infection prevention[1]?

NO YES

2. For those who answer YES [2]
   Please describe the activity as follows:
   a) Name of activity - programme ____________________
   b) Programme started? __________ ended? __________ still on __________
   c) Who are target groups (who is it aimed at)? ____________________
   d) What is the planned scope ____________________
   e) Basic activity contents ____________________
   f) Activity carriers? ____________________
   g) How is the activity carried out ? ____________________
   h) Was there any assessment made before this activity started ?

      No
      Yes - how was it done? ____________________
   i) Was there an evaluation at the end?

      No
      Yes - how was it done? ____________________

3. Do you know of any programme of the same or similar character undertaken in any other institution (organization)?

NO YES

   a. Name of institution ____________________
   b. Name of activity ____________________
   c. Any other data ____________________

Questionnaire filled by:

Name and surname ____________________

(mark as necessary)

Member of the National Advisory Board

Member of the City Advisory Board

School Principal or authorized person (function) ____________________

Director of health institution or authorized person (function) ____________________

Else (who) ____________________

1 This includes activities and programmes aimed at drug addiction prevention; activities in sexual and reproductive health fields; sexually transmittable diseases or HIV direct prevention

2 IF THERE SHOULD BE MORE THAN ONE ACTIVITY - PROGRAMME, PLEASE FILL IN ADDITIONAL QUESTIONNAIRES FOR EACH SEPARATELY

Supplement

Please describe other activities, if any, at your institution[3]

j) Name of activity - programme ____
____
____
____

k) When did the programme start ________ When did it end ________ Is it still on______________

l) Who are target groups (who is it aimed at) ______________________

m) What is the planned scope? ______________________

n) Basic activity contents ____
____
____
____

o) Activity carriers ____

p) How is the activity carried out ____

q) Was there any assessment made before this activity started?

No

Yes - how was it done ____

r) Was there an evaluation at the end?

No

Yes - how was it done ____

[3] Ako postoje i druge aktivnosti, molimo napravite kopiju ovog dela i popunite i za tu aktivnost. HVALA

ANNEX F - Interview with decision makers - politicians on different levels

Political level:

1. Minister of health, i.e. Secretary of Health, or member of the City Government in charge of health policy
2. Minister of Education, i.e. Secretary of Education, or member of the City Government in charge of education policy
3. Minister of social protection, i.e. secretary or member of the City Government in charge of social protection policy
4. Member of the Serbian Government in charge of the social activities department

Local coordinators are to take these interviews

Interview structure

- Many information sources point to an increase in young people's risk behaviour. What is your opinion?
- How would you describe such behaviour (i.e., according to you, what are the most serious health threatening risks for the young)?
- What causes, according to you, such behaviour?
- Could you divide the causes according to "origin"?
- Drug addiction, no doubt, is per se a very serious phenomenon among young people, and coupled with HIV infection threat it gets a new dimension. What is your opinion?
- Do you believe the phenomenon to be big and serious enough as to require prompt intervention?
- Who do you think should initiate the intervention, and how to realize it?
- Besides the mentioned risks, would you care to add any others, specific for drug addiction?
- Is anything undergoing in the department you manage related to risk behaviour of the young? What is it, can you elaborate?
- Is anything planned for the future?
- Anything to add (not included above)?

ANNEX G - Examples of MEGA grids

G -1 YOUNG DRUG USERS (IDU) - BELGRADE

DATA GATHERING METHOD AND LOCALITIES **IVDU - Belgrade**

Research conducted among drug addicts was aimed at investigating the attitudes, knowledge, and behaviour of young drug addicts, referring to drug abuse and sexual habits, concerning the HIV infection as focus of this research.
Subjects were 12 to 36 y/o. The questionnaires were distributed only to those not older than 25, and there were interviews with a few older persons whom we considered as a valuable source of information. Total of 80 persons were interviewed, abusers of psychoactive substances (56 males and 24 females), out of these 62 are intravenous addicts (15 of them are HIV-positive), and one drug dealer.
Research instruments: questionnaire with 30 plus 9 questions, (of closed and open types, respectively), focus group, unstructured interview, as well as observation of hot spots (junkie joints, meeting places). There were 34 interviews (15 in cafés, 9 in private flats, 3 in the street, and 4 in a juvenile delinquents home), 7 focus groups (with 9, 8, 7, two groups with 6 and two with 5 participants, plus a moderator; three groups were gathered in an apartment, two in a park, and one in a café), and 12 observations (2 cafés, 2 techno parties, 2 events in the streets, 2 in parks, as well as one in a school yard, in the juvenile delinquents home, an addict's apartment, and a dealer's flat. Mapping of hot sports were junkies get together in Belgrade was not to be made as such places are actually nonexistent (save for techno parties and the park across the Narco-Centre). All the information thus gathered was sorted out in 4 categories of factors: contextual factors, hazardous behaviour, health and social consequences, and policy of intervention.
The research was conducted in Belgrade in November and December of 2001, and in January 2002.
For the purpose of deepening and validating the gathered data, additional 10 interviews were made with members of the NGOs that deal with problems of risk behaviour, 3 interviews with show biz people (musicians), 3 interviews with politicians (Ministries of Health and Education), 2 interviews with medical staff at the Ward VI of the Infectious Diseases Clinic, 2 interviews with medical staff at the Institute for Addiction Diseases, 11 interviews with educational psychology-pedagogy staff (6 at high schools, and 5 at secondary vocational schools), 10 interviews with pharmacists at private pharmacies (plus one in a state-owned pharmacy), 2 interviews with Ministry of Interior officials. Additional secondary sources of information were used: protocols of hospitalized patients, health charts of the Institute for Addiction Diseases and Youth Team members (The F. V. Vujic Institute for Psychiatry), as well as available and relevant medical records of the Clinical and of the Emergency Centres of Serbia.

CONTEXT — IVDU - Belgrade

Area of assessment	Findings	Data sources	Comments
School Qualifications	• Out of 80 total drug addict interviewees, nine have completed elementary education, and only six are university postgraduates. The others are equally distributed among those who graduated from high schools and those who have begun but never completed university studies.	All interviews and focus groups	Dropping out of school causexd by drug abuse
Employment	• More than three fourths of subjects are unemployed (only 7 employed), two are in sex trafficking, one is family pension beneficiary, a girl lives with a much older drug dealer, and a great number of them (more than two thirds) engages in criminal activities as a means to provide for drugs.	s.a.a.	
Family Growing up conditions	• Thirteen respondents were growing or are reaching adulthood without their parents (in institutions, at foster homes, with relatives), dozen of them live in incomplete families, and almost all of the rest in a dysfunctional family, in frigid relations, misunderstood by their kin, (only 13 out of about sixty subjects claim their parents understand them and are fighting for them).	s.a.a.	
Parental engagement	• Most often it is the mother that fights for her child, and they usually take up the role of a guardian in the process of treatment, while fathers most frequently withdraw hastily.	Focus group with 6 participants at a key informant's flat (on Dec. 26, 2001)	
Parental insight	• In case of about a dozen addicts, parents are unaware of the problem, whether they live out of town, or the addict is still socially functioning properly, managing to hide the real condition.	3 focus groups with 9, 7, and 6 participants (on Nov. 29, Dec. 29, 2001, and Jan. 10, 2002	
Life attitude Initial motive for use of drugs	• Psychoactive substances are most often taken out of sense of emptiness and void, or boredom, for feeling that life has no sense, and as one of the main reasons they cited the expected liberation from constant anxiety and tension. • Besides, positive group dynamics, the sense of acceptance, and a "common cause" were also added.		Common slang ("nails"-ecstasy, "horse"-heroin, "gun"-syringe, "do oneself up"-change one's state of consciopusness, and similar)
Similiraity with modern youth?	• The same prevailing feeling is largely present today also among the young people, ways of solving the problem, too. There can hardly be any fun or a party with no alcohol or drug abuse. Observations made at Belgrade cafés show high degree of marijuana and alcohol abuse by young people (up to the age of 25) during their everyday outings and weekend fun and games, but quite seldom does one picture him or herself as a person with problems. For great majority of them marijuana use is the most common activity there is.	4 observations in cafés: Nov. 26, "Sir John" in Vracaru, Nov. 28, "Underground", Dec. 1, JAZAS party, Dec. 2, a café in Skadarlija.	
Later motives for drug abuse	• Transfer to other and harder drugs than marijuana leads to psychological and physical (or only psychological) addiction, and the main motive for taking the drug is no longer satisfaction, but fear of a "cold turkey withdrawal, entering paranoia" (abstinence crisis, fear of. madness) • Usually the whole life cycle and daily rhythm is closely connected with drug abuse. ("I have no alternative to drugs", says one of them.) There is	Several interviews and focus groups	

CONTEXT — IVDU - Belgrade

	nothing that they perceive in reality as more valuable than drugs, nothing to replace them. • The threshold of tolerance to frustration is lowered, pleasure must begin right here and now, not much could be sacrificed, as, according to them, nothing makes any sense, anyhow. • CASE STUDY: Still, a 17 year-old parentless child, protégé of a juvenile home, abandoned i.v. drug abuse and considerably diminished the overall intake of drugs after he had embraced God, was baptized and started going to church. Not attempting to interpret the phenomenon, the therapeutical impact of grasping long-term and higher goals, and of subjugating oneself to them, has to be empohasized.	Interview taken on Dec. 5, 2001, with a Childern and Juvenile Correctional Home protégé, confirmed by the inerview with his counselor.	
Street Some hot spots, broadly speaking	• There are no regular meeting places for junkies in Belgrade, no such points where they would gather in larger numbers days on end. • The park across the Institute for Addiction Diseases in Teodora Drajzera Street • Some clubs and cafés (Underground, Mondo, etc.) • Techno and rave parties (Cyberia-Lucky Strike Urban Experience in the Hall 14 of the Belgrade Fair was observed), • The park near Trade Centre Banjica • Vicinity of SKC (entrance, CD vendors' stalls, the park to the rear)	Observation on Dec. 19, 2001 Observation on Nov. 26, 2001 Observation on Dec. 15, 2001	Drug addicts on treatment
	• Doorways and vestibules, any secluded place in secondary school yards, these are just a small part of addicts' goings-on.	Observation of the St. Sava High School yardon Dec. 6, 2001	Resale of drugs, most commonly marijuana, but also the spots where drugs are consumed
	• The largest groups of junkies usually gather in somebody's apartment, waiting for the dealer to bring the stuff, or in the drug dealer's flat, where they buy drugs before they use them. • while making the deal on drugs, until they fix themselves. It almost invariably means takingthe drug in a group.	Observation of a junkie's flat on Dec. 2, 2001, and observation of a drug dealer's flat on Nov. 29, 2001	
Health services availability The Institute for Addiction Diseases	• Almost three fourths were treated at the Institute for Addiction Diseases in Teodora Drajzera Street and they ALL have an extremely bad experience: • Stern and often unfair rules as to whom to admit or not for treatment, so that many of them are left unassisted	All focus groups and several interviews Focus group with 6 participants, on Dec. 26, 2001 s.a.a.	
	• At the very entrance, at the reception desk, the nurses are heavily smoking, which is strictly forbidden to patients • Communication with doctors and nurses is cold and official, without any traces of human empathy and understanding, without true motivation	Interview with medical staff at the Institute on Dec. 26, 2001	Double standards
	• The prevailing mood at the Institute is that of alienation, patients feel like guilty parties, discarded members of society, instead of being treated as persons with problems	most of the interviews with previously treated patients of the Institute	According to majority of respindents it was only Dr Vesna Fridman that showed human com-

CONTEXT — IVDU - Belgrade

Area of assessment	Findings	Data sources	Comments
	• Small number of doctors as compared to the number of patients • There is no truly multidisciplinary approach to treatment, no real psychotherapy, no work therapy, at the same time getting together is not encouraged, necessary homogeneity of a group is not respected. • Sexual intercourses at the Institute are frequent, but there are no condoms!!!	1 focus group on 26 Dec. 2001, with 6 subjects, and several interviews	passion Enormous risk of STD and HIV!!!
	• Once caught in the act of drug abuse, the patients are discharged for 6 months to one year, the money deposit is held back, and they are thus pushed even deeper into abuse.	2 focus groups and interviews with a medical staff	
	• The methadone programme is available only to those who are addicts for more than 15 years, and to HIV-positive patients	focus group with 7 subjects treated with metadone on 13 January 2002	Methadone and Trodon are often mixed beer in order to endure
	• Methadone dosage is highly suspicious to most of the patients, for they do not feel the expected effects	s.a.a.	
	• Methadone is distributed on daily basis, so that even fifty year-old patients have to make a long journey every day, coming from surrounding towns to Belgrade for their daily doses, no compassion shown by the staff.	several interviews and focus groups	
Emergency Service	• On the onset of crisis they do not know whom to turn to • Ambulances arrive rather late, and then doctors know not where to take their patient to, particularly if they are HIV-positive.	s.a.a. focus group with 5 participants on 29 Dec. 2001, and one with 7 participants on Dec. 18, 2001	
Pharmacies	• Insulin syringe of the kind drug addicts use can seldom be found in pharmacies.	s.a.a, plus interviews with pharmacists	
Health Services availability in abstinence crises	• Not many health facilities would take them in when they come to seek help in crisis; there are no appropriate protocols for the purpose. The social medical service documentation of the Clinical Centre of Serbia states neither the drug addiction nor the drug types, especially as the diseases and the causes of death certificates do not legally require addiction to be reported. The International Classification of Diseases does not separate intravenous addiction as diagnosis. The admission protocol of the Emergency Centre of Serbia contains no section where addiction could be stated. The files at the Institute for Psychiatry are somewhat more in order (in 2000 - they had 2 cases, and in 2001 - 4 cases of polytoxicomany, 2 without i.v. 1 heroin addict without i.v. and 1 user of LSD).	Secondary sources of information: admission protocols of the Emergency Centre and the Clinical Centre of Serbia, as well as protocols of the hospitalized patients and health charts of the addiction diseases team and of the youth team of the Dr F. V. Vujic Institute for Psychiatry	
Educational prospects	• Most of the interviewees maintain that at the time they started using drugs they were not informed enough of risks and eventual consequences. • The interviewed teachers and pedagogy-psychology staff members at secondary schools emphasize a far better theoretical knowledge among the young people, as opposed to fully conscious, experienced perception of risks concerning the substance abuse and unsafe sex.	11 interviews with psychology-pedagogy services in Belgrade secondary schools	The similar situation is found with the gay population in Belgrade

RISK AND PROTECTIVE BEHAVIOURS — IVDU - Belgrade

Area of assessment	Findings	Data sources	Comments
Beginning of drug abuse			
Age	• The commonest age is 14 to 16, usually together with a small group of close buddies or at a party. Among our respondents the earliest beginning was at the age of 10, the latest at 19.		
First used drug	• The greatest number of respondents started using drugs by smoking marijuana, one started with sniffing glue, and two started directly by inhaling heroin (at the ages of 16 and 17).		
Transfer to hard drugs	• Move onto hard drugs (stronger substances) is caused by diminishment of marijuana effects, and by an urge to explore other states of consciousness. On the average, it happened after one up to three years from the first marijuana use (in our case, it was one month at the earliest, and at the latest it was 6 years after the use of marijuana, when the subject was 22 years old).	Interviews on Dec. 6 nad 8, 2001 Numerous interviews and focus groups	
Transfer to i.v. drug abuse	• The decision to start taking drugs intravenously is often in connection to an idol, a close friend, and an acquaintance, someone who initiates the individual into the ritual. At the onset of i.v. Drug abuse the activities are more likely to be performed in a group, rarely by oneself. • The wish to experince "the flash", a brief state of "oblivion", unattainable if the drug is taken nasally ("sniffing") due to insufficient blood concentration of the substance taken that way	s.a.a., plus observation of group drug abuse in a junkie's flat, on Dec. 1, 2001	
Substances: types, prices, ways of distribution	• The most commonly used substances in our country are: marijuana (grass), heroin (horse, dope), ecstasy (nails), LSD (trip), amphetamines, cocaine, benzodiazepines (Benzedrine mostly; others less frequently), analgesics (Trodon), and also anti-Parkinsonians (Akineton, Artane), opium poppy tea, and sometimes codeine powder or syrup.		
Marijuana	• Marijuana (Cannabis, Indian hemp) is often domestically grown or imported from Albania ("albanka"). It is dried, minced, and mixed with tobacco, so that it can be rolled into a specific sharp-smelling cigarette (joint). A single dose of marijuana (1g) costs about DM 1,5 - 2. It is very largely used at parties, in cafés, and it has become a household word of every young person's life in the cities.		
Heroin	• Heroin is seldom found pure, it is almost invariably mixed with flour or powdered sugar, with the ratio sometimes going up to 50:50 - same quantities of heroin and of added substance(s). The white powder is swallowed, sniffed, or used intravenously.	Several interviews and focus groups, plus an interview with a drug dealer on Jan. 10, 2002	Secondary consequences of drug abuse!
	• Sniffing can damage the nasal cartilage, so that improved techniques are introduced - new banknotes are rolled into a pipe and then used to snort the powder in through it. This causes bleeding in nasal cavity, and as the notes go round this may be a new channel of HIV blood transmission.	Observation at St. John Club on Nov. 26, 2001	Not corroborated yet!
	• The price depends on the market, most of all on quantity taken: 1/4g - DM 15-20, 1/2g - DM 30, 1g - DM 60, 5g - DM 200	Several interviews and focus groups	

RISK AND PROTECTIVE BEHAVIOURS IVDU - Belgrade

Area of assessment	Findings	Data sources	Comments
Cocaine	• Cocaine, white powder, usually sniffed, infrequently taken orally (rubbed onto gums), smoked, or injected, and the effects are stimulating, as opposed to those of heroin. • Unlike heroin, which is rather widely used among larger groups of show biz people (rock musicians use it together with grass and alcohol), cocaine is consumed by upper class rich people, nouveaux riches (so called businessmen), those on the other side of law, turbo-folk stars, and some politicians are also prone to use it on weekends on rare occasions.	3 interviews with show biz stars and musicians, an interview with Ministry of Interior officer on Dec. 11, 2001	
	• The price per 1g is DM 70-120 and higher, depending on total quantity purchased. • Cocaine is not used in this country as widely as in the States, becoming a scene among larger number of consumers only on weekends or at anniversaries and celebrations, such as New Year, when it is usually somewhat cheaper and more readily obtainable.	2 focus groups on Dec. 29, 2001, and.Jan. 10, 2002, 2 interviews with addicts on Dec. 29, and 1 interview with alcoholic beverages supplier to discotheques, on Jan. 3, 2002	Up to DM 300 for pure crystal coke
Ecstasy	• Ecstasy - psychostimulant synthetic (out of amphetamine), amply distributed at rave parties, but also widely used in general. • It comes in the form of spiky powder or tablets with impressed logo. • One tablet is DM 10-15 (DM 7 and higher).	Focus group with 5 participants, on Jan. 10, 2002	
Opium poppy tea	• Opium poppy tea is extremely popular with heroin addicts as an additional compensation for lack of heroin, but also as a complete substitution for heroin during an extent of time. • A small bag is DM 10-15, and 1dl of very strong tea is enough to replace a dose.	s.a.a. plus 2 interviews with a married couple of addicts, on Jan. 10. 2002	
Methadone	• Methadone (Heptanon) is a synthetic drug, substitute for heroin. It is used in substitutional therapy, distributed as liquid (drops) or tablets. A box of 20 tablets is DM 70-90, covering 2 to 5 days, depending on addiction status.		
	• All mentioned drugs are supplied by a drug dealer, but meeting points differ: addict's flat, the dealer's apartment, doorway or a café, street booth or a schoolyard. In case a larger quantity is bought, the price goes down considerably so junkies often pool their money.	several interviews and a few focus groups	No fixed meeting places!
Addiction to pills	• Unlike the abovementioned drugs, benzodiazepins, Trodon, anti-Parkinsonians are sold freely in private drugstores, (state-owned pharmacies follow the instructions on prescribed drugs), and what makes it worse is that they are not on the double-recipe list. As the Law on Psychoactive Drugs Trafficking does not regulate the sale at the federal level, the private pharmacies use this loop to sell these potentially dangerous drugs unprescribed. • These drugs are often consumed together with marijuana and alcohol.	several interviews and focus groups, 9 interviews in private pharmacies and 1 in a state-owned one	Six out of nine interviewed pharmacists admit they sell them without prescription to those they judge fit!!! Several interviews given by drug addicts confirmed this information!
Intravenous administration Exchange of needles	• Out of 62 i.v. Drug users only four of them have never used somebody else's syringe or given their own to others.	All interviews and focus groups with i.v. drug addicts	

RISK AND PROTECTIVE BEHAVIOURS IVDU - Belgrade

Area of assessment	Findings	Data sources	Comments
	• Great majority of them more often than not exchanged their needles and syringes in the past, and although they do it quite rarely now, it still happens with those they feel "secure" with. (An addict unwillingly infected her own sister with HIV this way and both are now deceased, as was reported in the focus group of Dec. 18, 2001)		Awareness of risk behaviour is still not high!
Frequency of drug abuse	• Frequency of use depends on one's financial means, degree of addiction, and similar. It ranges in our survey from 4-5 times a day (a female respondent living with a drug dealer) to several times a week, and four of our respondents made a six-month to one-year break trying to come off of the drug and get "clean".		
Ritual of drug abuse	• Preparation ritual and use of hard drugs is ALARMINGLY unhygienic and risky: • Heroin is boiled with tap water in a common spoon (boiling of the drug in a dirty bottle cap was observed across the Narco-Centre) where from it is filtered through cotton with a shared needle, into a shared gun, and only then it is shot into other syringes • The cotton balls are not wasted; they are routinely put aside in a box and stored for the time when there is no drug available around, when these are boiled over again in an attempt to drain the last droplets out of them. • Only slightly over one fourth of respondents use a single-use kit; most often the equipment is previously used, boiled in water afterwards or rinsed in alcohol, a bleacher, or even dishwashing liquids. • Attempts at pointing the needle to the blood vain can sometimes last up to 45 minutes, with different types of blood all over the place. Addicts are utterly mindless (the bloody cotton balls, if thrown away, are just hit into a trash bin).	Focus group with 7 participants on Dec 24, 2001, interviews with two i.v. drug addicts on Nov. 25, 2001, observation of an addict's apartment on Dec. 1, 2001, and observation of a drug dealer's flat on Nov. 29, 2001	Is it the same in other places? Great risk of various infections due to complete neglect of the most basic principles of asepsis! Another likely way of getting infected!

HEALTH AND SOCIAL CONSEQUENCES IVDU - Belgrade

Area of assessment	Findings	Data sources	Comments
Problems directly surrounding respondents	• Almost all respondents feel more or less stigmatized and rejected by the society, family and friends, and to a large extent by the health system expected to offer them adequate help. • Customarily, only members of their own sub-group understand them, and the plight is even worse with the HIV-positive persons.		
Mental problems	• Depression, ever present anxiety, lack of concentration, impaired physiology of the nervous system by substance abuse combined with constant fear, makes these people strung-out in permanent craving for drugs, scrounging for money, living in anguishing loneliness, without support and with everyday living problems making a vicious circle to live in.		

HEALTH AND SOCIAL CONSEQUENCES IVDU - Belgrade

Area of assessment	Findings	Data sources	Comments
	• A dozen of them have flashback recurrent experiences of formerly used LSD, and the same number had gone through an epileptic fit (caused by Trodon) • Almost one third of them feel the necessity to take strong antidepressants and anxiolytics due to severe attacks of depression.	2 interviews on Nov. 23 and 25, 2001, focus groups with 6 and 5 participants on Nov. 26 and Dec. 18, 2001	A fifteen year-old had OD'ed taking in a large dose of Carbamazepine with Trodon in order to prevent an epileptic fit
Health problems	• More than one third had gone through an overdose experience, and more than one half of these were in that state twice or several times.	s.a.a.	
	• One half tested for HIV, 15 are HIV-positive. A dozen of them have hepatitis B, the same number of hepatitis C, which is considered only to be the tip of the iceberg (many have never tested themselves for hepatotropic viruses). • One respondent is with diabetes.	an interview with a junkie on Dec. 23, 2001, and several focus groups	Early discovery of the disease rate - a principal problem of our health care in general - is rather low in this sub-population
Sexual behaviour Veteran addicts with damaged health	• Over one half of heroin addicts of long standing rank have a permanent sexual partner, having sex without protection. It seems that those who are not in permanent relationships do not have a considerable number of sexual contacts, most probably attributable to decreased sexual urge due to depression. More than one half out of the latter group use condoms sometimes or always.	several interviews and focus groups with veteran heroin addicts	
Young abusers of psychoactive substances	• On the other hand, teenage users of psychoactive substances, rave party goers, as well as those addicts whose mental health is not seriously damaged, have more frequent sexual intercourses, often rather uncritically, in a state of altered consciousness, and unfortunately, under such circumstances, safe-sex is the last thing they would think of. Less than one half of respondents in this group always or sometimes use condoms.	observation of a techno party on Dec. 15, and 3 interviews with junkies among the sub-population	
The youngest users of psychoactive substances	• The youngest drug abusers use condoms only on few occasions, the most common two reasons given are, "I'm looking for innocent girls to have sex with", recklessly heedless of the possibility to transmit a disease to the girl, and the second is, "I don't like condoms, and what's the point anyway, since they burst so often." (See comment)	focus group with 9 participants (Dec 5), 2 interviews (Dec 5), and 2 interviews (Ded. 14, 2001)	This again is evidence on inappropriate use of condoms, and on bad choice of the type of condoms
	• No less than three girls had aborted unwanted pregnancies.	3 anonimous interviews (1 on Dec. 23, and 2 more on Dec. 29, 2001)	
Crime in connection with dope Criminal acts	• As already stated, very few respondents are permanently employed. • Over a half of them, some rarely others more often, engage in crime in order to gain money for drugs.		
Treatment in prison	• Seven of our respondents were taken to prison for selling drugs, and once incarcerated they were beaten to blood (without a prior check-up of their HIV status, even though one of them is HIV-positive), three of them went though the abstinence crisis with no help provided, the crisis itself being turned against them as means of securing confession.	Interviews (Nov. 23, Dec. 18 and 24), and 2 focus groups (Jan. 10 and 12, 2002), both in key informant's flat	- possibility of HIV infection - lack of protocols on conduct with IDUs - inhumane treatment
Drugs and prostitution	• Five female respondents had sexual intercourse for money used to buy drugs.	2 interviews and 1 focus group (Dec. 29, 2001)	
Children and Juvenile Correctional Home	• Observation made at a Home for Juvenile Delinquents suggests that these institutions are in fact places where young people, left without proper work with	observation (Dec. 5, 2001), 2 interviews with inmates	during data collecting measures of interven-

HEALTH AND SOCIAL CONSEQUENCES — IVDU - Belgrade

Area of assessment	Findings	Data sources	Comments
	them in poorly organized establishments, gain extra craft and skills in criminal enterprises, and rarely does anyone leave an institution like that truly or at least partly rehabilitated. Thefts and burglaries in neighbouring apartments and vicinity, drug abuse, risky sex contacts, unwanted pregnancies, those make up the common background of these institutions. • In-patient clinic (where the correctional work begins) is not separated form the admission facility (with constant inflow of new wards), and together with pedagogically unjustified mixing of different types of personalities and of their delinquencies due to lack of space, these contribute unfavourably to addiction	on that same day, focus group on that day, 2 interviews on Dec. 14, 2001	tion undertaken: 2 health-educational lectures held, voluntary and testing free of charge for HIV on 19 December 2001 at the Students Polyclinic (all subjects found HIV-negative)
	• Out of 70 inmates at the Home, 50-60 use drugs constantly, 2 of them are i.v. addicts. In the last two months there were to ODs and two abortions.	Interview with two inmates on Dec. 19, 2001	

INTERVENTIONS — IVDU - Belgrade

Area of assessment	Findings	Data sources	Comments
Assessment of present state of affairs Health Protection Services	• All our respondents were unanimous in assessing that the past measures undertaken in AIDS prevention are insufficient, one-sided, and sporadic.	All interviews and focus groups	
	• Each and every respondent is completely dissatisfied with the Institute for Addiction Diseases, but then everybody praises and singles out Dr Vesna Fridman as the one and only professional at the Institute who worked hard and with enthusiasm. After the good doctor has left, one and all are in complete agreement that it is no longer an institution that could offer them any help.	s.a.a.	HIV-positive respondents are quite satisfied with the services at ther Infectious Diseases Clinic
	• Ambulances arrive late, health care institutions are entirely uncoordinated, and patients' admission protocols are incomplete, leaving no possibility for adequate statistical follow-up of patients who come with problems related to drugs.	focus group with 6 participants (Dec 26) in a key informant's apartment, and several interviews	
	• In case of onset of an abstinence crisis late in the evening or overnight the subjects do not know whom to ask or where to go for help. • Psychiatrists, who privately practice and apply different psychotherapies, methods and programmes of resocialization in treatment of drug abusers, charge minimally DM 30 per session, thus remaining unavailable to most of the addict sub-population.	s.a.a.	
	• Addicts are often mistreated by the medical staff as crooks and law offenders, having only themselves to blame for their own predicament, and not as persons with problems.	Interview with a rock band leader (Jan. 09, 2002)	
Show-biz scene	• A lot of rock musicians ruined their careers because of heroin addiction, some of them died, many are rather interested in joining the prevention activities,		

INTERVENTIONS — IVDU - Belgrade

Area of assessment	Findings	Data sources	Comments
	but do not know how, so that some form of organizing them is evidently needed.		
Situation in schools	• The assessments made by psychology-pedagogy staff at secondary schools show presence of marked aggressiveness among young people, intolerance to everything that differs, use of marijuana is growing enormously, sexual activities start at a decreasingly lower age and almost never with protection, cooperation between parents and teachers is almost nonexistent, as are organized measures of prevention.	All 11 teachers interviewd were unanimous	
	• Besides the St. Sava High School where they developed a project "Talking Makes Us Happy", and the 13th Gymnasium where the Group 484, in the form of workshops, conducts addiction prevention programme "Escape To Dead-End Street", all other prevention measures (education of teachers by Ministry of Interior officers, various forms of peer education, occasional lectures by JAZAS Youth), are sporadic, incoordinated, and most often initiated by teachers and school services themselves.	Structured interviews with pedagogues at thetwo mentioned Gymnasiums (on Dec. 6 and 7, 2001), and with an NGO (Group 484) representative (Jan. 10, 2002)	
	• Secluded and dimly lighted corners of a school yard may often turn to be a meeting point of local addicts, and sometimes of school children, and elementary school pupils are lately used by drug dealers as means of getting through to high-school students.	Interview with a teacher, confirmed by the observation of a school yard (Dec. 15, 2001)	
	• There is not a single organized prevention programme at the Ministry of Education level		
Inter-ministry cooperation	• Ministries of Interior, Health, Education, and the Ministry of Work and Social Issues have their coordination teams set up to follow the health situation i nthe country, and the Institute for Addiction Diseases and the Institute for Mental Health (Serbian Government is founder of both institutions) are undertaking a juvenile addicts programme	Taken from an interview by the assistant to the minister of health (Dec. 2, 2001)	
NGOs	• There are several NGOs dealing with issues of addiction and sexuality:		
	• GOD - Generation Response To Drugs / Generacijski odgovor drogama, with goals set to offer support to young people in getting themselves out of the addiction problem	Interview with GOD representative (Jan. 17, 2002)	
	• ALEXO - struggle for social justice and medical protection of HIV-positive people and those affected with AIDS	Interview with ALEXO representative (Jan. 17, 2002)	
	• HIV/AID - in January 2001 a concert of classical music was organized at the Kolarac University for the benefit of AIDS affected people, and the amount of money collected was used to buy reagents for counting CD4 lymphocytes.	Interview with HIV/AID representative (Jan. 17, 2002)	
	• JAZAS,		
	• JAZAS Youth (Omladina JAZAS-a) - with the aim of preventing HIV/AIDS and addiction diseases, as well as the programme of psychosocial support to affectedpersons	Interview with Omladina JAZASa representative (Jan. 15, 2002)	
	• Group 484 - programmes of addiction prevention ("Escape To Dead-End Street"), educational-prevention programmes	Interview taken on Jan. 10, 2001	

INTERVENTIONS — IVDU - Belgrade

Area of assessment	Findings	Data sources	Comments
	• Sexology Studies Centre (Centar za seksološke studije) www.geocities.com/cssbelgrade, • Belgrade Open Club (Belgradeski otvoreni klub) with an Internet counselling service (www.savetovaliste.org.yu), but their actions are incoordinated and few. • There is no coordination betwen the Government of Serbia, so that their drives (except in case of JAZAS) often pass unnoticed, while the young people hardly know they exist.	Interview taken on Jan. 14, 2001 s.a.a.	
Proposal of measures	The level of PRIMARY PREVENTION: • organized, coordinated, continuous, and expert action of the social community aimed at target groups: population under risk (preadolescents and adolescents), parents and teachers, the police, as well as drug abusers themselves • Education of adolescents has to comprise a complex, specific approach to personality as a whole, and should enable them to cope with social pressures in a constructive and not a defensive way. Education of educators is to be completed beforehand. • Education of adolescents is to respect in full the progressive and modern methods, renouncing the preachings ex cathedra • Education of parents - learning of constructive communication with their children • Programmes of peer education • Education of teachers and psychology-pedagogy staff in recognizing the problem, in constructive conversation, in giving example of positive use of social skills • Lighting of school yards with improved supervision • Propaganda of programmes and projects of different institutions, NGOs, individuals and services, whose work may be useful to young people • Education of journalists in television and newspaper houses, in constructive approach to addiction problems, not the provocative way and sensationalism which make false heroes • AntiAIDS campaigns organized continuously and well proportioned, not only on the occasion of the Anti-AIDS Day, which turns the initial intention into a frivolous one • Coordinated action of the ministries of health, education, and the interior, on the one hand, and schools, on the other, the object of which is to devise a long-term and continual prevention programmes • Inclusion of ever growing number of ex-addicts, as well as HIV-positive persons, which can prove to have multiple positive effects • Strict control of admittance age at techno and rave happenings (so far, those younger than 18 were also admitted) • Improvement of police actions in disclosing and suppressing the drug spreading routes • Continuous education of young addicts, informing them of consequences, protective measures, and preservation and improvement of health • Making the health protection system accessible to this sub-population, controlling the health situation		

INTERVENTIONS — IVDU - Belgrade

Area of assessment	Findings	Data sources	Comments
	and early discovery of illnesses • Placement of condome slot machines at several places downtown • Establishment of coordinated activities of NGOs dealing with the same or similar issues, attempts at uniting forces in joint ventures, establishment of coordination between the NGOs, the Government, and the relevant minitries, and foundation of adequate health services • Introduction of centralized control of drug distribution, and more severe fines for pharmacists who supply unprescribed drugs (establishment of special inspections for this purpose). The level of SECONDARY PREVENTION: • Education of selected personnel at key positions in health protection institutions in good management and appropriate policy realization • Introduction of standardized therapy protocols on the whole territory of Yugoslavia, thereby avoiding arbitrariness of doctors and uncontrolled application of treatment • Adoption of multidisciplinary approach to addictions: medical, social, and rehabilitation programmmes • Serious application of psycho-social and family therapies, beside medical treatment of addiction • In addition to hospital treatment, determined introduction of partial hospitalization (day and night hospitals where addicts could come for help day and night), and establishment of adequate clinics with counselling services for addicts and their families • Work at a more humane, highly emphatic approach to people with a problem • Standardization of admission protocols for easier statistical follow-up of the phenomenon The level of TERTIARY PREVENTION: • programme of comprehensive long-term (1-5 years) resocialization of individuals • establishment of rehabilitation centres for drug addicts • coordinated action of the police, the Narco-Centre services, and of the Social Work Centre • efforts in introducing former addicts into everyday activies, finding them jobs, etc. • education on healthy life styles, precaution measures, safe sex contacts, and use of i.v. kit (in case no treatment is saught for) • programme of needle exchange decreases the risk of transmitting virus infections, and helps the society in creating a more realistic picture on number of i.v. addicts, and in realizing certain action measures and education of this group ofpeople (opportunity for direct contact) • day-and-night availability of single-use needles and syringes in all pharmacies, diminishing to a certain degree the necessity to use one needle in a group		Presently, they can be obtained at some private and stateowned pharmacies, the price is 9,05 dinars for a set

G -2 YOUNG MEN WHO HAVE SEX WITH MEN (MSM) - NIS

DATA GATHERING METHOD AND LOCALITIES MSM - Nis

The survey among gey population was performed with persons between 17 and 40 years of age. Most of the interviewees covered by the survey were up to 25 years of age, and a small number of those from 25 to 29. The survey was aimed at different forms of behaviour, especially risky behaviour of this category of young people and of their attitudes related to risk and perception of risk.

The data were gathered in the following ways: through the survey, which covered 81 homosexual man, through non-structured and half-structured interviews, observations and focus groups. More than 10 interviews were conducted, 4 focus groups led and 10 observations performed. The interviews helped deepen the issues of global and risky behaviour, while the focus groups confronted the views on different topics relevant to life styles of homosexuals. The observations enriched the knowledge of hot-spots, ways of meeting and selecting partners and patterns of behaviour of the observed persons. A map of the observed places was designed, although not entirely specified since there are not official places for meetings and gatherings for homosexual population in Nis.

The research started on the 18th November 2001 and was finalised in Nis on the 15th January 2002. It covered not only the population in Nis, but also people from the suburban areas and neighbouring villages who inclined to the city of Nis for entertainment sake and to find partners. There is also a smaller number of people from other places who frequently come to Nis as a more dynamic centre with better possibilities for gey encounters.

The following experts were interviewed: psychologists and psychiatrists from the Institute for Mental Health in Nis, general practitioner of the Heath Care Centre, doctors and the director of the Gastroaenterological Clinic, directors and doctors of the Students Clinic, as well as the interviews about the data from the Police in Nis.

CONTEXT MSM - Nis

Area of assessment	Findings	Data sources	Comments
School	• Primary and secondary school Students	Interviews Focus groups with homosexuals	
Employment	• Usually unemployed • Occasional jobs - according to the average employment level • The employed ones are well corresponding to their jobsUsually poor and primitive • The well situated ones come from arts, fashion business, politics, media, etc. • Usually supported by their families they live with They come from the middle class, mostly	Inquiries Interviews Focus groups	
Family structure	• Usually brought up by families with rigid cultural values • Usually unmarried, some are bisexual with secondary families • Usually parents aren't acquainted with their kids sexual orientation, or they suspect their homosexuality, but don't want to face the situation	Inquiries Interviews Focus groups	
Parents information about sexual Orientation of Their children	• The common parent-child communication is based upon questioning about actual heterosexual partners • The parents are often satisfied with, usually false, answer about a girlfriend their son is going to introduce to	Inquiries Interviews Focus groups	
SocialCommunications	• They feel unaccepted by the majority of society who doesn't share their sexual orientation • Unaccepted, unacknowledged	Interviews Focus groups Study cases	

CONTEXT — MSM - Nis

Area of assessment	Findings	Data sources	Comments
	• They don't feel free to talk about their choices, they think it's better to keep their sexual orientation as their secret • They feel lonely		
The available-ness Of the help services	• When contacting medical services, they usually don't declare themselves as homosexuals. There are no patient lists in hospitals considering sexual orientation!! • Even confronted with personal condiloma virus diagnosis, they refuse to admit anal sexual contact • They refuse to admit anal contact even when they have problems with haemorrhoids • They rarely contact medical services • There are no registered homosexuals in the student medical units	Interviews with homosexuals Interviews with doctorsFocus groups	

RISKY AND PROTECTIVE BEHAVIOUR — MSM - Nis

Area of assessment	Findings	Data sources	Comments
The beginning of the sexual activity	• The usual age for gay behaviour is secondary school and college	Interviews	
The information About sexual behaviour and the risks	• The average informative level is insufficient and inadequate • They don't have enough information about the ways of transmission (oral sex) • The middle class level us the most informed one	Interviews Focus groups Study cases	
Sexual behaviour	• They hide their sexual orientation • Their sexual contacts are the "quicky" ones	Focus groups Study cases	
The number of the sexual partners	• The frequent change of partners is distinctly present, the relations are promiscuous • The partners are usually "new faces" - main bus station, prostitutes from Romania • The steady gay relationships are very rare	Interviews Focus groups Study cases	
	• In the streets, letting the other part know one's intentions by looking in the eyes - they look at each other with interest - "Then you turn after the one that looked at you, and you wait him by the nearest window-shop, or you approach him, which rarely happens" • In the cafes, in restaurants - "some older men can offer to buy you a drink, or to send it over your table. Or they can stare at you when you are in a crowdy café". • Usually by a common gay friend - "It is consider to be a favour - when someone finds you a date you must find him a guy. Sometimes favours are even counted." • Very often in parks - "You can sit down on a bank and then wait 'till someone asks you for a cigarette. Sometimes a person can pass near you for several times. If you're interested and he doesn't want to sit on your bank, you can go after him. Usually, that person goes to the nearest bush and starts to masturbate, so you can join him without words."	Interviews Focus groups Study cases Observations	

RISKY AND PROTECTIVE BEHAVIOUR — MSM - Nis

Area of assessment	Findings	Data sources	Comments
Meeting ways and spots	• At the city bus stop - "the daring, usually older ones start a conversation who looks gay, or provocative, and then he checks out if he's got any chance. "The acquaintance" can be made also in a bus. • Often in trains and at the railway stations - "because there is enough time to "check out" the situation. You can have a conversation in a train, but the questions can be provocative. • Very rare in public toilettes, because the frequency of the people is low, but there are spots ate the main bus and railway station. • By newspapers announcement • By internet announcement or chatting • By telephone - a common friend gives the phone number.	Interviews Focus groups Study cases Observations	
Meeting ways and spots	• In the gym dressing rooms it can be obvious who is interested - "so you can make your step when there is nobody (during shower you can have sex, usually without a word) • In public squares, public places, at the crossroads, hotels, common public meeting spots - e. g. public toilettes downtown, waiting rooms • In the saunas, at the swimming pools, in the dressing cabins - "all you have to do is to start a conversation" • At parties, weddings, and funerals - "cousins or friends can go on a quiet place. Usually the older ones start the talk with the younger ones - it is a common situation among primitive people, whether it is between two persons of an opposite sex, whether of the same one.	Interviews Focus groups Study cases Observations	
Meeting ways and spots	• In the army, where the major part of the younger ones finds out for the first time that they are attracted by the same sex • In prisons • Medical employees - doctors toward medical technicians • Clericals - the elder ones toward the younger ones • Hairdressers or waiters - "the nature of their jobs facilitates the making of a contact and the specific conversation they have with their customers allows them to ask different questions to get the needed information" • By hitch-hiking - "if the one that hitch-hikes provocatively, he can be picked up by someone who's interested. There are also cases when a young boy is picked up by an elder man - the one in the car notices the young one at the bus stop, he picks him up and usually goes right on to the point, not leaving enough time to the younger one to get himself together."	Interviews Focus groups Study cases Observations	
Meeting ways and spots (Hot spots)	• The Citadel - "the north pathway and its west part. The other most out-of-the-way spots - small walks through bushes, corridors and tunnels in the walls of the Citadel". • Public square in the city centre - "also, the big bus station for the night lines". • Walk path near the river - "the most frequent part is near the amphitheatre, but gay people go all over to the Bridge of the Youth and further along the main boulevard - usually during the night". • Main bus stop - "at the platforms, in front of the station, as well as in the toilettes - usually during the night" • Railway station - in the waiting room, at the platforms outside, in front of the station (in the parking lots) - usually during the night."	Interviews Focus groups Study cases Observations	

RISKY AND PROTECTIVE BEHAVIOUR — MSM - Nis

Area of assessment	Findings	Data sources	Comments
Gay people behaviour in public places	• Gay people try to avoid the most frequent walks through the park. They don't want any contact with other population - especially students. They avoid walkers and pairs sitting on banks - they are embarrassed, they are afraid not to be recognized, not to be asked: "What are you doing here all alone?" • They meet each other on a path where the banks are. The ones that want contact are usually sitting on a bank. The other ones are strolling and looking at everyone that comes close to them. If they like someone, they stop, sit on a bank, and ask anything. They get up try to see if the other part is going after them. • Some of them don't want any kind of contact or acquaintance, only sex. They try to draw one's attention by walking several times through path, especially near the one they have noticed, usually staring at him, or whistling. Then they go on a hidden, quiet place, so that the other one can find him "by accident". The one that is waiting already masturbates, so the other one can join him. They can both be disguised with hats, sunglasses, scarves, their faces can be covered completely. • Then, they have sex in silence, constantly overhearing every noise. After sex, they go in quiet and don't have to say hello to each other when they meet again.	Focus groups Study cases Observations	
The use of condoms The knowledge and attitudes about the protection	• People have information about AIDS and HIV, but usually that isn't enough - especially in the suburb and near by villages - "I don't know what is HIV, what is AIDS!" • One third of the population, at least, is not acquainted with the ways of transmission • The only important thing to them is to have 5min of pleasure, even if that "choice" carries death risk • The majority thinks that the situation in Nis is not dangerous, but only in Belgrade, or "somewhere else" • Only the minority is aware of the risk • Almost everyone think that there is a great need for talk and breaking up the prejudice that the AIDS is "the illness of the homosexuals"	Interviews Focus groups Study cases	
The frequency of using the condoms	• Rare use during the anal and oral contact • The general opinion is that condom is not the best protection (it can break, be broken with teeth, the problems while opening the package) • The negative attitude in general - the condoms aren't "popular"	Interviews Focus groups Study cases	
The reasons for using the condoms	• The use of condoms is not popular among gay people. Only ones that are extremely frightened not to catch AIDS use it.	Interviews Focus groups Study cases	
The reasons for not using the condoms	• The lack of possibility to buy condoms when already in situation to have sex. Not knowing how to use it. • They don't think about danger because the sex is usually very quick one. • The lack of possibility to use it properly - in the dark, in parks… • The use of condoms makes negative associations - the thought of getting the disease frightens them and provokes the impotency	Interviews Focus groups Study cases	
Using drugs	• The drugs are used extremely rare among the ones we asked, and even in those cases, only marihuana and tablets.	Interviews	

RISKY AND PROTECTIVE BEHAVIOUR — MSM - Nis

Area of assessment	Findings	Data sources	Comments
Commercial sexual behaviour	• They usually didn't have sex for the money. It is almost a rule to take or to offer a certain amount of money. Many of them want sex and don't know how to get it • Very rare cases of commercial sexual behaviour in our study	Interviews Focus groups	
The differences in homosexual behaviour - then and now	• Once, to be a gay person was a big problem - taboo, less talk about it, it didn't exist officially, but it was easier to find gay partner in parks, cafés… • Today, people are more informed, on a higher cultural level, people in general, friends and parents are more tolerant, but people behave more dangerous, less cautious, especially the young ones • The health and other protection of gay people is better • Gay people communicate easier than they used to.	Interviews Focus groups	
What increases the risk?	• The isolation of an individual because of the nationalism, wars, traditionalism • Incautiousness, the lack of information! • The young ones are unrestrained, without an example how to manage their lives.	Interviews Focus groups	

HEALTH AND SOCIAL CONSEQUENCES — MSM - Nis

Area of assessment	Findings	Data sources	Comments
Health consequences			
Accepting one's sexual orientation and psychological problems	• A young man is aware of his sexual needs at the age of 15-16, in his imagination, fantasies, excitement when surrounded by persons of the same age and same sex. He is frightened because he notices that he is different. Sometimes, this can happen to him for the first time while he is in the army. If he comes from a conservative patriarchal family, it is hard to accept his own wishes. He feels fear, uncertainty, doesn't have the courage to express his own needs, until he finds himself in a suitable situation. Then, he is able to make, in general, only a quick contact with an older, maybe ill, unknown person - what is actually called "quick sex"! • A gay person is often shy of himself and sometimes he hides himself from his partner (he wears a hat, glasses, scarves). He avoids kisses, because it's often considered as a sign of weakness, a gesture of intimacy, although he has sex). • He doesn't accept himself and the consequence is an aggressive behaviour toward another man - possible partner - so that he'd prove he's not gay • Homophobia is present within latent homosexual group • Some of the gay population that accept their sexual orientation become hater of women	Interviews Focus groups Study cases Observations	
Mental problems	• Fear that they can't manage to have a normal everyday life • Fear not to be punished	Interviews Focus groups Study cases	

HEALTH AND SOCIAL CONSEQUENCES — MSM - Nis

Area of assessment	Findings	Data sources	Comments
	• Problems to accept their orientation • Not having a clear concept of their identity • Feeling guilty - being conscious what they are • Thinking they are a lonely case, and not a part of bigger group • Not having strength to fight with society and to declare themselves as gay • Sometimes having a girlfriend as a cover	Interviews with neuropsychia-trists and thera-pists	
Somatic problems	• Uretritis • Penis injuries • Anal injuries • Condiloma virus • Hemorrhoids • Hepatitis B and C • Dermal diseases • SPI • Insufficient consciousness and awareness • Not knowing enough about medical complications	Interviews with homosexualsInt erviews with doctors	
Social conse-quences	• The negative attitude of the society and police forces: • Indignation because of the police forces behaviour. Police patrols find them in parks, question them about whom they are waiting for and why are they alone in the park. Police asks them to admit they are gay; some-times the police patrol informs their parents. Police uses verbal insults, takes them to the local police station. They take down their names; using the excuse they need the information because of the resent murders in the Town citadel. • Every arrest by the MUP (Ministry of Interior Affairs) is so unpleasant and severe that a young boy doesn't think ever to come again to that park • Negative attitude of doctors and medical stuff toward health problems of gay population. Prejudices, suspi-cions, mockery or condemnation. That's why gay peo-ple rarely decide to ask for help from a psychiatrist or other medical treatment • Negative attitude of the surrounding, family or friends • Marginalisation	Interviews Study cases Interviews with therapist Focus groups	
Homosexuality and criminal behaviour	• Sometimes they are trapped, robbed, bitten or even killed • There are heterosexual groups who wait in an ambush to bit homosexuals • From CASE STUDY:"…I was waiting a train that was very late. A small gypsy was passing often near the place I was sitting. He was a bit shorter than I was, but of my age. When he noticed that I "spotted" him, he approached the opposite bank and set on it. He wanted to know me. He asked me, with a smile on his face: "What are you doing?" I felt confused, and he added: "Well, in sex!" He suggest-ed we go somewhere to have a drink. I said I hadn't got any money - I spent it on my train ticket. He said he had some money, and that a cup of coffee was cheap in the buffet across the place we were in. I agreed to go with him, I hadn't got anything smarter to do at the moment. While we were going there, he tried to agree with everything I said.When we crossed the street he suggested we go to the park, just to? just that. I said I wouldn't do that, trying to get out of the situation, suggesting to him that park was	Interviews Focus groups	

HEALTH AND SOCIAL CONSEQUENCES — MSM - Nis

Area of assessment	Findings	Data sources	Comments
	crowded with people. He wanted to go to the toilette cabins, so that we could lock ourselves inside. I said: "We have to pay for the toilet", he answered: "I got the money." He started to insist. It didn't sound a good idea to me, so I said: "Maybe some other time." Then, he repeated several times: "Since you don't want to come with me, you'll have to pay 10 DM for this conversation." I looked at him, surprised and frightened, he added: "What do you think, you can get this for free - for looking at "this" you'll have to pay 10DM, or 200 dinars", having his hand on his pants and penis. I told him he should go away, and he insisted: "I was in a??? You think I'm gonna loose time with you - pay me!"He threatened he was gonna hit me. He tried to take something out of my pocket, I started to resist. Some boys approached us and drove him away. Later on, I found out he was working for the money, and that sometimes railway station stuff or Bulgarians leave him a dinar or so. And he can't get the money by begging, he tries to threaten, thus getting the money."		
The police forces behaviour	• During their night shift, policemen are often checking men and mail couples - taking down their names, checking if they know the name of the other one - provoking them to admit they are gay, they take away to the local police station the younger ones (minors) and call their parents to come and take them home.	Interviews Focus groups	

POLICY AND INTERVENTIONS — MSM - Nis

Area of assessment	Findings	Data sources	Comments
The evaluation of the up-to-date situation	• The lack of medical education and informing level • The avoidance of medical help - the fear of the unknown • Almost everyone considers there were no interventions and doesn't appreciate JAZAS although it is the only group they've heard of • The majority doesn't know what, where and how something should be done, but they know when - NOW, everyone is aware the problem is urgent • No one has ever contacted them in a civilized manner, so they haven't called for help either • The vanity and the envy of the medical stuff, the lack of humanity and sense for reality • The lack of education considering sexual and homosexual issues at schools • Prejudices and way of thinking of the young people here No one is taking HIV tests, only by accident • They have no confidence in medical stuff, so they get to know if they are positive only by giving their blood in medical causes	Interviews Focus groups with homosexuals Focus group with doctors	
Taking steps - a suggestion On the individual level	• To minimize the resistance of the medical stuff toward gay people!!		

POLICY AND INTERVENTIONS — MSM - Nis

Area of assessment	Findings	Data sources	Comments
	• To explain clearly, using the understandable vocabulary • Psychiatric help in identity crisis problems and the acceptance of the sexual variety		
On the city level	• The condomats are needed in a bigger number all over the city • A higher health culture and hygienic level • More talks about sex, sexual behaviour and sexual deviations • The existence of gay and lesbian societies • A space for gatherings, movies • Campaigns, platforms, lectures • Talks, debates about SPI, AIDS • Information servicesSOS phones • A service that would deal with gay/lesbian/ transvestite population problems and needs, needed information and other sort of help • Educational programs for medical stuff, doctors and psychiatrists to accept new values, methods and directions • Books, magazines, newspapers, leaflets about HIV, AIDS, SPI and GAY • Medical campaign - suggested form: everyday, short, non-violent, moderate, pleasant, modern, for young ones • Centre, spaces, NGOs for the ones that want more • Lectures in schools • During the campaign one should be persistent and creative • The campaign needs gay activists and people from media • The campaign should ensure safety and anonymity		
On national level	• A positive-thinking attitude about condoms - "Condom is in" - e.g. it could be kept in small begs hang on trousers, or something like a fashion detail… • The anti AIDS campaign should be more aggressive, even averse - with scary pictures of the disease itself that would present the AIDS as something very present and near everyone • A suggestion to ask an obliged test on HIV virus among the young population no matter the sexual orientation • A better protection from the radical and neo-fascistic groups (SKINHEADS) and nationalistic groups (OBRAZ) • To define a law about wider freedom and rights for gay people; to demarginalise gay population • To work with public services, police forces, education system, health system, modernization, liberalization • To stop the arresting and the torture by police forces		

CASE STUDY MSM - Nis

Case study 1

The telephone rings and the gay opens his eyes. He picks up the receiver, speaks for a while to the person at the other end of the line and then puts down it down. But the telephone rings again. The gay remains in bed and doesn't get up until the telephone rings for the third time and forces him to get up and put some water on the hotplate to boil. Then he returns to bed.

Now he has to get up and make coffee, not only for himself but (this time, too) also for a friend, another gay who had announced his intention to spend the whole day with him. This is an everyday, often performed ritual for a gay who lives alone - his playing host to a number of gays.

While the coffee is cooling down, he is trying to remember what he did (who he slept with) last night, what he can and what he should not tell his colleague in sexual orientation.

Once he has decided on the matter, he makes his first phone call, drinking his first cup of coffee of the day. He opens his "gay book" (his phone book with the telephone numbers of his gay friends) and looks through the numbers. It would be best to talk to someone far away (for starters, it is best to call someone in another country - and everywhere it is better than in our country). The other gay finally appears - more than an hour late (always bad organization and circulation as well). Gossiping follows, rumors, retelling, exaggerations. Soon, however, they have enough of it; they need some fresh air (the smoke of numerous cigarettes is in the air). They agree to go out.

As soon as they are out, the gays become aware of their ISOLATION from society. Nobody must know they are gay (better that way). They are everywhere, but invisible, as if they didn't exist. And completely alone. - and to be alone in the world - is terrible. The more they circulate through society, the more EXHAUSTED they become. They must "disguise" themselves - to be like others, which demands constant concentration - what they are saying, what is going on. "Was my expression overly effeminate?" An empty promise to the girl living next door that I will "introduce her to my girl-friend Sanja". They go from store to store, looking at the "rags". A gay doesn't fail to handle a woman's blouse, he might even have managed to see for himself that it is a woman's blouse. Here's where the HUMILIATION starts, as the salesgirl says "Look, a faggot". In case of a male shop-assistant or a boss raised in the male, patriarchal tradition, a gay might be met with a juicy threat, something like "Don't dirty my store - get out, or else...". In a case like this, you must be a false YOU, or you might get BEATEN UP, as everybody knows that this is how the Serbs most often solve most of their problems, with many unavoidable threats. The best one can hope for is a senseless demand of the type: "I don't mind what you do, just don't do that!", or even a biblical "Do what you like, except sexual intercourse".

The two gays come out of the store under rigid CONTROL, overwhelmed by FEAR, SHAME, GUILT and a feeling of INFERIORITY, something already directed at the Roma, the blind, the poor... Of course, the gays will return home and. perhaps, be treated to a TEMPORARY MERCY in the form of a gay movie, advertisement (maybe a kiss of two girl models) on TV - the savior, and remain in front of it the whole afternoon.

In the evening, a "normal" friend will appear and he will DISTORT the whole situation by a rationalization (minimization) or negation: "You are not gay, you just love men".

At night, there is a possibility of HIGH BLOOD PRESSURE, PALPITATION, HEADACHE, SLEEPLESSNESS, UNEASINESS, INSANITY, that is, the real disease. And tomorrow, tomorrow is just another day.

CASE STUDY MSM - Nis

Case study 3

I am 32 years old and I am gay. I realized I was gay a short time ago. Still, I would like to get married and have children. I tried it twice, but without success. Women always leave me.

I was born in Niš, in the center of the city. My mother used to work in the Electronics Industry in Niš. She died five years ago. My father was a policeman and he died seven years ago. Because of his job, we often moved from one place to another. My parents were nice and they did not tell me hat and how I should do this or that. They let me live my life without interfering.

I completed secondary school in Niš and then went to Belgrade, to study German. I haven't graduated as yet. I had a hard life. I am rather withdrawn and I find it very difficult to make friends. I am very shy; I have always been shy. I used to go in sports -handball, in fact, so that I had a well developed body even in elementary school. The girls liked me so I had relationships ever since I was in the fifth grade. I had the opportunities, young though I was, to sleep with the girls (a friend of my brother's, three years older than I, wanted to sleep with me, but I turned her down, saying I wasn't ready for sex as yet). Feelings were more important for me - love, a frank and devoted relationship. Many girls I used to meet at that time didn't think so. It was only a beautiful girl that I met at the university in Belgrade who fulfilled all my desires, but she wasn't ready for marriage. It was difficult for me to get over her. After that I went steady with a girl for five years. She didn't believe in marriage, not in the least, and I was completely disappointed.

CASE STUDY MSM - Nis

Case study 2

Two years ago, a lady-friend of mine who I used to study with stop seeing me, for reasons known only to her. I couldn't bear it as she was at that time the only person I could speak to openly. After that, I stopped going out and mixing with people.

I had my first homosexual experience in the secondary school, at the home of a friend where I was doing something for school. He was very attractive and the type of a person who's experimenting all the time. He was bored so he began undressing to get my attention. I didn't want to look at him, although I did wish to do so. He started fondling himself, which excited me very much. He noticed that, but I was petrified with uncertainty, there was nothing he could do make me relax. It took five, six years for me to collect courage and attempt, seriously, to touch a man. It gave me great pleasure. I didn't have many gay friends as I insisted on any sexual relationship to be founded on emotions. That's why I became interested in pornography.

There are many things in sex that I don't like (both with women and men). I believe one has to be very cautious about sexual intimacy. Young people in particular should be more responsible. One should have sexual intercourse only when one is mature enough in all respects (psychic, in particular), so as to avoid risks and wanton behavior. Of course, there are many who are careless and this is why they suffer the consequences and traumas. Unrestrained sexual behavior in one's youth leaves serious "consequences" on the psychological make-up of a man.

Case study 3

I was born in Nis. My parents came from old city families and were engaged in the medical profession. They started their family rather late in life. They had two children, my sister and me. We have always been close in my family. My sister has known about my homosexual inclinations ever since we were children. She must have guessed it, watching me grow up. She spoke about it with my mother and the two of them got interested in the gay affairs. I remember how, at home, there always were talks and arguments about the matter with my father and our friends.

I lived in a congenial environment and had a wonderful and carefree youth. My father is rather phlegmatic so my mother has always been a slightly dominant figure in the family. They never set any limits to my behavior, nor did they forbid me this or that.

I was rather successful in my academic career - an excellent student in the elementary school, very good in the secondary and I graduated from a university with the delay of only two years.

I had problems communicating with people until secondary school. It was difficult for me to make new friends - I may not have been interesting enough to my peers. I wanted to have a true friendship, one which would last until my university days, but I failed. I did not realize why I needed such a friend, one that would last all my life, inseparable, devoted to one another.

Once, at the beginning of my secondary school, I managed it, but the friendship, because of the influence of the environment, lasted for two years only. Everybody condemned our closeness. They thought our need to see each other every day was queer. Even our parents got close, the way it happens when a boy and a girl go steady for a couple of years. Everything had to end by force as his parents forbade him to see me. It was difficult for me to understand this. I was hurt. Ever since, I have wondered about myself - what am I, who am I. I noticed that the girls had no attraction for me, that my behavior was different from that of other men, that I was looking at some of them some of them from a different point of view. I spoke with my sister first. She took it in her stride. We spoke about it a number of times and it was only then that I realized that she had suspected it for a long time. She tried to determine the degree of my homosexual orientation. When I realized who I was, I wasn't too much shaken with it. - it was something quite natural for me. Finally, I found myself and I could behave in accordance with my desires. I was free to have fantasize about sex with the men, something which, earlier, was hidden from me with a different attitude.

My sister's support meant a lot to me although she didn't approve of it wholeheartedly, but she did try, and did want me to be happy. I trusted her absolutely. I decided to meet men who could realize my fantasies. I wasn't choosy about the means, but I was choosy about my sexual partners. Nothing shocked me in all this relationship. I found it easier to talk to girls and, even, to have a couple of relationships with them. I was two or three times in love with some guys at the university. I also had a more lasting relationship and I suffered a lot when it "broke".

It was then that I told my mother about me. My sister was with me. My mother never truly accepted that, but she still supports me secretly in my intentions to live in accordance with my nature. Father was never very much interested in all this. His slogan was: "Everybody lives his or her life the way he or she sees fit". He doesn't speak about my life, nor does he get interested in it. best friends know about me - and have been much better friends since. The draft board has relieved me of the obligation to do a military service. I began working. I've been living with a friend, in his apartment, for five years now. I am 28 now and I hope to live like this until my old age.

G-3 YOUNG SEX TRADE WORKERS (STW) - KRAGUJEVAC

DATA GATHERING METHOD AND LOCALITIES — STW - Kragujevac

Research of risk behaviours to HIV/AIDS (RAR - UNICEF) was conducted in Kragujevac as part of the national research, which lasted from the end of November 2001 until January 2002. The object of research was to identify high-risk behaviours to HIV/AIDS in groups of particularly vulnerable young people. Suggestions given by the project are aimed at improving the existing interventions and creating new ones to enhance health of young people, minimizing the risk of transmitting the HIV infection.The primary target group consisted of female respondents who are sex trade workers. The group filled in 32 questionnaires and gave 10 interviews. The respondents were 18 to 25 years old; the group of interviewed SWs included some older ones too (19-31 y/o). One male respondent of homosexual orientation is selling sexual favours, but the report is part of another (gay) group. Not a single respondent is HIV positive. A few of them use narcotics intravenously. Research instruments were: questionnaire, interviews (semistructured), focus group, observation, mapping, and secondary data. There were 33 interviews: 1 KII, 1 pimp, 1 customer for escort agency services, 1 student, 1 secondary school teacher, 4 physicians, 1 social worker in prison, 2 NGOs (JAZAS), 1 solicitor, 4 school psychologists, 1 pedagogue, 1 hotel receptionist, 2 celebrities, 1 police inspector, 1 journalist (23+10). Intreviews were taken in private apartments, cafés, in the street (place of work), at health institutions.During the realization of the project there were 11 focus groups organized with total of 71 participants. Focus groups comprised various participants: students, parents, STWs, IV DUs, taxi drivers, journalists, physicians. They varied in number of participants (from 4 to 10, beside moderator).Observations were carried out in selected, previously identified places, as well as places which became the object of research after the traingulation (day and night observation of the "stajga" - the walking path towards the exit to the highway, and the pubs) Secondary data in general are not a solid source of information for this group, simply because they are missing.

CONTEXT — STW - Kragujevac

Area of assessment	Findings	Data sources	Comments
Organization of prostitution	• Research results point to the following prostitution types: street or public; agency; sex trade in hotels; students		
	• STREET. comprised of two distinctly separated groups of prostitutes: a mixed group of girls and women from local community (one third up to one half of them are Romas), and another one consisting of girls who are intravenous drug abusers (iv DUs/SWs).	Observation, interviews, in depth interview with a pimp	
	• AGENCY. Not present in our town. A male respondent, frequent customer of these agencies in Belgrade, provided us with data on this kind of service and SWs.	Interview with agency's customer	
	• There were indefinite hints that perhaps one of the model agancies might be involved in this kind of prostitution. There was an agency of this kind active in the summertime, but no data were confirmed by triangulation.	Interview with a solicitor	
	• Several sources pointed to female students in prostitution. Triangulation proved this form does exist.	Interview with a receptionist, interview with STW student, focus groups with students, interview with a solicitor	
	• Some sporadic prison cases point to foreign female subjects dealing in prostitution in surrounding villages (Romanians). They	Interview with a prison social worker (Dec 27, 2001)	Plan of interventions in cooperation with surround-

CONTEXT **STW - Kragujevac**

Area of assessment	Findings	Data sources	Comments
	were imprisoned for irregular residence papers.		ing countries; not utilized enough
	• Taxi drivers take groups of sex workers to their clients. Several of them offer sexual favours instead of money. The group they contact does not use drugs.	Focus group with taxi drivers (Dec 21, 2001)	
Duration of prostitution	• One of them started when she was 16. A student of 20. A prostitute who hustles independently in élite restaurants started when she was 18, after leaving high school. Prostitutes working with pimps started at 18. He claims not to work with minors. Length of service is from 1 to 10 years. IV DUs are longer in the trade.	Interview with STWs, interview with a pimp, focus group with STWs, focus group with IVDUs	The prostitutes we met were not younger than 18 Forced to work longer as they must secure drugs
Scope of the problem	• A group of prostitutes works only with a pimp. In our research this group comprises about 60 % of the sample. Up to 25 % are drug addicts who regularly sell sexual favours in order to obtain drugs. 15 % of the group is comprised of students and persons dealing in sex trade independently in hotels and élite restaurants. The rest belong to other forms not encompassed by this research.	Observation, Interview with key informants, focus group	
Pimp	• About 60 % of girls work with a pimp. Some of them started independently, but after a few years they had to find a pander.	Interview on Dec 17, 2001	
	• The pimp is married, and at the same time he has a partner from among the girls who sell sexual services. One must have a pimp, he protects the girls.	Focus group on the highway, interview with a pimp	A girl's friend and protector!
	• He is always around while the girls work. He is hidden, and there is a collection of signs and codes that the girls use in order to signal problems with a trick.	Focus group, interview with STW (Dec 17, 2001)	
	• Pimps take care of their girls' health status, and supply them with condoms. One girl among the prostitutes is in charge of their hygiene.	Observation, focus group, interview	Might be useful in interventions, e.g. distribution of condoms by pimps
	• Part of earnings goes to the pimp, but they refuse to state how much.	Focus group, interview with a pimp	
	• Sex is necessary as a sort of exhaust valve, so is prostitution. Extremely negative attitude toward drug addicts in the trade.	Interview with a pimp (Dec 3, 2001)	Favourable for implementing the intervention
Group of girls hustling the streets for a pimp (attitudes, knowledge, information)	• They are satisfied with their status and treatment by the pimp. THEY LOATH GIRLS WHO ARE DRUG ADDICTS AND SELL SEX FOR DRUGS.	Focus group, interview with STW, interview with a pimp, interview with key informants	Street prostitutes despise drug addicts in the same trade
	• Drug addicts who sell sexual services are the source of AIDS, as AIDS is transmitted by needle	Focus group with STWs	Verbally they prove to know how infection may be transmitted, but perception of risk is nil
	• They have no bad feelings about their line of work, it's just a job like any other.	Focus group STWs	One has a family and kids, her hus-

CONTEXT — STW - Kragujevac

Area of assessment	Findings	Data sources	Comments
			band is aware of her trade
Prices	• DM 30 for oral sex, DM 50 - the rest, without fondling	Focus group, interviews with STWs	Hey sister, what's oral sex? Case report - oral sex is performed by hand!!!
	• DM 10 for oral sex, or DM 20 per hole, or DM 60 -100 depending on service	Focus group with parents (Nov 29, 2001)	DM 20 per hole
	• DM 30 or more; blow job DM 20	Interviews with journalists (Nov15, 2001)	

RISK AND PROTECTIVE BEHAVIOURS — STW - Kagujevac

Area of assessment	Findings	Data sources	Comments
Use of condoms in the group working with pimps	• THERE IS NO PRICE TO MAKE THEM WORK WITHOUT CONDOM	Focus group, interviews with STWs, interview with a pimp	
	• They willingly show condoms. They are regularly supplied by their pimp.	Focus groups, interviews Focus group, Inerviews	This seems to guarantee quality of service, but along with their low perception of risk, it is not certain whether they always use them
	• They know how to use condoms, but regard the HIV infection by syringe to be the main source of infection, not the sexual contact.		Low perception of risk. Presence of condoms point to quality of service provided to clients by the pimp, more than to the prostitutes' fears concerning their risk behaviour.
Clients (sorts, number, requests)	• Clients come from local community or other parts. The place of work is favourable for out-of-town tricks.		Exut to highway
	• They are of all ages - from very young to married or elderly ones.		Observed case
	• Very specific explanations of sex services.		Hand/oral sex, with client's consent; sex between thighs, rubbing, frottage, no kissing or fondling
	• Number of clients in winter is from 5 to 20, and 10 to 20 or even 30 in summertime.		They start working after dark (around

RISK AND PROTECTIVE BEHAVIOURS STW - Kagujevac

Area of assessment	Findings	Data sources	Comments
	Duration of work, which is tied to the length of nighttime, directly affects the number of clients.		4 pm in wintertime), later in summer. The number of tricks is unpredictable!
	• The work place is the exit part to the highway, to the right.	Observation, focus group	They are disguised, and anyone not city-wise could mistake them for hitch-hikers.
	• Direct sexual intercourse takes place at the nearby parking lot, in the vehicle, or beside it if weather permits. They do not operate in cafés identified in other conversations, nor in apartments, restaurants, or hotels.	Interview with a pimp, focus group with STWs	There is a strict division of territory - confirmed from several sources
Motives to deal in this business	• Financial reasons, mostly. This is the way to support their families, provide for the studies, or they were forced to go into business due to family poverty.	Interviews	
	• Drug addicts are in the business to indulge their heroin habit.		The road deep into drugs is the way to sex trade. As they earn money this way, they do not come to hospitals for treatment, and they rarely take part in crimes
	• Students are in prostitution to furnish living and university fees. Some hinted to it as a way to pass an exam.	Interviews (Dec 14, 2001)	Commented by a receptionist in his interview, refusing to go into personal detail not to compromise customers
School	• Presently, only one sex worker is at studies. The rest are unemployed. • Others graduated from elementary school (some incomplete) or a secondary three-year school. Lower educational level among the street prostitutes than among the other SWs • Students are also in SW group	Surveys, focus group (Nov 30, 2001), Interviews (Dec 5 and 6, 2001) Interview (Dec 25, 2001), focus group	Comment by a prostitute (not in streets) is that the profession has nothing to do with education, it is irrelevant. The trade is a choice, and prostitutes thus come from different venues and levels of education.
	• There is no prostitution in the students' dormitories, but it thrives with promiscuity	Interview with director, focus group with students	Promiscuity is not prostitution?
Family	• Originating from lower classes	Interviews (Dec 5, 6, 17 and 25, 2001)	
	• Their families know nothing of their trade; otherwise it would be a terrible, inadmissible disgrace.	Interviews	
	• One woman in street prostitution is married, has two children, and her husband knows about her trade.	Interview with STW (Dec 7, 2001)	
	• Some said they knew a woman in the neighbourhood who was a prostitute, and	Focus group with parents (Dec 9, 2001)	More discriminating stance toward the

RISK AND PROTECTIVE BEHAVIOURS STW - Kagujevac

Area of assessment	Findings	Data sources	Comments
Drug addicts in prostitution Students in prostitution	she had also introduced her daughter into the business.		phenomenon
	• Family of the student prostitute know nothing about it.	Interview (Dec 25, 2001)	It would be a common disaster
	• The pimp has a family of his own, but also a partner who is herself in the street hustling business.	Interviews, focus groups with STWs	
	• Families that drug addicts who are sex workers originate from are manifestly dysfunctional: parental alcoholism, divorces, brawls, and other addictions.	Interviews, focus group, focus group with parents	Brother is peddling heroin, sister is prostituting herself for heroin (case)
	• Family of a pimp's prostitute knows about her trade, but being poor they favour it.	Interview Dec 17, 2001	The trade the daughter is in is her great sacrifice for the family
	• Drug addicts are usually not married and have no children. Some have relation with their dealer, but that is also impermanent. In case they have a steady partner, the relationships last briefly.	Interviews, focus group with IVDUs, interviews with key informants	It seems only a part of the drug addicts are in a so-called regular sex trade. Others are forced to sell sex favours, but it is not termed prostitution.
	• Girls in Belgrade agencies are mostly refugees, or those who have just arrived for studies.	Interviews with key informants	Our source states that in agencies he has not met a girl on drugs
	• A separate group in all aspects: they work alone, on a separated part of the highway exit, near the viaduct, the bridge.	Interviews with key informants, interviews, focus group with STWs, focus group with IVDUs, focus group with MUP	Clearly marked group in the city setting
	• Their clients are mostly men from the country.		It is common knowledge that they are drug addicts so their services are sought less frequently. Or not at all!!!
	• Their price is far below the street fare. They consent to DM 10		
	• They work with condoms, always.		Other sources state differently.
	• If a client offers a bit higher price (even a couple DMs), they work without condoms.	Interviews with key informants, focus group, focus group at the Ministry of Interior, interview with a solicitor	It saves time to get heroin more quickly.
	• The sex contact is performed as fast as possible, in 10 to 15 minutes, so they can have many clients in a day. They keep wok-	Interview with STW/IVDU (Dec 20, 2001)	She caters to 10 - 20 tricks in a working day, or

RISK AND PROTECTIVE BEHAVIOURS STW - Kagujevac

Area of assessment	Findings	Data sources	Comments
	ing until they collect enough bread for heroin. It takes DM 100 per day.		less if they offer better price.
	• A girl used to deal drugs in order to furnish her habit, but then discovered prostitution was an easier and faster way to get money.	Interview with STW/IVDU (Dec 20, 2001)	Less risk as there is less contact with low enforcement
	• Often a client is fooled, robbed of money, and left unserviced.	Interview with STW/IVDU (Dec 20, 2001)	
	• With her steady partner she prefers not to use condoms, as she trusts him, etc. She also had an HIV-positive partner.	Interview with STW/IVDU (Dec 20, 2001)	Low perception of risk
	• They do not choose this to be their permanent occupation, but a necessity to get through studies.	Interview (Dec 25, 2001) focus group, interview with a solicitor	
	• This is not a permanent occupation; they stay in business for some time until their financial status improves.	Interview (Dec 25, 2001)	In the trade until they find better way to gain money
	•		
	• She disapproves of street prostitution and does not allow any comparison to women of that sort.		
	• This is their secret business, they move in narrow circles of people who are their customers.	Interview (Dec 25, 2001)	
	• They always use condoms and there is no money to make them do it without one. They do not use condoms with steady partners.	Interview (Dec 25, 2001)	
	• Reluctant to speak about fares, which depend on quality and kind of service rendered.	Interview (Dec 25, 2001)	
	• She never uses drugs, despises addiction.	Interview (Dec 25, 2001)	

HEALTH AND SOCIAL CONSEQUENCES STW - Kragujevac

Area of assessment	Findings	Data sources	Comments
Health and social consequences	• Prostitutes take regular gynaecological examinations with pimps, students, women who hustle in élite restaurants.	Interview with a pimp, focus groups, interviews	Indispensable condition to work for a pimp is to have a clean medical record
	• They take check-ups by private doctors, not disclosing their trade. Some use state health service, always keeping their business secret.		
STD testing	• They deny to have had any STD.	Focus group with STWs, interview with a pimp	When offered to take a test, they found no reason to do it
	• Drug addicts fail to have regular control. They do not worry about health in the least.		

HEALTH AND SOCIAL CONSEQUENCES STW - Kragujevac

Area of assessment	Findings	Data sources	Comments
	• Students think they do not risk acquiring HIV for they use condoms. Thus they do not test themselves.		
	• A SW from élite restaurants goes for regular testing and all results are normal.	Interview (Dec 14, 2001)	HIV and Hep C negative
	• Some addicts had tested for HIV, tests were negative. One continued to behave risky (using other addicts' equipment, unsafe sex with HIV-positive partner); so it is not certain what the results might be this time. As they do not perceive risk, no regular controls are made.	Interviews, focus groups, interview with an infectologist, secondary data	Tested for HIV, never for Hep C
	• A private gynaecologist keeps contacts with SWs, he regularly reports abortions, and includes this group too.	Interview with a gynecologist (Dec 16, 2001)	
	• Women in prostitution do not come to skin doctors, no controls are organized, and they think there is no control at all.	Interview with a dermatologist (Dec 18, 2001)	Probably directed to private doctor's office
	• JAZAS has no data on the issue.	Interview (Dec 4, 2001)	No interest for this group
	• One of the sex workers was blood donor couple of months ago.	Interview with STW (Dec 6, 2001)	Tested routinely for transfusion: negative
Mental problems	• SWs look spirited in the street; they do not seem to be under the influence of alcohol or other substances, just smoking.	Observation, focus groups	They did not report to psychiatrists as they have no problems
	• Drug addicts do not come to psychiatry, as they feel no crisis, denying other mental disturbances.	Interview, focus groups with IVDUs, interview with key informants	Drug addicts in prostitution have a constant source of finances. This is not the case with men, who report to psychiatrists more often. This concerns crimes as well
	• Some of those working the streets supplied us data on abortions.	Focus groups, interviews	Regular use of condoms covers only the clients, not steady partners or spouses. They seek help in private doctor's offices.
	• No data on other ways of contraception.	Focus groups, interviews	Lack of concern for reproductive health, low level of information on consequences…
	• Street prostitution is not a felony, so they have no conflicts with the police. In cases of incarceration pimps aid them.	Target group and the police	They were put in custody for traffic offences (jamming the exit to highway)
	• Drug addicts had problems with law enforcement before they started to sell sexual favours. They had to steal; deal, and one had a 2-year prison term.	Interviews	Policemen are used to ask for sexual services gratis

HEALTH AND SOCIAL CONSEQUENCES STW - Kragujevac

Area of assessment	Findings	Data sources	Comments
	• Prostitutes in élite restaurants never had any problems with law enforcement.	Interview (Dec 14, 2001)	Some policemen were her clients
	• Several times we witnessed a pimp smacking a prostitute	Interview with a celebrity (café owner in the vicinity) (Dec 16, 2001)	There is violence. Police was not informed
	• Many customers turn nasty and aggressive,	Interview with STW (Dec 17, 2001)	Stepping in of the pimp is essential
	• There was violence and threats to a juvenile prostitute in a hotel, with police intervening.	Interview with a professor (Dec 25, 2001)	NO ONE INTERVENED

INTERVENTIONS STW - Kragujevac

Area of assessment	Findings	Data sources	Comments
Interventions	• THERE IS NOT A SINGLE INTERVENTION AIMED AT THIS GROUP, WHETHER IT BE DRUG ADDICTS IN THIS TRADE OR THE GROUP DESPISING USE OF DRUGS	All sources and methods	This refers to primary and secondary prevention. Perhaps a tertiary protection (cure of consequences) does exist, but ways to access it are dubious
	• No harm reduction programmes for groups of prostitutes	Triangulation of all data	
	• No harm reduction programmes for groups of SWs/iv DUs	Triangulation of all data	
	• None of the NGOs deals in these issues. The sole organization with anti-AIDS programme HAS NO CONTACTS WITH VULNERABLE GROUPS	Interview (Dec 4, 2001), focus group - CAB	Although not working directly with target groups, similarity of prevention strategies and work methods are to be used to unite forces
	• NGO DDD works in prevention of addiction, but without contacts with target groups	Interview (Dec 27 2001) focus group - CAB	Find way to do something jointly
	• There are health services and they are accessible, but contacts with prostitutes are few and have to be improved, so that these services are used easily (anonymously, in agreement with sensitive physicians, and similar).	Interview, focus group, interview with a physician, focus group - CAB	Actual offer of a dermatovenerologist (member of the CAB) to work with this group - find way to cooperate
	• Education of health workers on the issue.	Focus group - CAB, interviews with key informants, interviews	Voluntary principle in lobbying
	• Relatively good cooperation with the police, but it might be improved.	Focus groups with STWs, focus group with the police	Education of the police to recognize the problem clearly and to intervene

INTERVENTIONS STW - Kragujevac

Area of assessment	Findings	Data sources	Comments
Legalization of prostitution	• Street prostitutes rely on their pimps.	Focus group STWs	Low educational level and extreme submission to the pimp - ignorance on one's own rights
	• Prostitution should be legalized: the state would levy taxes, health control would be heightened.	Interviews (Dec 25, 2001)	Even though prostitution is a side business, she has an attitude
	• Drug addicts must be forbidden to deal in prostitution, as they are the source of infection.	Interviews (Dec 17, 2001)	Street prostitution group
	• A pimp advocates for legalization and counselling service for the girls.	Interview with a pimp (Dec 3, 2001)	
	• A more aggressive anti-prostitution campaign is needed. Some form of legalization is prerequisite for a legal framework.	Interview (Dec 14, 2001)	A girl from high society
	• Society neglects those in this trade, together with their families. They do not know whom to turn to for help.	Focus group with parents (Dec 9, 2001)	An example with a neighborhood family
	• "Prohibitions and punishments can help less than information and education"	Interview with a café owner (Dec 20, 2001)	
Association of SWs and IV DUs	• They are hard to reach for interventions, they work alone; avoid telling about their trade.	Interview with key informant (Nov 23, 2001)	Venture a relation of confidence first, and then try to implement some harm reduction steps.
	• A drug user in this group deems prevention of drug addiction should be organized at the earliest age. Also, dealers are to be arrested in order to curb addiction.	Interview (Dec 20, 2001)	Prevention is directed to drug addiction, not prostitution

PRILOG H - PHOTOGRAPHS

RAR team in Serbia *UNICEF / Elsie Wong*

Scene from one of Belgrade discotheques *UNICEF / Milos Loncarevic*

Graffiti in Kragujevac
UNICEF / RAR team Kragujevac

Opservation of haustor in a suburb of Kragujevac *UNICEF / RAR team Kragujevac*

Ways of preparing heroin for i.v. usage *UNICEF / RAR team Kragujevac*

NOTES

CIP - Katalogizacija u publikaciji
Narodna Biblioteka Srbije, Belgrade

616. 988: 578. 8281: 316 (497.11)

RAPID Assessment and Response on HIV / AIDS Among Especially Vulnerable Young People in Serbia / report prepared by Viktoria Cucic. - (Belgrade : Radunic). - 160 str.

Tiraz 400.

ISBN 86-82471-45-0

1. Cucic, Viktorija
a) Sida - Adolescenti - Socioloska istrazivanja - Srbija
COBISS - TD 102888204

ISBN 86-82471-44-2