Rapid Assessment and Response on HIV/AIDS among Especially Vulnerable Young People in South Eastern Europe

Report prepared by Elsie Wong

Canadian International Development Agency
Agence canadienne de développement international
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UNICEF's mission is to advocate for the protection of children's rights, to help meet their basic needs and to expand their opportunities to reach their full potential. The greater their vulnerability, the higher the priority.

UNICEF is mandated by the United Nations General Assembly to advocate for the protection of children's rights, to help meet their basic needs and to expand their opportunities to reach their full potential.

UNICEF is guided by the Convention on the Rights of the Child and strives to establish children's rights as enduring ethical principles and international standards of behaviour towards children.

UNICEF insists that the survival, protection and development of children are universal development imperatives that are integral to human progress.

In SEE UNICEF aims to assist national and local authorities to rehabilitate and maintain basic health and education services and to promote the implementation of the Convention on the Rights of the Child. UNICEF's role is that of a technical support agency providing assistance at all levels, from government to community and its staff include specialists in the field of education, protection, child psychology, information and logistics. UNICEF depends entirely on voluntary donations.

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ABBREVIATIONS and ACRONYMS

BiH. . . . . .Bosnia and Herzegovina
CIDA . . . . . .Canadian International Development Agency
EVYP. . . . . .Especially Vulnerable Young People
FBiH . . . . . .Federation of Bosnia and Herzegovina
FRY . . . . . .Federal Republic of Yugoslavia
FYR Macedonia. . . . . .Former Yugoslav Republic of Macedonia
HIV/AIDS. . . . . .Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome
IDU . . . . . .Injecting Drug Use/user
MSM . . . . . .Men who have Sex with Men
NGO . . . . . .Non-Governmental Organisation
OSI . . . . . .Open Society Initiative
PLWHA . . . . . .People Living With HIV/AIDS
RAR. . . . . .Rapid Assessment and Response
RS . . . . . .Republika Srpska
SEE . . . . . .South Eastern Europe
STI. . . . . .Sexually Transmitted Infection
UNAIDS. . . . . .United Nations Joint Programme on HIV/AIDS
UNICEF. . . . . .United Nations Children's Fund
WHO . . . . . .World Health Organisation

EXECUTIVE SUMMARY

The past 10 years of political, social and cultural transition combined with the devastating impact of conflict, have resulted in deterioration of all aspects of life, in all the countries of South Eastern Europe (SEE). This has increased the context of vulnerability to risk behaviours such as unsafe sex and drug use.

Growing up under these conditions has increased the vulnerability of young people to HIV. Enabling factors contributing to this include widespread unemployment, increased migration, family hardships and breakdown, inability to access health care services, poor educational systems, and the position of countries on the trafficking routes for drugs and humans through the region to Western Europe.

The prevalence of HIV is currently reported to be low in the countries of SEE. However this is misleading, because low prevalence can disguise epidemics that are occurring in vulnerable groups. Young people are potentially at the forefront of these epidemics. According to the UNAIDS/WHO, approximately one-third of those currently living with HIV/AIDS are between the ages of 15 and 24 years.

To date little behavioural data has been collected to provide an indication of the risk factors that make young people vulnerable to HIV infection. The goal of this RAR[1] was to gather behavioural data to better understand the context of vulnerability and the types of risk behaviour in which young people engage. A clearer understanding of the risk behaviours of these vulnerable young people (aged 10-24 years) would then provide the basis for developing and implementing appropriate interventions to improve the health of young people by minimising their risk of HIV, and would contribute to the prevention of the spread of HIV infection in SEE.

An additional goal was to build the capacity of local research teams so that they could implement future RARs.

The objectives of the RAR Project were to:

- Assess the context in which risk behaviours of vulnerable young people take place;
- Describe the behaviours that put vulnerable young people at risk of HIV and also to describe the associated health and social consequences of these behaviours;
- Assess the extent and effectiveness of existing interventions available to vulnerable young people;
- Develop and implement, or enhance existing interventions to minimise the risk of HIV among vulnerable young people;
- Increase the awareness and support of local communities with regards to vulnerable young people and HIV/AIDS.

Five countries in SEE participated in the RAR Project: Albania; Bosnia and Herzegovina; Croatia; the Federal Republic of Yugoslavia; and the Former Yugoslav Republic of Macedonia. Twenty-six cities from these five countries participated in the RAR Project. A Regional Coordinator and an International Consultant were contracted to provide technical expertise and support to the project for five months from October 2001 to February 2002. During these five months, the 26 Field Teams received training in the RAR research methodology, established Community Advisory Boards, and conducted fieldwork (i.e. data collection). Data analysis was performed concurrently with data collection. A total of 26 cities each simultaneously conducted a rapid assessment during the five-month period. Based on their key RAR findings, UNICEF and other actors are now developing action plans that consist of recommendations for interventions. Once these action plans are completed, responses and activities will implemented.

Countries selected various vulnerable groups of young people for the RAR Project, but most chose to study the following target groups:

- Young people in school;
- Young people who use drugs;
- Young people who inject drugs;

1. Rapid Assessment and Response (RAR) is a research methodology that is designed to rapidly assess a current vulnerable situation (e.g. injecting drug use) in a community. The collected information is then used to make informed decisions about the development of interventions that are needed to reduce the adverse health and social consequences of the vulnerable situation.

- Sex workers;
- Young MSM.

Additional target groups selected by some cities were

- Mobile population;
- Sailors;
- Juvenile delinquents;
- Young people deprived of parental care;
- Out-of-school youth or Roma youth.

To incorporate some standardization into the RAR Project so that comparisons could be made between the different countries, a set of 18 core questions were included in each of the various questionnaires. A total of 13 different questionnaires were used in this RAR Project.

The technique of snowball or network sampling was used to recruit young people to participate in interviews or focus groups or to complete questionnaires. Over 5,100 questionnaires were completed and 2,200 young people participated in either interviews or focus groups.

The findings and recommendations presented in this report were prepared at regional and country levels according to target groups. A separate country summary was prepared from each country's RAR report. Based on these country summaries, a regional summary was prepared.

Through questionnaires, interviews, focus groups, existing information, observations and mapping, data were collected and analysed. At the regional level, key findings emerging from the data included:

1. Drugs were easily accessible. The problem was accessing the money to purchase the drugs. Drug users and injecting drug users overcame this problem by obtaining funds from their parents, by stealing or by selling drugs. There was reported increase in juvenile delinquency, although the association between drug use and delinquency has not been clearly established.
2. The drugs most frequently used by the different target groups (i.e. drug users, injecting drug users, sex workers and young MSM) were alcohol, cannabis, ecstasy and pharmaceutical drugs . Most did not perceive alcohol as a drug. Moreover, many believed that there was no harm in using cannabis occasionally.
3. Over 90% of injecting drug users had sex under the influence of drugs yet only 14% used condoms regularly. Similarly, most sex workers (93%) had sex under the influence of drugs yet only 47% used condoms regularly. Low condom use among sex workers could be attributed to clients who were willing to pay more for sex without condoms.
4. Over 60% of injecting drug users shared needles and syringes. Reasons for sharing included lack of money to purchase new needles and syringes, sharing as a sign of trust, and not even considering the risk of sharing when the desire to inject was imminent. Furthermore, most did not properly clean their needles and syringes. Injecting drug users did not like purchasing needles and syringes from pharmacies because the staff there treated them with disrespect.
5. Although harm reduction services (e.g. needle exchange programmes, methadone therapy, counselling services and detoxification centres) were provided in most SEE countries, the issues of accessibility to and quality of these services needed to be addressed.
6. Of the young people who did not use drugs (n=2,594), 21% stated that they had sex. Of those who had sex (n=564), 55% always used condoms during sex. Young people reported that they could recognise a "safe" partner by their tidy physical appearance. Condoms were usually not used with these "safe" partners. If condoms were used during sex, they were used for protection against unwanted pregnancies rather than against STIs.
7. Of the young MSM who had sex (n=233), approximately 10% had one sexual partner in the past year and 54% always used condoms. Promiscuity and unsafe sexual behaviour was common among young MSM, even among those who were in steady relationships. Some even practiced "blind dating" when not knowing the partner did not preclude one from engaging in sex on the first date.
8. Most young people stated that if HIV testing was anonymous, free and accessible that they would get tested. HIV testing was available in all the SEE countries, although anonymous HIV testing was, for the most part, not available. Furthermore, pre- and post- HIV test counselling was generally not provided.
9. HIV/AIDS, drug and sex education in the school curricula was either non-existent or inadequate.
10. Only a few interventions that targeted sex workers were being implemented. There were no interventions specifically targeting young MSM.

The regional findings revealed that young people are engaging in risk behaviours that put them at risk of HIV. Based on the above findings and on the recommendations outlined in the various country RAR reports, recommendations at the regional level were prepared for this report. These recommendations were grouped under the following subject headings:

- Policy and Legislation;
- Harm Reduction Services;
- HIV Testing;
- Condoms;
- Young People;
- Sex Workers and Young MSM;
- Surveillance and Research.

Rapid Assessment and Response on HIV/AIDS among Especially Vulnerable Young People in South Eastern Europe

INTRODUCTION

!t has been estimated that 40 million people globally are living with HIV/AIDS, as of the end of 2001 (United Nations Joint Programme on HIV/AIDS (UNAIDS) and the World Health Organisation (WHO). In many parts of the developing world, the majority of new HIV infections are occurring in young adults. About one-third of those currently living with HIV/AIDS are between the ages of 15 and 24 years. Many of them are not even aware that they carry the virus. Young people are central to the course of the HIV epidemic as behaviours they learn now will influence its spread in the future.

HIV incidence is rising faster in Eastern Europe, particularly the Russian Federation, than anywhere else in the world (UNAIDS/WHO). In 2001, there were an estimated 250,000 new HIV infections in Eastern Europe (UNAIDS/WHO). In South Eastern Europe (SEE) the rates of sexually transmitted infections and injecting drug use are also on the rise, although they are still at considerably lower levels than elsewhere in Eastern Europe (UNAIDS/WHO).

The countries of SEE are currently reported as having low rates of HIV infection. A low prevalence of HIV, however, can be misleading in that it can disguise epidemics that are occurring in specific vulnerable groups. Rather than complacency as a result of the low overall prevalence, efforts need to be taken now to avert the potential spread of HIV infection.

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 behaviour, 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, with funding provided by the Canadian International Development Agency (CIDA), is implementing a "HIV/AIDS Prevention with Young People in South Eastern Europe" project, between 2001 and 2004. The goal of this project is to improve the health of young people, reduce vulnerability and strengthen prevention through targeted interventions. One of its key activities is the implementation of a Rapid Assessment and Response (RAR) in various cities across SEE between 2001 and 2002.

There are five countries in SEE participating in the RAR activities:

- Albania
- Bosnia and Herzegovina
- Croatia
- Federal Republic of Yugoslavia
- Former Yugoslav Republic of Macedonia

1.1 What is Rapid Assessment and Response?

In May 1998, WHO produced the Rapid Assessment and Response guide for injecting drug use (IDU-RAR guide). WHO used the IDU-RAR guide to collect data on injecting drug use, which provided the basis for making informed decisions about the kinds of interventions required. Since 1998, WHO has produced and implemented additional RAR guides for sexual behaviour (SEX-RAR guide) and for Especially Vulnerable Young People (EVYP-RAR guide).

RAR is designed to assess rapidly a current vulnerable situation (e.g. injecting drug use) in a community. This information is then used to make informed decisions about the development of interventions that are needed to reduce the adverse health and social consequences of the vulnerable situation.

AIMS

2.1 What makes young people in SEE vulnerable to HIV/AIDS?

Many changes have taken place in SEE, creating the unstable conditions that make young people especially vulnerable to HIV infection. The factors that have contributed to this increased vulnerability include the following:

- High unemployment;
- Post conflict stress;
- Lack of or inadequate sex education in schools;
- Increased mobility: voluntary and involuntary, legal and illegal;
- Desire to be “trendy” or more westernised;
- Major trafficking routes for both drugs and women across SEE;
- Living in rural areas;
- Lack of access to prevention services (e.g. STI testing and treatment, HIV voluntary counselling and testing);
- High cost of quality condoms.

2.2 Vulnerable Groups Selected for the RAR

RARs were implemented in several cities, in each of the five participating countries. In total, 26 cities implemented a rapid assessment. In most of the countries the vulnerable target groups that were studied were:

- Young people in school;
- Young people who used drugs;
- Young people who injected drugs;
- Sex workers;
- Young Men who have Sex with Men.

Additional vulnerable groups studied in some cities included mobile populations, sailors, juvenile delinquents, out-of-school youth, and young people deprived of parental care. It was recommended that each city select a maximum of two different target groups to study. A city could select a third target group to study provided it had sufficient capacity.

Appendix A provides a detailed breakdown of the vulnerable groups studied by city.

Reasons for selecting these vulnerable groups included the following:

- Most of the data available on these vulnerable groups were only anecdotal thus the RAR was an opportunity to collect data to verify or disclaim the anecdotes.
- There were no behavioural data available on these vulnerable groups.
- It was evident that these vulnerable groups were at risk of HIV infection.

2.3 Goal and Objectives

The overall goal of the RAR Project was to collect and analyse data on the risk behaviours of vulnerable young people.[2] These analyses will, in turn, provide recommendations for interventions that will improve the health of young people by minimising their risk of HIV infection.

The objectives of the RAR Project were:

2. In this RAR Project, young people were defined as individuals between the ages of 10 and 24 years.

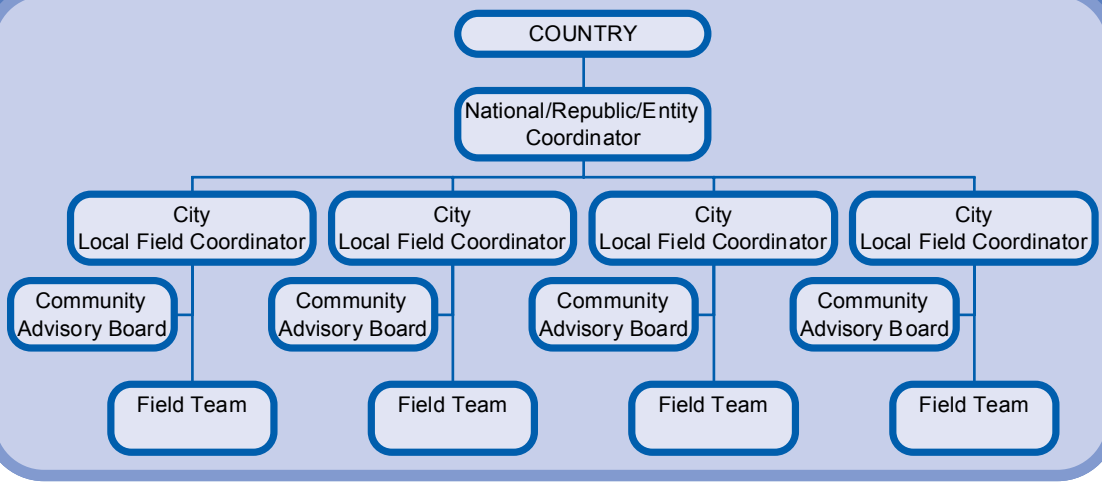
- To assess the context in which risk behaviours of EVYP take place;
- To describe the behaviours that put EVYP at risk of HIV infection and also to describe the associated health and social consequences of these behaviours;
- To assess the extent and effectiveness of existing interventions available to EVYP;
- To develop and implement or enhance existing interventions that will minimise the risk of HIV infection amongst EVYP.
- To increase the awareness and support of the local communities with regards to EVYP and HIV/AIDS.

An additional goal of the RAR Project was to build local capacity so cities could implement future RARs and individuals could carry out similar research.

THE RAR PROCESS

Figure 1 outlines the overall structure of the RAR Teams in each of the five SEE countries participating in the RAR Project.

FIGURE 1 Organogram of a Country RAR Team



3.1 RAR Team

National/Republic/Entity Coordinator

In each country, there was a Coordinator that oversaw the implementation of the RARs in the various cities. Two of the five participating countries had two Coordinators: Bosnia and Herzegovina (Entity Coordinators) and the Federal Republic of Yugoslavia (Republic Coordinators).

Thus, there were seven National/Republic/Entity Coordinators[3] as outlined in Table 1. For the purposes of this report, there were seven locations participating in the RAR Project.

The UN Administered Province of Kosovo (FRY) did not participate in this RAR Project. A RAR was implemented in Kosovo by WHO and UNICEF in April and May 2001, and focused on psychoactive substance use in young people.

Local Field Coordinator

In each of the 26 cities, there was a Local Field Coordinator who oversaw the day-to-day fieldwork of the RAR, and also supervised and provided support to the Field Team.

Core Team

The Core Team was comprised of the National/Republic/Entity Coordinator and the respective Local Field Coordinators. The Core Team met on a regular basis to discuss RAR findings and any problems or emerging issues.

3. The Republika Srpska Entity Coordinator also provided support to the Brčko District RAR Team.

TABLE 1 National/Republic/Entity Coordinators

Location	Coordinator
Albania	National
Bosnia and Herzegovina	
Federation of Bosnia and Herzegovina	Entity
Republika Srpska	Entity
Croatia	National
Federal Republic of Yugoslavia	
Serbia	Republic
Montenegro	Republic
Former Yugoslav Republic of Macedonia	National

Local Field Team

In each of the 26 cities, there was between five and six Field Team members who collected, recorded and analysed the data. The Field Team members were allocated various responsibilities depending on their expertise and interests. For example, some Field Team members were more easily able to access vulnerable young people while other Field Team members were interested in conducting focus groups. During the data collection phase, Field Team meetings were held on a regular basis to discuss the ongoing implementation of the RAR (e.g. new data, data analysis, problems, etc.).

Data Entry Expert

Each of the seven RAR teams included a Data Entry Expert except for Croatia. For each Country/Republic/Entity, all of the completed questionnaires from the various cities were forwarded to the Data Entry Expert who entered the data into a single database. In Croatia, a Local Field Team member in each city completed the data entry.

3.2 Technical and Administrative Support for the RAR Team

Regional Coordinator

The Regional Coordinator was responsible for providing technical expertise for the overall implementation of the RAR Project. In particular, the Regional Coordinator provided support to Albania, Croatia, FRY Serbia and FYR Macedonia.

International Consultant

The International Consultant was responsible for providing technical expertise during the data collecting and analysis phases of the RAR Project. In particular, the International Consultant provided support to Bosnia and Herzegovina and FRY Montenegro.

International Technical Advisory Group

An International Technical Advisory Group was established prior to implementing the RAR Project. The Advisory Group was comprised of technical experts from various backgrounds (e.g. RAR, young people, injecting drug use, drug use, HIV/AIDS, etc.). The role of the Advisory Group was to provide technical expertise and guidance for the RAR Project. The Regional Coordinator and the International Consultant maintained communications with the Advisory Group through e-mail and/or telephone correspondence.

UNICEF Focal Points

There was a UNICEF Focal Point in each of the Countries/Republics/Entities. The Focal Points provided the RAR Teams with administrative and logistical support (e.g. contracts, travelling arrangements, obtaining Ministerial support for the RAR Project, etc.).

3.3 Workshops

UNICEF/WHO Regional Training Workshop on RAR

Date: 22 to 26 October 2001

Place: Neum, Bosnia and Herzegovina

The workshop was conducted in English. Technical experts from WHO Geneva, OSI, Health Canada and UNICEF provided five days of RAR training to the seven Core Teams and their respective UNICEF Focal Points. In total, there were 45 participants. The goal of the workshop was to provide Core Teams with the knowledge and skills to conduct a RAR. A week after the workshop, each participant received an electronic copy of all workshop presentations and handouts. Appendix B provides a summary of the workshop.

Local RAR Training Workshops

Date: November 2001

Place: Respective Locations

During November, the Field Team members from the various cities within each Country/Republic/Entity attended a RAR training workshop. Each of the seven Core Teams prepared and delivered the 3-day training workshop to their respective Field Teams. The workshops were conducted in local language.

UNICEF developed and produced a RAR Training Workbook that was translated into local language. The purpose of the workbook was to provide Field Team members with a step-by-step guide on how to collect and record data (e.g. how to prepare and conduct a focus group, how to complete an activity grid, how to respond to frequently asked questions by respondents, etc.).

Either the Regional Coordinator or the International Consultant attended most of the training workshops to provide Core Teams with support if needed. Due to conflicting dates, neither the Regional Coordinator nor the International Consultant could attend the training workshop in FBiH. The International Consultant, however, travelled to each of the cities (i.e. Mostar, Sarajevo and Tuzla) in FBiH to meet with the Local Field Coordinator and Field Team prior to their training workshop.

UNICEF/OSI Regional Action Plan Workshop

Date: 11 to 13 February 2002

Place: Sarajevo, Bosnia and Herzegovina

The workshop was conducted in English. Technical experts from WHO Geneva, OSI, Health Canada and UNICEF provided three days of training to the seven National/Republic/Entity Coordinators, their respective UNICEF Focal Points, and two other Field Team members or members of their local NGOs. The goal of the workshop was to provide participants with the knowledge and skills to develop and implement an action plan. In total, there were 40 participants. Similar to the Regional RAR Training Workshop, each participant received an electronic copy of all workshop presentations and handouts a week later. Appendix C provides a summary of the workshop.

3.4 Community Advisory Board

In each city, a Community Advisory Board was established. Most of the Field Teams established and met with their Advisory Board before starting data collection. The purpose of the Community Advisory Board was to provide support to the RAR and also to assist with the establishment of a climate for intervention development based on the RAR findings.

In the various cities, the range of representatives and key individuals on the Community Advisory Boards included young people, Ministry representatives, the media, social workers, representatives from NGOs and international organisations, and local police.

3.5 Timescale of Activities

Table 2 outlines the month-by-month timescale of RAR activities that took place from October 2001 to February 2002.

3.6 Challenges and Successes

Like any research study, the RAR Project encountered problems and successes. Listed below are the main challenges and successes as outlined in the various country RAR reports.

TABLE 2 Timescale for RAR Project

Month	Activity
October 2001	- Recruit N/R/E Coordinators, LFC, and CT.
	- Select RAR study sites (i.e. cities).
	- Determine scope of RAR.
	- Regional Coordinator started 1 October.
	- Plan for 5-day Regional Training Workshop.
	- Trained CT on RAR at 5-day Regional Training Workshop.
	- Recruit FT.
November 2001	- Pilot test core questions.
	- Develop, produce and distribute Training Workbook for FT.
	- Train FT on RAR at 3-day local Training Workshop by CT.
	- Establish Community Advisory Board.
	- Advocate at each RAR study site.
	- Administrative tasks (e.g. set up office, photocopy questionnaires, etc.)
	- Field work: data collection; recording; analysis.
	- Weekly FT meetings.
	- Create Epi Info data dictionaries and databases.
December 2001	- Field work: data collection; recording; analysis.
	- Weekly FT meetings.
	- CT meeting.
	- Site visits by RC or IC.
January 2002	- Field work: data collection; recording; analysis.
	- Develop draft interventions and responses.
	- Site visits by RC or IC.
	- Weekly FT meetings.
	- Meeting with Community Advisory Board.
	- Develop, produce and distribute format for RAR report.
	- CT meeting.
	- Write RAR report at each RAR study site.
	- Write RAR report for Country/Republic/Entity.
	- Plan for 3-day Action Plan Workshop.
February 2002	- CT meeting.
	- Write RAR report for Country/Republic/Entity.
	- Meeting with Community Advisory Board.
	- 3-day Action Plan Workshop.
	- Write regional RAR report.
	- Disseminate RAR findings to city, country, region.

N/R/E – National/Republic/Entity
LFC – Local Field Coordinator
CT – Core Team
RC – Regional Coordinator
IC – International Consultant
FT – Field Team

Challenges

- Very tight timescale for completing the RAR Project. Field Teams had to dedicate much more time to the RAR Project than originally anticipated.
- Fieldwork occurred during the holiday season (i.e. Christian Christmas, New Year, Orthodox Christmas and other religious holidays).
- Fieldwork took place during the unfavourable winter weather conditions.
- Selection of Epi Info software to develop databases. Many of the statisticians did not have working knowledge of this software.
- Certain institutions refused to provide existing information.
- Not enough information was provided on how to establish a Community Advisory Board.

Successes

- Academic researchers, government representatives, NGOs worked together with young people including those from vulnerable groups, mostly for the first time.
- Accessed difficult to reach target groups (e.g. sex workers). Furthermore, individuals from these target groups were willing to participate in interviews and/or focus groups and in some locations were team members.
- RAR Project was a positive learning experience for Field Teams.
- Very positive community interest in the RAR Project, which in turn assisted in the implementation of responses.
- Cooperation and interest of the Community Advisory Boards in the RAR Project.
- Networks established as a result of this RAR Project can be used for future research studies.
- It was the first time that the RAR methodology had been implemented in most of the countries.

METHODOLOGY

4.1 Framework of RAR

In accordance with the RAR methodology, data were collected using the following six methods:

- Existing information;
- Questionnaire;
- Focus groups;
- Interviews and key informant interviews;
- Observations;
- Mapping.

Data were collected to answer questions in the following four areas:

- Context[4];
- Risk and protective behaviours;
- Health and social consequences that are related to the risk behaviours;
- Existing or future interventions that attempt to reduce the health and social consequences.

Data were collected from the following three key source groups:

- Vulnerable young people[5];
- Service providers[6];
- Policy makers/community leaders[7].

4.2 Sampling Technique

In this rapid assessment, there was not enough time or resources to select a representative sample. Instead, theoretical sampling was used. A theoretical sample was obtained by using mainly the technique of snowball or network sampling. In addition, cluster sampling was used in Republika Srpska. There were no set rules for the sizes of the theoretical samples.

4. Data is gathered on factors that influence the current and potential vulnerable situation, its accompanying adverse health consequences, and the opportunities for the development of interventions (e.g. literacy levels, unemployment rates, routes for trafficking drugs or humans, societal stigmatisation of MSM, etc.).
5. Examples include drug users, injecting drug users, sex workers, young MSM and sailors).
6. Examples include physicians, outreach workers, teachers, police and counsellors.
7. Examples include the Minister of Health, the Minister of the Interior and religious leaders.

Snowball or network sampling involved the Field Team member interviewing a vulnerable young person who was from the target group then asking this youth to introduce the Field Team member to another youth from the target group to interview. In turn, the Field Team member asked this youth to introduce yet another youth from the target group to be interviewed.

Recruiting young people to participate in the RAR Project continued until there were no more young people to recruit for interview, or until the time allocated for data collection ended.

4.3 Questionnaires

Core Questions

At the Regional Training Workshop in October 2001, a sub-working group was established to develop a set of closed end core questions. All participants agreed that each city would include these 18 core questions in their questionnaires. These 18 core questions were pilot tested on young people in Sarajevo, Bosnia and Herzegovina. Revisions to the core questions were made in accordance with the findings from the pilot testing.

Appendix D provides a list of the 18 core questions.

Additional Questions

Each of the Countries/Republics/Entities developed additional questions to add to the 18 core questions. Technical support was provided by the International Consultant to assist the Countries/Republics/Entities in developing their questionnaires. There were 13 different questionnaires used in this RAR Project.

In general, the questionnaire was administered to all young people who participated in the RAR. Each young person that was recruited to participate in an interview or focus group also completed a questionnaire. The questionnaire was not administered to service providers, policy makers or community leaders.

4.4 Ethical Considerations

Field Team members had an obligation to ensure that the young people who participated in the RAR Project were protected and that their anonymity was maintained at all times.

During the fieldwork (i.e. data collection), Field Team members maintained the following ethical standards:

- Respect for the life choices made by the young people who participated in this RAR Project. Field Team members had to be non-judgmental;
- Participants were not made to feel obligated to participate in this RAR Project;
- Each young person who participated in this RAR Project was given a thorough explanation of the study so that he/she could make an informed decision about whether to participate in an interview, focus group or complete a questionnaire;
- Participants could withdraw from the RAR Project, refuse to answer any question, or terminate the interview at any time;
- Participants were assured that all observations, interviews, questionnaires and focus groups completed would be confidential;
- To maintain anonymity, each participant who completed a questionnaire was assigned a number. There was no identifying information kept on any participant.

4.5 Sample Size

Tables 3 and 4 provide a breakdown of the number of participants by vulnerable group and data collection method. It was recommended that the each young person recruited to participate in a focus group or interview would also be asked to complete a questionnaire.

TABLE 3 RAR Project Participants

Group	Questionnaires	Interviews	Focus Groups
Young People who USE DRUGS	1,068		
Young People who INJECT DRUGS	652	497	992
Young People who DO NOT USE DRUGS	2,594		
Sex Workers	199	61	98
Young MSM	362	105	126
Mobile Population	91	50	55
Out-of-School Youth / Roma Youth	37	4	22
Sailors	50	4	26
Young People Deprived of Parental Care	61	12	89
Juvenile Delinquents	67	6	67
TOTAL:	5,181	739	1,475

TABLE 4 RAR Project Participants

Group	Interviews	Focus Groups
Service Providers	415	195
Policy Makers / Community Leaders	76	74
Others*	47	130
TOTAL:	538	399

*Others included prisoners, students, journalists, teachers, club owners, and parents.
In addition, over 100 observations were completed and mapping was completed in the various cities.

4.6 Recording Data

Questionnaires

The data collected from the questionnaires were entered in databases that were created using Epi Info version 6 software. Blanks on questionnaires were left as blanks in the data entry process.

Interviews, Focus Groups and Observations

Qualitative data collected from interviews, focus groups or observations were recorded by taking notes. The notes were then quickly transferred onto activity grids. A separate activity grid was completed for each interview, focus group or observation. Completed activity grids were eventually summarised on one of four mega grids: context; risk and protective behaviours; health and social consequences; and interventions. Appendix E provides an example of an activity/mega grid.

4.7 Data Analysis

Questionnaires

The data were analysed descriptively (i.e. frequency counts, means or averages, and percentages). It was recommended that the questionnaire data be analysed according to target groups.

Core Teams performed the data analysis of the questionnaires. In turn, the results of the analysis were distributed to the respective Local Field Coordinators for cross checking (i.e. triangulation) with the qualitative data that were collected.

A separate analysis of the questionnaire data was conducted for the regional report thus the questionnaire results presented in this report may be different from those presented in the original country RAR reports. For this report, only questionnaires completed by young people between the ages of 10 and 24 years were included in the data analysis. Due to time constraints, no other checks were performed on the dataset. Furthermore, the young people target group data were analysed differently in this report than in the original country reports.

The core question regarding whether one had a sexually transmitted infection provoked confusing responses and thus was not well answered. For this reason, no analysis of this question was undertaken in this report.

Interviews, Focus Groups, Observations, and Mapping

During their team meetings, the Field Teams analysed the qualitative data that they had collected and transferred onto activity grids. To get an overall impression, the data were read and re-read.

Common words, phrases or themes that kept recurring on the different activity grids were noted and transferred onto the appropriate mega grid (i.e. context, risk and protective behaviours, health and social consequences, or interventions). The initial analysis of the qualitative data was performed concurrently with data collection. Thus, new questions that arose (i.e. induction) during the analysis could still be answered, since data collection was still taking place.

For this regional report, only the major themes from the various original country reports are presented.

REGIONAL FINDINGS

Young people, predominantly those attending secondary schools, were the vulnerable target group that FBiH, Monetenegro and FYR Macedonia selected to study for this RAR Project. For the purposes of this regional report, the young people target group was sub-divided, according to their risk behaviours, into the following groups:

- Young people who use drugs;
- Young people who inject drugs;
- Young people who do not use drugs (study the sexual behaviour of young people)

Most countries studied similar target groups in this RAR Project, so the quantitative and qualitative findings for this regional report will be presented for the following vulnerable target groups:

- Young people who use drugs or drug users (excluding injecting drug users)
- Young people who inject drugs or injecting drug users
- Young people who do not use drugs or sexual behaviour of young people
- Sex workers
- Young men who have sex with other men

For countries that selected other vulnerable target groups to study, a summary of their quantitative and qualitative findings are presented in the latter sections of this report under their respective country summaries. These other target groups were:

- Out-of-school young people or Roma youth - Croatia;
- Sailors - Montenegro;
- Young people deprived of parental care - FYR Macedonia;
- Juvenile delinquents - FYR Macedonia.

As mentioned, Appendix A provides a breakdown of the vulnerable target groups studied in each city.

5.1 South Eastern Europe

South Eastern Europe is a region currently undergoing transition. Political tensions, high unemployment, inadequate enforcement of the law, ineffective drug legislation, and a lack of resources to combat crime have facilitated the trafficking of drugs and women through SEE to Western Europe.

The basic institutions of society, school and family are losing their traditional importance. Parents are increasingly preoccupied with their own problems of economic survival and thus have less time to spend with their children. Communication between young people and their parents is poor. Consequently, young people often escape from their home lives by engaging in risk behaviours.

5.2 Young people who use drugs

Young people use drugs for many reasons:

- Desire to belong to a group or peer pressure;
- Escape reality;
- Curiosity;
- Boredom.

Most young people do not perceive alcohol as a drug. Moreover, many believe that there is no harm in using cannabis occasionally. Cannabis is usually consumed in large group settings in public areas such as cafes or bars. Ecstasy is often consumed at rave parties on the weekends. Recently, there has been a notable increase in the use of ecstasy among young people. One of the major risks of consuming ecstasy is the potential for dehydration therefore it is essential that considerable amounts of liquids (e.g. water) are consumed when using the drug.

Drugs are easily accessible. The problem is accessing the money for their purchase. Young people overcome this problem by obtaining funds through their parents, by stealing or by selling drugs. There is a reported increase in juvenile delinquency, although the association between drug use and delinquency has not been clearly established.

Questionnaire Results - Young people who use drugs

The questionnaire was administered to 1,068 drug users, 646 males and 415 females. There were 7 questionnaires for which the respondent's gender was not known. The following provides a summary of the descriptive data based on the core questions from the questionnaire (n = 1,068)[8,9]

- Mean age ranged from 17.0 to 20.2 years.
- Mean age when first used drugs ranged from 15.4 to 16.2 years.
- 66.6% had sexual intercourse.
- 44.9% thought that they were at risk of HIV or other STIs.
- 8.6% had been tested for HIV.

In the past month, the following drugs had been used:

- Alcohol 80.7% of respondents;
- Cannabis 55.5%;
- Ecstasy 17.3%;
- Diazepam 9.8%;
- Heroin 8.7%;
- Analgesics 6.8%;
- Cocaine 6.2%;
- Amphetamines 4.1%;
- Glue 3.8%;
- LSD 3.7%;
- Methadone 1.8%;
- Poppy tea 1.2%.
- 50.3% used two or more drugs at the same time.
- 40.5% had sex under the influence of drugs.

Of those who had sexual intercourse (n=711):

- Mean age at first sexual intercourse ranged from 15.7 to 17.0 years;
- 4.5% had no sexual partners in the past year;
- 38.1% had one sexual partner in the past year;

8. Injecting drug users were not included in this sample.
9. Percentages were calculated using n=1,068 as the denominator unless noted otherwise.

- 41.8% had between 2 and 5 sexual partners in the past year;
- 7.2% had between 6 and 10 sexual partners in the past year;
- 4.8% had more than 10 sexual partners in the past year;
- 27.3% “always” used condoms during sex;
- 69.8% “sometimes” or “never” used condoms during sex;
- 6.6% had sex in return for money, drugs, etc.

Reasons for not “always” using condoms during sex:

- Trust in partners;
- Do not like sex with condoms;
- Difficult to use;
- Embarrassed to purchase condoms.

Where to access information about HIV or other STIs:

- No place - do not access HIV/STI information;
- Friends or peers;
- Media.

5.3 Young people who inject drugs

Usually young people begin to inject drugs in the presence of more experienced drug injectors. Heroin is the drug most frequently injected. Young people often use cannabis and other non-injecting drugs in public areas, but those who inject drugs often do so in private areas such as their homes, the homes of friends, or in isolated abandoned places.

There is considerable risk of overdosing when injecting drugs. Most young drug injectors are inexperienced and lack safe injecting skills. Most reported attempts to clean their needles and syringes, although many do not use bleach. Furthermore, the steps involved in preparing the drug for injecting are alarmingly unhygienic:

Heroin is boiled with tap water in a common spoon. Boiling of the drug in a dirty bottle cap was also observed. The boiled drug is then filtered through a cotton ball with a shared needle into a shared gun and then into other syringes. The cotton balls are not wasted. They are routinely stored in a box. At a time when there is no drug available, these stored cotton balls are boiled again in an attempt to drain the last droplets of heroin out. To clean drug injecting equipment, it is either boiled in water, rinsed with alcohol, bleach or dish washing liquid.

(RAR Report for Serbia, 2002)

Many of the young people share their needles and syringes, the reasons for which include the following:

- Lack of money to purchase new needles and syringes;
- Sharing is a sign of trust;
- An imminent desire to inject, when the risk of sharing is not considered;
- Sharing provides a sense of belonging to the group.

Young people do not purchase their needles and syringes from pharmacies, because pharmacy staff treat them with disrespect. They were often “looked below the eye” by the pharmacy staff.

Questionnaire Results - Young people who inject drugs

The questionnaire was administered to 652 injecting drugs users, 491 males and 161 females. The following provides a summary of the descriptive data based on the core questions from the questionnaire (n = 652)[10]

- Mean age ranged from 20.8 to 21.8 years.
- Mean age when first used drugs ranged from 14.9 to 17.1 years.
- Mean age when first injected drugs ranged from 17.3 to 19.1 years.
- 96.3% had sexual intercourse.
- 72.1% thought that they were at risk of HIV or other STIs.
- 52.5% had been tested for HIV.

In the past month, the following drugs had been used:

- Heroin 75.9% of respondents;
- Cannabis 70.9%;
- Alcohol 68.1%;

10. Percentages were calculated using n=652 as the denominator unless noted otherwise.

- Diazepam 39.6%;
- Analgesics 36.8%;.
- Methadone 27.9%;
- Ecstasy 26.1%;
- Cocaine 18.3%;
- LSD 8.0%;
- Amphetamines 6.7%;
- Glue 4.0%;
- Poppy tea 3.5%.
- 62.1% shared drug-injecting equipment.
- 89.3% used two or more drugs at the same time.
- 92.3% had sex under the influence of drugs.

Of those who had sexual intercourse (n=628):

- Mean age at first sexual intercourse ranged from15.6 to 17.1 years;
- 2.2% had no sexual partners in the past year;
- 22.8% had one sexual partner in the past year;
- 51.0% had between 2 and 5 sexual partners in the past year;
- 11.3% had between 6 and 10 sexual partners in the past year;
- 4.6% had more than 10 sexual partners in the past year;
- 14.3% “always” used condoms during sex;
- 84.9% “sometimes” or “never” used condoms during sex;
- 14.5% had sex in return for money, drugs, etc.

Reasons for not “always” using condoms during sex:

- Do not like sex with condoms;
- Trust in partners;
- Embarrassed to ask partners to use condoms.

Where to access information about HIV or other STIs:

- Media;
- Friends or peers;
- No place - do not access HIV/STI information.

5.4 Young people who do not use drugs

Young people want to experiment. Often they engage in sexual intercourse unprepared for the potential consequences. Young people reported that they could recognise a “safe” partner by their tidy physical appearance. Condoms were usually not used with these “safe” partners.

If condoms were used during sexual intercourse, it was for protection against an unwanted pregnancy rather than against STIs.

Questionnaire Results - Young people who do not use drugs

The questionnaire was administered to 2,594 young people who do not use drugs, 1,000 males and 1,577 females. There were 17 questionnaires for which the respondent’s gender was not known. The following provides a summary of the descriptive data based on the core questions from the questionnaire (n = 2,594).[11]

- Mean age ranged from 16.3 to 17.7 years.
- 21.7% had sexual intercourse.
- 50.0% thought that they were at risk of HIV or other STIs.
- 4.4% had been tested for HIV.

Of those who had sexual intercourse (n=564):

- Mean age at first sexual intercourse ranged from 15.3 to 16.8 years;
- 3.5% had no sexual partners in the past year;
- 48.8% had one sexual partner in the past year;
- 35.6% had between 2 and 5 sexual partners in the past year;
- 4.4% had between 6 and 10 sexual partners in the past year;
- 2.8% had more than 10 sexual partners in the past year;

11. Percentages were calculated using n=2,594 as the denominator unless noted otherwise.

- 55.1% “always” used condoms during sex;
- 47.1% “sometimes” or “never” used condoms during sex;
- 6.7% had sex in return for money, drugs, etc.

Reasons for not “always” using condoms during sex:

- Do not like sex with condoms;
- Trust in partners;
- Condoms are not easily available.

Where to access information about HIV or other STIs:

- Media;
- School;
- Family.

5.5 Sex Workers

Condoms were expensive to purchase. Condom use among sex workers was moderate. Many sex workers stated that they did not use condoms with their regular clients, their permanent partners, or with clients who were willing to pay more for sex without condoms. Sex workers were often abused, both physically and mentally, by their clients and protectors.

In the Brčko District (BiH), it was difficult to recruit sex workers to participate in the RAR Project since data collection coincided with the District Prosecutor’s campaign against human trafficking and sex workers. During this campaign, the police were trying to close down nightclubs (i.e. brothels).

Questionnaire Results - Sex Workers

The questionnaire was administered to 199 sex workers, 17 males and 182 females. The following provides a summary of the descriptive data based on the core questions from the questionnaire (n = 199).[12]

- Mean age ranged from 19.3 to 21.8 years.
- 54.8% had used drugs.
- Mean age when first used drugs ranged from 16.5 to 16.7 years.
- All have had sexual intercourse.
- 77.9% thought that they were at risk of HIV or other STIs.
- 50.8% had been tested for HIV.

Of those who used drugs (n=109), the following drugs had been used in the past month:

- Alcohol 89.0% of respondents;
- Cannabis 78.0%;
- Heroin 41.3%;
- Ecstasy 30.3%;
- Analgesics 24.8%;
- Diazepam 23.9%;
- Cocaine 21.1%;
- Methadone 13.8%;
- LSD 11.9%;
- Amphetamines 4.6%;
- Glue 2.8%;
- Poppy tea. 1.8%.

Of those who have used drugs (n=109):

- 33.0% had injected drugs;
- Mean age when first injected drugs ranged from 17.0 to 21.0 years;
- Of those who injected drugs (n=36), 86.1% shared drug-injecting equipment;
- 74.3% used two or more drugs at the same time;
- 93.6% had sex under the influence of drugs.

Of those who had sexual intercourse (n=199):

- Mean age at first sexual intercourse ranged from 15.3 to 16.7 years;
- 0.5% had no sexual partners in the past year;
- 3.0% had one sexual partner in the past year;
- 7.5% had between 2 and 5 sexual partners in the past year;
- 8.5% had between 6 and 10 sexual partners in the past year;

12. Percentages were calculated using n=199 as the denominator unless noted otherwise.

- 3.5% had between 11 and 19 sexual partners in the past year;
- 1.0% had between 20 to 49 sexual partners in the past year.
- 15.6% had between 50 and 99 sexual partners in the past year;
- 52.8% had 100 or more sexual partners in the past year;
- 47.2% "always" used condoms during sex;
- 52.7% "sometimes" or "never" used condoms during sex;
- 98.0% had sex in return for money, drugs, etc.

Reasons for not "always" using condoms during sex:

- Clients pay more to have sex without condoms;
- Do not consider using condoms with their protectors;
- Embarrassed to ask partners to use condoms;

Where to access information about HIV or other STIs:

- Friends or peers;
- Media;
- No place - do not access HIV/STI information.

5.6 Young Men who have Sex with Men (MSM)

In the past few years, discussions regarding sexual orientation have become more open and free. Even so, young men who have sex with men (MSM) still encounter animosity, stigmatisation and discrimination.

Many of the young MSM still have not informed their parents of their sexual orientation for the fear of their parents' reaction. Of the MSM who have informed their parents of their sexual orientation, they claim that their parents' acceptance is merely verbal as evidenced by their lack of willingness to communicate about the subject matter.

Promiscuity is common among MSM, even among those who are in steady relationships. It is not uncommon to have more than one sexual partner during a single night. Some even practice "blind dating" where not knowing the partner does not preclude one from engaging in sex on the first date.

Very few men could distinguish the difference between condoms that were used for anal sex and those that were used for oral sex. In Serbia, only oil-based lubricants are used since water-based lubricants are not available.

Questionnaire Results - Young MSM

The questionnaire was administered to 329 young MSM. The following provides a summary of the descriptive data based on the core questions from the questionnaire

(n = 329).[13] In FYR Macedonia, this target group emerged near the end of the data collection phase, so a different questionnaire was administered to the 33 young MSM or bisexuals recruited for the RAR Project. These 33 individuals were not included in the descriptive data below.

- Mean age ranged from 21.0 to 21.3 years.
- 35.3% had used drugs.
- Mean age when first used drugs was 16.2 years.
- 70.8% had sexual intercourse.
- 75.1% thought that they were at risk of HIV or other STIs.
- 38.0% had been tested for HIV.

Of those who used drugs (n=116), the following drugs had been used in the past month:

- Alcohol 87.1% of respondents;
- Cannabis 62.9%;
- Ecstasy 26.7%;
- Diazepam 19.8%;
- Analgesics 12.1%;
- LSD 6.9%;
- Heroin 6.9%;
- Cocaine 3.4%;
- Methadone 1.7%;
- Glue 0.9%;
- Amphetamines 0.9%;
- Poppy tea None.

13. Percentages were calculated using n=329 as the denominator unless noted otherwise.

Of those who have used drugs (n=116):

- 13.8% had injected drugs;
- Mean age when first injected drugs was 17.2 years;
- Of those who injected drugs (n=16), 43.8% had shared drug-injecting equipment;
- 62.9% used two or more drugs at the same time;
- 69.0% had sex under the influence of drugs.

Of those who had sexual intercourse (n=233):

- Mean age at first sexual intercourse ranged from 16.5 to 17.1 years;
- 3.0% had no sexual partners in the past year;
- 12.4% had one sexual partner in the past year;
- 39.1% had between 2 and 5 sexual partners in the past year;
- 19.3% had between 6 and 10 sexual partners in the past year;
- 9.4% had more than 10 sexual partners in the past year;
- 54.1% “always” used condoms during sex;
- 87.2% “sometimes” or “never” used condoms during sex;
- 20.2% had sex in return for money, drugs, etc.

Reasons for not “always” using condoms during sex:

- Do not like sex with condoms;
- Trust in partners;
- Condoms are too expensive to purchase.

Where to access information about HIV or other STIs:

- Media;
- Friends or peers;
- School.

Harm Reduction Services

Although harm reduction services (e.g. needle exchanges, methadone therapy, counselling services, outreach programmes, and detoxification centres) are provided in some SEE countries, the issues of quality and accessibility still need to be addressed.

Many young people stated that they wanted access to services to treat their drug addictions, but several barriers were preventing them from doing so:

- Lack of properly trained health care professionals to treat young people with addictions;
- High fees for methadone therapy or counselling sessions;
- Limited hours of operation for needle exchange programmes, where they exist;
- Discriminatory attitudes of health care professionals towards young people with drug addictions;
- Lack of enough detoxification or recovery beds to meet demands;
- Lack of alternative drug treatment approaches, didactic medical approach is still common.

HIV Testing

The cost of an HIV test prevents some young people from seeking voluntary testing. Most young people stated that if HIV testing were anonymous, free and accessible, they would get tested. HIV testing is available in all the SEE countries, although, for the most part, it is not anonymous. Furthermore, HIV pre- and post-test counselling is generally not available.

Education and Awareness

Each year on 1 December, a World AIDS Day awareness campaign is held in most countries. Young people and service providers agree that HIV/AIDS awareness campaigns need to happen more than once a year. Awareness campaigns need to take place at various times throughout the year.

HIV/AIDS, drug and sex education in the school curriculum is either non-existent or inadequate.

NGOs provide various HIV/AIDS support services, including HIV/AIDS peer education. These services need to be coordinated in order to minimise overlap within a country.

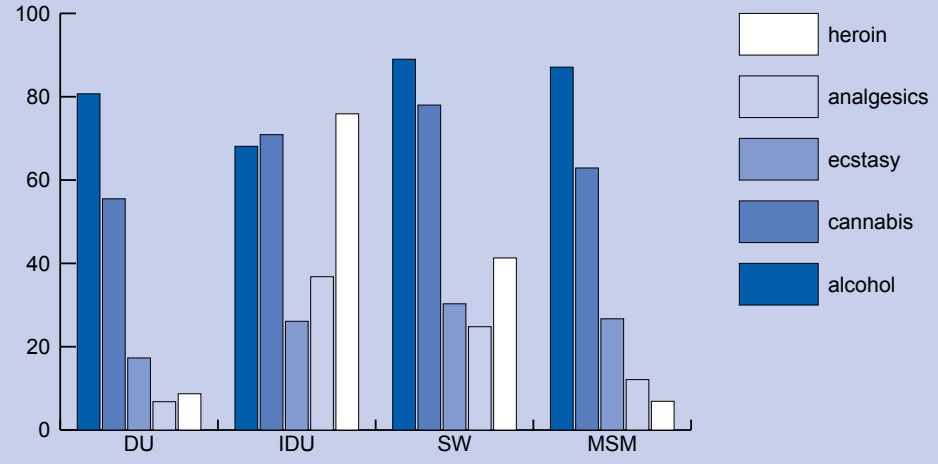
Sex Workers and Young MSM

Albania (NGO Vatra), Croatia (NGO Help Society) and Macedonia (NGO HOPS) provide some support and outreach services for sex workers. Otherwise, only a few interventions are being implemented that target sex workers, and there are currently no interventions specifically for young MSM.

DISCUSSION

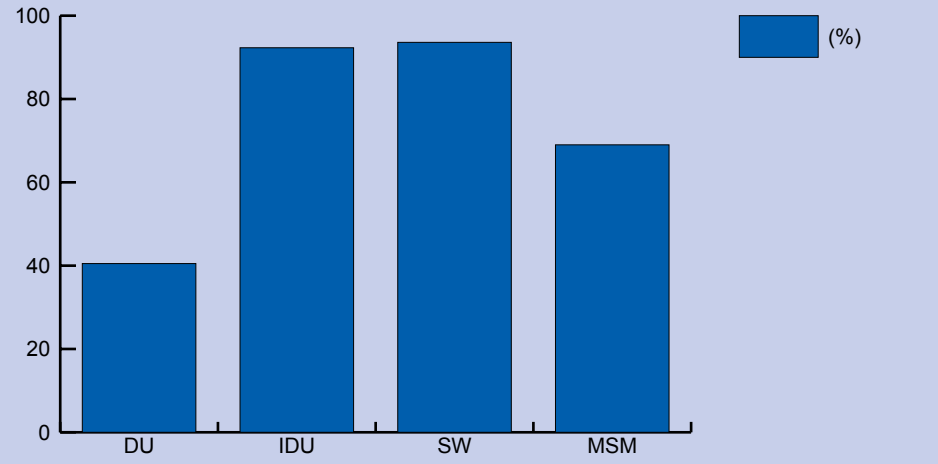
The regional findings reveal that young people are engaging in risk behaviours that put them at risk of HIV infection. Presented below are several graphs that illustrate the comparison between different target groups by risk behaviours. The graphs were prepared using data from the core questions of the questionnaire. (DU drug users; IDU, injecting drug users; YP, young people; SW, sex workers; MSM, men who have sex with men)

GRAPH 1 **Drugs used in the past month by target group**



Alcohol and cannabis are the most frequently consumed drugs for all target groups, but especially for sex workers and young MSM. Most young people do not perceive alcohol as a drug and think cannabis is harmless when used occasionally. In Republika Srpska's RAR report, sex workers make additional money if they sit with their clients for drinks. Heroin is the drug most often used by injecting drug users and the third most often used drug by sex workers.

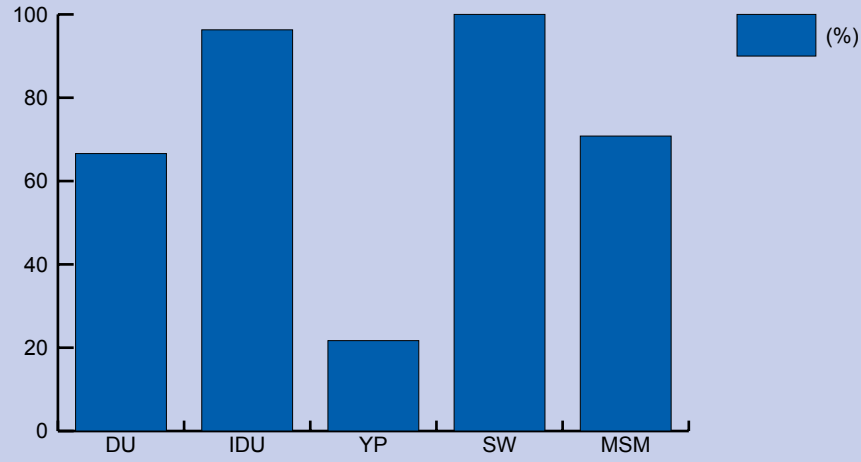
GRAPH 2 **Having sex under the influence of drugs by target group**



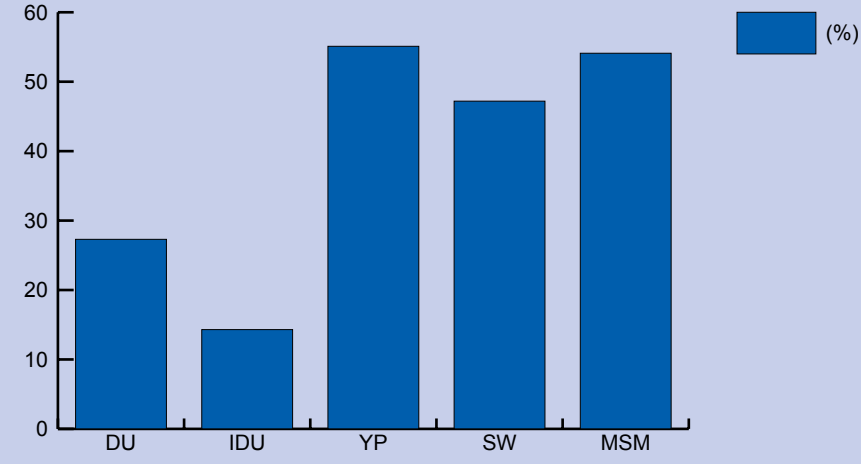
Over 90% of injecting drug users had sex under the influence of drugs. Most sex workers also had sex under the influence of drugs. In Republika Srpska, sex workers reported that using alcohol helped to make their work easier and more bearable. Furthermore, many clients offered them drugs before sex.

All sex workers had sex. Most injecting drug users also had sex. Only one fifth of the young people stated they had sex.

GRAPH 3 Ever had sex by target group



GRAPH 4 "Always" use condoms during sex by target group



Although only one fifth of the young people stated they had sex, half of them stated that they always used condoms during sex. Most injecting drug users had sex, although very few used condoms regularly. Low condom use on a regular basis among sex workers may be attributed to clients who are willing to pay more for sex without condoms.

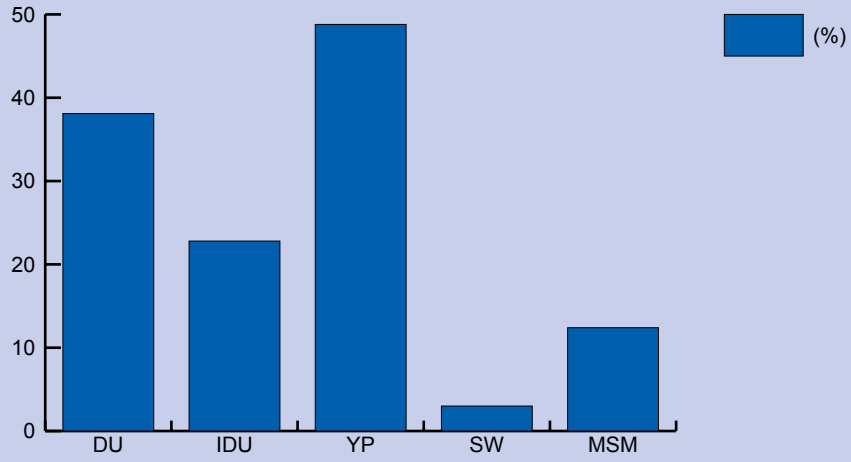
It is not surprising that very few sex workers had only one sexual partner in the past year. Over 50% of sex workers reported that they had 100 or more sexual partners in the past year. Approximately 10% of young MSM had one sexual partner in the past year. As mentioned, promiscuity is common among MSM even among those who are in steady relationships.

Based on the findings in this report, the different target groups were fairly accurate in perceiving themselves at risk of HIV infection or other STIs. It is interesting to note that more young people perceived themselves at risk than drug users, although drug users engaged in more at-risk behaviours.

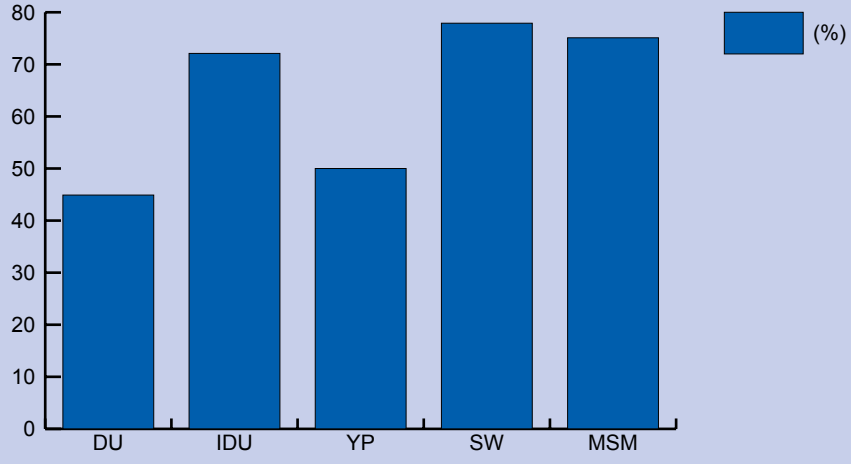
Injecting drug users and sex workers are most at risk. Most IDUs have sex under the influence of drugs yet very few use condoms regularly. Over 60% of IDUs share needles and syringes. Most sex workers have sex under the influence of drugs yet less than 50% use condoms regularly. Furthermore, over 50% of sex workers had 100 or more sex partners in the past year.

Young MSM are also very much at risk due to their promiscuous sexual behaviour and moderate regular use of condoms. Moreover, the risk is compounded in smaller cities where the network of sexual partners is smaller, so that HIV infection can spread more quickly.

GRAPH 5 Having one sexual partner in the past year by target group



GRAPH 6 Perceive self at risk of HIV infection or other STIs by target group



There are very few interventions that target sex workers or young MSM, yet they are very much at risk. Sex workers and young MSM will not access health care services in the traditional setting (e.g. hospitals, or clinics) for fear of stigmatisation, discrimination or arrest. Thus, any interventions that are developed and implemented should ideally include an outreach component. There is a need to take the interventions to the places where sex workers and young MSM congregate.

Reducing the harm that is associated with drug use and injecting drug use is desirable. IDUs need access to clean needles and syringes yet they also need access to other drug injecting equipment (e.g. spoons, filters, clean water, etc.). In addition to drug-injecting equipment, IDUs need access to condoms. Needle exchange programmes with an outreach component are one method of distribution.

If drug users, including injecting drug users, say that they want support to stop using drugs, then informing them that they are on a waiting list for treatment (e.g. methadone therapy, detoxification services, counselling, etc.) will not suffice. Most young drug users cannot cope with not using drugs while they wait for treatment. Drug users must be admitted for treatment when they are ready and willing to stop using drugs.

According to the RAR findings, young people (who do not use drugs) are least at risk, yet they are still vulnerable. They live in a context of increasing vulnerability. Parents are preoccupied with problems of economic survival and thus have less time to spend with their children. Communication between parents and their children is reported to be generally poor. Unemployment is high so the future outlook for finding

jobs after completing school is not positive. Young people are curious. Young people are bored. Young people want to escape reality. All these factors put young people at risk of engaging in behaviours that may lead to HIV infection.

Knowledge is the best means of prevention to discourage young people from beginning to engage in risk behaviours. Hopefully, if young people are aware, educated and knowledgeable about HIV/AIDS, STIs, drugs and sexual behaviour, they may decide not to use drugs or decide to delay the onset of sex. If, however, young people do decide to use drugs or engage in sex they will base their behaviour on appropriate knowledge and are more likely practice those behaviours more safely.

In all target groups studied in this RAR, less than 55% were using condoms regularly. The main reasons cited for not always using condoms during sex included: not liking sex with condoms; trusting their partners; and being embarrassed to ask partners to use condoms or to purchase condoms. Young people are not comfortable with condoms. Moreover, it is not instilled in the minds of young people that condoms can prevent the transmission of HIV. Condom use needs to be made more socially acceptable and fun for young people. Furthermore, young people need to be made aware that condom can be used as a barrier to prevent infection and not just as a contraceptive.

It is important that each location[14] has in place a national HIV/AIDS strategy that describes the country's perspective and stance on HIV/AIDS. More importantly, the strategy should outline the guiding principles of HIV/AIDS prevention, treatment, care and management. The strategy provides a framework for understanding the collective efforts of those who work in the field of HIV/AIDS.

RECOMMENDATIONS

Table 5 provides a summary of the recommendations for interventions. These recommendations incorporate many of those that are outlined in the various country RAR reports. The recommendations are grouped under various thematic or sectoral headings.

It is important to keep in mind that most of the recommendations listed below are fairly general since they are based on regional findings. In other words, these recommendations would need to be tailored to each of the various countries.

CONCLUSION

The countries of South Eastern Europe are currently viewed as having a low prevalence of HIV. However, low prevalence can often mask hidden HIV epidemics that are occurring in the various vulnerable groups. For this reason, UNICEF has undertaken the task to gain a clearer understanding of the risk behaviours in which vulnerable young people engage that place them at risk of HIV infection.

The scope of the RAR Project was ambitious. Twenty-six cities from five different countries participated in the RAR Project. Each of the 26 cities simultaneously conducted a RAR over a five-month period. Over 5,100 questionnaires were completed and 2,200 young people participated in interviews and/or focus groups.

Findings from the RAR Project reveal that different vulnerable groups are engaging in behaviours that place them at risk for HIV infection. Most injecting drug users are having sex under the influence of drugs yet their condom use is alarmingly low. Sex workers are also having sex under the influence of drugs to help make their work easier and more bearable. Promiscuity is common among young MSM and in smaller cities where the sexual networks are small, the potential exists for HIV infection to spread quickly.

The key to preventing HIV transmission in the various vulnerable groups is to enable these groups to practice safer drug injecting and sexual behaviours. For young people who are not engaging in risk behaviours, the most effective HIV prevention for them is to instil in them knowledge about HIV/AIDS, STIs, drugs and sex.

All the cities have successfully completed their rapid assessments. Based on their key RAR findings, the cities are currently developing their interventions. Once the interventions are developed, these responses can then be implemented.

14. Location also refers to Republic and Entity.

TABLE 5 Recommendations

Policy and Legislation
Develop and adopt a national HIV/AIDS policy and strategic plan of action.
Explore the issue of decriminalisation then legalisation of prostitution.
Develop, adopt and enforce stricter penalties for drug trafficking and possession.
Develop and adopt anti-discrimination legislation.

Harm Reduction Services
Educate health care professionals about harm reduction.
Implement needle exchange programmes. Incorporate an outreach component.
Deliver education to health care professionals and pharmacy staff to sensitise them to the needs and experiences of young drug addicts.
Establish a continuum of addiction services (i.e. detoxification, treatment and recovery).
Educate physicians about methadone therapy.
Establish support services for families of young drug addicts.
Ensure water or other liquids are available at rave parties.

HIV Testing
Increase accessibility to free and anonymous HIV testing.
Provide HIV pre-and post- test counselling.

Condoms
Install condom vending machines at venues frequented by young people.
Increase accessibility to condoms by reducing prices and improving quality.
Implement condom awareness campaigns.
Increase accessibility to water-based lubricants.

Young People
Educate teachers and school counsellors about HIV/AIDS, STI, drugs and sexual behaviour.
Improve or introduce HIV/AIDS, STI, drug and sex education into the school curriculum.
Introduce healthy lifestyle education into the school curriculum.
Establish youth friendly services.
Provide free after school and weekend activities for youth.
Deliver communication skills building workshops to parents and their children. Provide honorariums to parents who attend the workshops.
Implement an HIV/AIDS media awareness campaign.

Sex Workers and Young MSM
Implement an outreach programme that includes HIV/AIDS education, HIV testing, counselling, and condom distribution.
Educate health care professionals to sensitise them to the experiences of sex workers and young MSM.
Create accessible safe spaces for sex workers and young MSM.
Ensure condoms are placed in rooms that sex workers and their clients use.
Implement a campaign to promote people with diverse backgrounds, including MSM.
Establish support groups for parents of MSM, bisexuals or lesbians.

Surveillance and Research
Develop or improve HIV/AIDS and STI surveillance activities.
Conduct further analysis on the questionnaire data, especially the data on drugs used.
Compare findings from this RAR Project with findings from other RARs conducted in Europe.

SUMMARY OF COUNTRY RAR REPORTS

A summary was prepared for each of the Country/Republic/Entity RAR reports. As mentioned, a separate analysis of the questionnaire data was conducted for this regional report, including the questionnaire data presented in the RAR summaries. The questionnaire results presented in these summaries may, therefore, be different from those in the original Country/Republic/Entity RAR reports.

A copy of any of the original Country/Republic/Entity RAR reports is available on request from country UNICEF Focal Point.

ALBANIA

The political transition from a dictatorship to democratic government has brought about additional changes: the transition from a centralised economy to a free market economy; and the transition from a rural to a more urban society. In other words, Albania is currently undergoing a delicate transition towards a market economy and democratic governance.

Migration from the rural mountainous areas to the central urban belt has greatly impacted urban life; sewage, roads, waste management, access to green space, transport and building regulations have been compromised. Migration has also contributed to the increased levels of conflict and crime in the urban centres. The 1999 Kosovo crisis resulted in an influx of Kosovo Albanians (more than 450,000 refugees) across the northern border of Albania, which further increased migration.

Some socio-economic facts about Albania:

- The country is currently undergoing an acute energy crisis due to scarce rainfall and poor management of the energy sector;
- Foreign aid still provides the major share of finance for public investment;
- The country has lowest income per capita in Europe;
- Official unemployment is 15% (2001);
- It is estimated that 0.5 million of Albanians have emigrated since 1991 and now live abroad.
- Although it is estimated that households require a minimum income of 31,000 Lek (235.40 EUR) per month to function, the average household income is only 17,000 Lek (129.10 EUR) per month;
- The average age is 28.6 years. Approximately 40% of the population are under 18 years of age and 50% of the population are under 25 years of age;
- Schools in the urban centres are overcrowded;
- School dropout rate is high;
- Illiteracy among the younger age groups is growing.

HIV/AIDS in Albania

At the end of November 2001, there was a reported cumulative total of 71 HIV cases, of which 23 (32%) had developed AIDS. Of these 71 HIV cases:

- 58 cases (82%) are males;
- 13 cases (18%) are females;
- 52 cases (73%) are aged between 20 to 39 years old;
- Predominant mode of HIV transmission has been sexual, either MSM or heterosexual;
- Over 80% reported contracting HIV while abroad.

UNICEF RAR Project in Albania.

Dr Arjan Harxhi was the National Coordinator for the RAR Project in Albania, and oversaw the overall planning, development and implementation of the project in four cities, Korca, Shkodra, Tirana and Vlora.

Table 6 gives the vulnerable target groups studied in each city, and the Local Field Coordinators.

TABLE 6

City	Target Group(s)	Estimated Size of Target Group(s)	Local Field Coordinator
Korca	Mobile Population		Mr Berti Skenderasi
Shkodra	Drug Users*	760 drug users	Ms Fatbardha Kaduku
Tirana	Drug Users*	8,000 drug users	Dr Lajla Pernaska
Vlora	Sex Workers		Dr Krenar Malaj

*Drug users included injecting drug users.

Reasons for the Selection of Cities and Vulnerable Target Groups

Table 7 presents some of the reasons for the selection of particular cities and target groups.

TABLE 7

City	Target Group	Reason(s) for Selection
Korca	Mobile Population	On Albanian-FYR Macedonia- Greek border. Highly mobile population, especially young people. Over 80% of the HIV cases reported that they had contracted HIV abroad.
Shkodra	Drug Users*	On the route for trafficking in drugs and women. There is evidence of the production of cannabis sativa.
Tirana	Drug Users*	Capital city. Has the highest number of drug users in Albania.
Vlora	Sex Workers	City is a port and is considered the transit point for trafficking women to Western countries via speedboats to Italy.

*Drug users included injecting drug users

Context

Weak state structures, political tensions, inefficient law enforcement and a lack of resources to combat crime, have facilitated the trafficking of drugs and women through Albania to Western Europe.

Drug Users

In addition to trafficking in cocaine and heroin, Albania is also recognised for producing its own cannabis sativa. For many reasons, the trafficking and production of drugs has been spreading rapidly through Albania:

- Lack of preparedness to address the issues of drugs;
- Poor enforcement of the law;
- Ease of movement across the borders;
- Poverty;
- Desire to get rich quickly;
- Lack of socio-cultural opportunities for young people;
- Recent conflicts in the Balkans

Sex Workers

Over the past ten years, it has been estimated that thousands of Albanian women have been working in the sex industry in Western Europe and the other Balkan countries. Many of these women have been trafficked for sex work either through false promises of marriage or employment, or through coercion at the time of kidnapping. These women come from all parts of Albania, although increasingly they come from rural areas. Most of them are aged between 20 and 24 years.

Albania is one of the main transit countries for trafficking in women who originate from Central and Eastern Europe, from Moldova, Ukraine, Russia and Bulgaria. They are generally bought and sold in cities near the borders and then sent to the Albanian ports of Durres or Vlora from where they will eventually be sent to Italy. Although prostitution is illegal in Albania, these women are often forced into sex work while waiting to leave Albania.

Mobile Population

In general, there are three types of young people who move abroad:

- Long term emigrants;
- Seasonal or temporary emigrants (including tourists);
- Students.

Over the past ten years, Albanians have emigrated both legally and illegally, although illegal emigration has been more common. Data from a survey of Albanians in Greece and Italy gave the main reasons for emigration as higher wages, better working conditions, better living standards, better educational opportunities, ability to provide financial help to families still living in Albania, and political reasons.

Risk and Protective Behaviours

Drug Users

Table 8 provides a breakdown of the number of participants by group and data collection method. Questionnaires were administered to 167 drug users/injecting drug users. Interviews were conducted with 53 drug users/injecting drug users and a total of 87 drug users/injecting drug users participated in 16 focus groups.

TABLE 8

Group	Questionnaires	Interviews	Focus Groups
DRUG USERS	83	53	87
INJECTING DRUG USERS	84		
Service Providers		20	49
Policy Makers / Community Leaders		9	
TOTAL:	167	82	136

Note 1: Only questionnaires completed by young people between the ages of 10 and 24 years were included.
Note 2: Conducted 16 focus groups with drug users/injecting drug users.
Note 3: Conducted 6 focus groups with service providers.
Note 4: Completed 20 observations at high schools, bars, discos and pubs.

During fieldwork, it was very difficult to access female drug users, because they were not using any of the harm reduction or treatment services. It was also noted during fieldwork that there appears to be an increase in drug use among Roma young people.

Young people used drugs for many reasons:

- Pressure and influence from their peers;
- To fit in;
- To experience something new;
- To escape reality;
- To be trendy.

In Tirana, most drug users came from two-parent families in the mid to low economic levels whereas in Shkodra, more than half of the drug users came from families with divorced parents or other familial problems. Furthermore, young people in Tirana started using drugs at a later age (17 to 18 years old) than young people in Shkodra (14 to 15 years old). Young people from both cities, (Shkodra and Tirana) started injecting drugs at approximately the same age (18 to 19 years old).

Recently, there has been an increase in the use of ecstasy, which is known also as the “pill of love”. Only a few young people can afford ecstasy due to its high cost.

Questionnaire Results - Drug Users

The questionnaire was administered to 83 drug users, 77 males and 6 females. The following provides a summary of the descriptive data based on the core questions from the questionnaire (n = 83).[15],[16]

- Mean age was 18.2 years.
- Mean age when first used drugs was 15.4 years.
- 66.3% had sexual intercourse.

15. Injecting drug users were not included in this sample.
16. Percentages were calculated using n=83 as the denominator unless noted otherwise.

- 27.7% thought that they were at risk of HIV or other STIs.
- 4.8% had been tested for HIV.

In the past month, the following drugs had been used:

- Cannabis 69.9% of respondents;
- Alcohol 49.4%;
- Heroin 32.5%;
- Diazepam 12.0%;
- Ecstasy 10.8%.
- 68.7% used two or more drugs at the same time.
- 57.8% had sex under the influence of drugs.

Of those who had sexual intercourse (n=55):

- Mean age at first sexual intercourse was 17.0 years;
- 3.6% had no sexual partners in the past year;
- 49.1% had one sexual partner in the past year;
- 41.8% had between 2 and 5 sexual partners in the past year;
- 9.1% “always” used condoms during sex;
- 90.9% “sometimes” or “never” used condoms during sex;
- 5.5% had sex in return for money, drugs, etc.

Reasons for not “always” using condoms during sex:

- Trust in partners;
- Do not like sex with condoms;
- Difficult to use;
- Embarrassed to purchase condoms.

Where to access information about HIV or other STIs:

- Nowhere - do not access HIV/STI information;
- Friends or peers;
- Media.

Injecting Drug Users (IDUs)

There is a high level of needle and syringe sharing among IDUs. Reasons for sharing needles and syringes include the following:

- No consideration for the risk of sharing when there is an imminent need to inject;
- Lack of financial resources to purchase new needles and syringes;
- Sharing with sexual partners indicates trust;
- Lack of perceived risk of acquiring Hepatitis C through sharing

Furthermore, IDUs often inject themselves in isolated abandoned places thus making it difficult to access clean needles and syringes. Many reported that they made attempts to clean their needles and syringes, but they did not use bleach.

Questionnaire Results - Injecting Drug Users

The questionnaire was administered to 84 injecting drugs users: 80 males and 4 females. The following provides a summary of the descriptive data based on the core questions from the questionnaire (n = 84).[17]

- Mean age was 20.8 years.
- Mean age when first used drugs was 17.1 years.
- Mean age when first injected drugs was 18.6 years.
- 91.7% had sexual intercourse.
- 53.6% thought that they were at risk of HIV or other STIs.
- 20.2% had been tested for HIV.

In the past month, the following drugs had been used:

- Heroin 96.4% of respondents;
- Alcohol 45.2%;
- Cannabis 35.7%;
- Cocaine 25.0%;
- Diazepam 13.1%.

17. Percentages were calculated using n=84 as the denominator unless noted otherwise.

- 72.6% shared drug-injecting equipment.
- 89.3% used two or more drugs at the same time.
- 84.5% had sex under the influence of drugs.

Of those who had sexual intercourse (n=77):

- Mean age at first sexual intercourse was 17.1 years.
- 9.1% had no sexual partners in the past year.
- 48.1% had one sexual partner in the past year.
- 41.6% had between 2 and 5 sexual partners in the past year.
- 15.6% “always” used condoms during sex.
- 83.2% “sometimes” or “never” used condoms during sex.
- 13.0% had sex in return for money, drugs, etc.

Reasons for not “always” using condoms during sex:

- Do not like sex with condoms;
- Trust in partners;
- Embarrassed to ask partners to use condoms.

Where to access information about HIV or other STIs:

- Media.
- Friends or peers.
- Nowhere - do not access HIV/STI information.

Sex Workers

Table 9 provides a breakdown of the number of participants by group and data collection method. Questionnaires were administered to 50 female sex workers. Interviews were conducted with 30 sex workers and a total of 22 sex workers participated in four focus groups.

TABLE 9

Group	Questionnaires	Interviews	Focus Groups
SEX WORKERS	50	30	22
Service Providers		21	
Policy Makers / Community Leaders		15	
TOTAL:	50	66	22

Note 1: Only questionnaires completed by young people between the ages of 10 and 24 years were included.
Note 2: Conducted 4 focus groups with sex workers.
Note 3: Completed 6 observations at motels, the port, and private homes.

More than half of the sex workers reported that they had had “hundreds” of sexual encounters each month. There was an alarmingly low level of condom use among sex workers. The majority of sex workers stated that they did not use condoms with their regular clients, their permanent partners (i.e. protectors), or clients who paid more or forced them to have sexual intercourse without condoms. All of the participants had had sex under the influence of drugs.

Questionnaire Results - Sex Workers

The questionnaire was administered to 50 female sex workers. The following provides a summary of the descriptive data based on the core questions from the questionnaire

(n = 50).[18]

- Mean age was 19.3 years.
- 38.0% used drugs.
- Mean age when first used drugs was 16.5 years.
- All had sexual intercourse.
- 78.0% thought that they were at risk of HIV or other STIs.

18. Percentages were calculated using n=50 as the denominator unless noted otherwise.

- 26.0% had been tested for HIV.

Of those who used drugs (n=19), the following drugs had been used in the past month:

- Cannabis all respondents;
- Alcohol 78.9%;
- Heroin 15.8%;
- Ecstasy 10.5%.

Of those who used drugs (n=19):

- 15.8% injected drugs;
- Mean age when first injected drugs was 17.0 years;
- Of those who injected drugs (n=3), 66.7% shared drug-injecting equipment;
- 78.9% used two or more drugs at the same time;
- All had sex under the influence of drugs.

Of those who had sexual intercourse (n=50):

- Mean age at first sexual intercourse was 15.3 years;
- 62.0% had between 50 and 99 sexual partners in the past year;
- 30.0% had 100 or more sexual partners in the past year;
- 12.0% "always" used condoms during sex;
- 88.0% "sometimes" or "never" used condoms during sex;
- All had sex in return for money, drugs, etc.

Reasons for not "always" using condoms during sex:

- Clients pay more to have sex without condoms;
- Do not consider using condoms with their protectors.
- Embarrassed to ask partners to use condoms.

Where to access information about HIV or other STIs:

- Friends or peers;
- Media;
- Nowhere - do not access HIV/STI information.

Mobile Population

Table 10 provides a breakdown of the number of participants by group and data collection method. Questionnaires were administered to 91 mobile young persons. Interviews were conducted with 50 mobile young persons and a total of 55 mobile young persons participated in five focus groups.

TABLE 10

Group	Questionnaires	Interviews	Focus Groups
MOBILE POPULATION	91	50	55
Service Providers		2	
Policy Makers / Community Leaders		3	
TOTAL:	91	55	55

Note 1: Only questionnaires completed by young people between the ages of 10 and 24 years were included.
Note 2: Conducted 5 focus groups with mobile population.
Note 3: Completed 6 observations in the outskirts of the city, at high schools, bars and disco clubs.

Alcohol and cannabis are the drugs most widely used by mobile young people. Cannabis is easy to find, relatively inexpensive, and regarded as a "light" drug that is similar to cigarettes.

The participants in this RAR Project were a sexually active group. Many have had more than one sexual partner in the past year. Furthermore, many have had sexual intercourse with sex workers. Their level of condom use with sex workers was low.

Some of the young men reported having sexual intercourse in exchange for money, drugs or other favours.

Questionnaire Results - Mobile Population

The questionnaire was administered to 91 young mobile persons, 65 males and 26 females. The following provides a summary of the descriptive data based on the core questions from the questionnaire (n = 91)[19]

- Mean age was 20.6 years.
- 54.9 % used drugs.
- Mean age when first used drugs was 17.7 years.
- 92.3% had sexual intercourse.
- 48.4% thought that they were at risk of HIV or other STIs.
- 5.5% had been tested for HIV.

Of those who used drugs (n=50), the following drugs had been used in the past month:

- Alcohol 50 % of respondents;
- Cannabis 32 %;
- Ecstasy 7 %;
- Heroin 5 %.

Of those who used drugs (n=50):

- 14.0% injected drugs;
- Mean age when first injected drugs 18.1 years;
- Of those who injected drugs (n=7), 14.3% shared drug-injecting equipment;
- 19% used two or more drugs at the same time;
- 27% had sex under the influence of drugs.

Of those who had sexual intercourse (n=84):

- Mean age at first sexual intercourse was 17.1 years;
- 2.5% had no sexual partners in the past year;
- 42% had one sexual partner in the past year;
- 38% had between 2 and 5 sexual partners in the past year;
- 18% “always” used condoms during sex;
- 82% “sometimes” or “never” used condoms during sex;
- 18% had sex in return for money, drugs, etc.

Reasons for not “always” using condoms during sex:

- Trust in partners;
- Do not like sex with condoms;
- Embarrassed to purchase condoms;
- Embarrassed to ask partners to use condoms.

Where to access information about HIV or other STIs

- Media.
- Friends or peers.
- School.

Health and Social Consequences

Drug Users and Injecting Drug Users

Depression, suicidal thoughts or aggressive behaviour are not unusual among drug users. Drug users are at considerable risk of overdosing. Most young IDUs are inexperienced and lack safe injecting skills. The impurity of drugs is cited as one of the causes for overdosing. Drug users considered themselves relatively well informed about HIV/AIDS, although the RAR Project discovered that the accuracy of their knowledge on certain HIV/AIDS issues was not satisfactory.

Sex Workers

Sex workers are often abused, both physically and mentally, by their protectors and their clients. Most of the sex workers (over 80%) have had an STI and often seek over-the-counter treatment for their STIs. The more experienced sex workers appear to have better STI/HIV/AIDS knowledge than the less experi-

19. Percentages were calculated using n=91 as the denominator unless noted otherwise.

enced ones. In addition, the sex workers who have worked abroad appear to have better STI/HIV/AIDS knowledge than the sex workers who have only worked in Albania.

Mobile Population

Anecdotal data indicates that there is a higher prevalence of STIs and HIV among the mobile population. Over 80% of the HIV cases reported that they had contracted HIV when they were abroad.

Existing Interventions

Health authorities have identified as public health concerns the lack of financial resources, the increasing incidence of various diseases, the deterioration in living conditions, the dilapidated health structures, the poor quality of service delivery and the lack of health specialists. These concerns are reflected in the data collected by this RAR Project.

In Shkodra, there is a lack of proper infrastructure and expert staff to manage and treat drug addictions. In other words, no methadone therapies, harm reduction services or needle exchange programmes exist in Shkodra. Drug addicts from Shkodra can seek specialised medical treatment at the University Clinic of Toxicology in Tirana, although most drug addicts cannot afford this.

There is an overall increase in the demand by drug addicts for access to medical treatment for their drug habit. Methadone therapy is available, but only privately following a physician's prescription, and only in Tirana.

In Vlora, there is currently a lack of outreach services for sex workers.

Young people who are abroad, especially illegal emigrants, do not usually seek health care due to fears of expulsion, legal action brought against them, or simply due to a lack of information regarding what health services are available to them when abroad.

Some of the organisations and/or NGOs that provide HIV/AIDS support services to vulnerable young people are listed in Table 11.

TABLE 11

Organisation	HIV Testing	Needle Exchange	Methadone Therapy	Education Or Support
In Tirana:				
University Clinic of Toxicology (1)				✓
Community Emanuel (2)				✓
Harm Reduction Centre		✓		✓
Institute of Public Health (3)	✓			
Microbiology Laboratory at UHCT (4)	✓			
Centre for Blood Donors	✓			
In Shkodra:				
Centre for Blood Donors	✓			
Local HIV Laboratory	✓			
School Curriculum				✓
In Vlora:				
NGO Vatra (5)				✓

(1) The University Clinic also provides detoxification treatment, overdose treatment and psychological support.

(2) Emanuel provides shelter for drug users. It is also a day centre that provides counselling, psychosocial support and information on drug use.

(3) Although the Institute provides free confidential HIV testing with pre and post-test counselling, its unfavourable location makes access a problem.

(4) UHCT = University Hospital Centre for Tirana

(5) Vatra also provides short-term shelter for repatriated sex workers.

Recommendations

The recommendations below are based on the data collected for this RAR Project through questionnaires, interviews, focus groups, existing information, observations and mapping. Once the collected data was analysed, key findings from the rapid assessment were used to develop the recommendations.

Tables 12-14 provide a summary of the recommendations for interventions that are outlined in the RAR Report for Albania, 2002. The recommendations are grouped according to the key findings for each vulnerable target group.

TABLE 12

Key Finding – DRUG USERS	Recommendation(s)
Drug users and injecting drug users are engaging in high-risk sexual behaviours (i.e. low condom use and multiple sexual partners).	• Improve drug and sex education in the school curriculum. • Develop and distribute IEC materials about STI/HIV/AIDS and condom use. • Distribute condoms. • Peer education.
In Shkodra, there are no harm reduction programmes.	• Establish needle exchange programme. • Establish outreach and drop-in programme. • Peer education. • Train one medical physician on detoxification and drug treatment therapies.
In Tirana, the harm reduction programmes are limited.	• Expand needle exchange and outreach programs. • Increase awareness about using bleach to clean needles and syringes. • Peer education. • Increase access to HIV counselling and testing. • Increase access to Hepatitis B immunisation. • Expand methadone programme. • Advocate at policy and ministerial levels.

TABLE 13

Key Finding – SEX WORKERS	Recommendation(s)
Low level of STI/HIV/AIDS knowledge among sex workers.	• Peer education. • Increase awareness about condom use among matrons/hotel owners/pimps. • Distribute condoms to sex workers via matrons/hotel owners. • Develop and distribute IEC materials.
Low condom use among sex workers.	• Develop and distribute IEC materials. • Peer education.
Increase awareness about existing services among sex workers.	• Develop and distribute IEC materials. • Peer education. • Inform social workers at the Shelter about existing services.
Improve quality of and access to services that are available to sex workers.	• Sensitise social workers and health care providers to the experiences of sex workers and educate them about the care and treatment needs of sex workers. • Peer education. • Establish Youth Friendly Services. • Advocate for legalising prostitution in Albania to reduce the vulnerability/exploitation of sex workers.

TABLE 14

Key Finding – MOBILE POPULATION	Recommendation(s)
Low level of condom use among the mobile population.	• Develop and distribute IEC materials about STI/HIV/AIDS, condom use and HIV testing. • Distribute condoms. • Peer education. • Media campaign.
Health seeking behaviours are minimal among the mobile population.	• Develop and distribute IEC materials. • Peer education. • Media campaign – map existing services.
Lack of available accurate STI/HIV information.	• Develop and distribute IEC materials about drugs, condom use, STI/HIV/AIDS and testing. • Peer education. • Deliver training to teacher and parent associations about STI/HIV/AIDS, drugs and condom use.

BOSNIA AND HERZEGOVINA

The Dayton Peace Agreement of 1995 ended the conflict in Bosnia and Herzegovina. Under the Agreement, Bosnia and Herzegovina was divided into two entities: the Federation of Bosnia and Herzegovina; and Republika Srpska. In addition, an international arbitration was conducted to determine the status of the Brčko area. In March 1999, the Final Brčko Arbitration Decision was passed, which defined the Brčko District as an administrative unit of local self-government, under the sovereignty of Bosnia and Herzegovina.

Thus, Bosnia and Herzegovina comprises two entities and one district:

- Federation of Bosnia and Herzegovina
- Republika Srpska
- Brcko District

Each entity has its own parliament, government, military forces and police, as well as education and health care systems and other public services.

(h2)FEDERATION OF BOSNIA AND HERZEGOVINA (FBiH)

FBiH is divided into ten Cantons, each with its own government and assembly. There are several ethnic groups within FBiH, all of which are free to express their religious affiliations. There is still an international presence in FBiH (i.e. UN soldiers, foreign representatives and international community-based organisations).

Some socio-economic facts about FBiH:

- Unemployment rate is 38.7% (in 2000);
- GDP per capita is US$ 1,129 (1,226 EUR) (in 2000);

Prior to the conflict, GDP per capita was US$ 2,398 (2,605 EUR);

- Average monthly salary is 413 KM (211.20 EUR);
- The level of international financial assistance is decreasing;
- Literacy rate is 99% among those aged 15 to 24 years (MICS 2000).

The FBiH economy is still recovering from the conflict and will continue its recovery for many more years.

HIV/AIDS in the Federation of Bosnia and Herzegovina

The first AIDS case was reported in FBiH in 1986. Between 1992 and 2001, a total of 17 AIDS cases were reported. The number of reported AIDS cases among the various risk groups (i.e. injecting drug users, men having sex with men, and heterosexuals) was similar. Most of the AIDS cases reported that that they contracted HIV while abroad.

Between 1998 and 1999, a total of 90 HIV cases were reported.

Currently, surveillance data on HIV and AIDS are insufficient.

UNICEF RAR Project in the Federation of Bosnia and Herzegovina

Dr Enida Imamovic was the Entity Coordinator for the RAR Project in FBiH. She oversaw the overall planning, development and implementation of the Project in three cities, Mostar, Sarajevo and Tuzla.

Dr Jelena Ravlija was the Epidemiological Advisor and Mr Zoran Prskalo was the Data Entry and Processing Expert for the RAR Project in FBiH.

Table 15 gives the vulnerable target groups and the Local Field Coordinators for each of the three cities selected for the RAR Project.

TABLE 15

City	Target Group(s)	Local Field Coordinator
Mostar	Drug User Young People	Dr Zarema Obradovic
Sarajevo	Drug Users Young People	Ms Iva Trezner
Tuzla	Drug Users Young People Young MSM	Mr Emir Nurkic

TABLE 16

City	Target Group(s)	Reason(s) for Selection
Mostar	Drug User Young People	Cities have large populations. Presence of governmental and non governmental organisations and international agencies.
Sarajevo	Drug Users Young People	Presence of universities, clinics and other resources that are needed to implement the RAR Project.
Tuzla	Drug Users Young People Young MSM	Context and the behaviours practised by young people place them at risk of HIV infection. Young MSM are marginalised and discriminated against.

Context

The family unit is undergoing changes. Parents are increasingly preoccupied with their own problems and thus have less time to spend with their children. Parents are often reported to consider the problems of young people as unimportant. For these and other reasons, many children are experiencing a more liberal upbringing.

Young people often escape from their problems or from boredom by engaging in highly risky behaviour (e.g. drug use).

Drug Use

The abuse of drugs was first registered in BiH in 1973. Even so, the experts and society elected to deny that a drug problem existed. As a result, the police have maintained few statistics related to drug smuggling and acknowledgement of the drug scene has only emerged slowly.

FBiH is a transit point for trafficking in drugs to Western Europe. Certain quantities of these drugs are more than likely to stay in FBiH, to be sold to dealers at affordable prices. The amount of drugs confiscated is extremely low and thus not a good indicator of the drug market scene. The small amounts of drugs that are confiscated, however, do highlight how well drug trafficking is organised, the lack of police efficiency and the inadequacy of the current drug legislation.

Despite the prevention measures that have been undertaken thus far, the quantity of drugs on the market is growing and is paralleled by the number of young people experimenting with drugs.

Risk and Protective Behaviours

Table 17 provides a breakdown of the number of participants by group and data collection method. Overall, questionnaires were administered to 676 young people from the different vulnerable target groups. A total of 93 interviews were conducted with young people, service providers and policy makers. A total of 253 young people participated in 29 focus groups.

TABLE 17

Group	Questionnaires	Interviews	Focus Groups
Young People who USE DRUGS	212		
Young People who INJECT DRUGS	34		
Young People who DO NOT USE DRUGS	400		
Young MSM	30		
Service Providers			
Policy Makers / Community Leaders			
TOTAL:	676	93	253

Note 1: Only questionnaires completed by young people between the ages of 10 and 24 years were included.
Note 2: The Ministry of Education, Culture, Science and Sports did not allow the questionnaire to be administered in Sarajevo Canton schools because the questionnaire was deemed not "suitable" for secondary school students. Instead, the Sarajevo RAR Team administered the questionnaire to young people at various meeting places (e.g. cafes, bars).
Note 3: Conducted 29 focus groups. Breakdown by vulnerable target groups was not available.
Note 4: List of completed observations was not available.

Young People who USE DRUGS

Young people use drugs for many reasons:

- General discontent;
- Escape from family problems;
- Lack of self confidence;
- Curiosity;
- Boredom;
- To prove themselves;
- Sense of being overwhelmed;
- To belong to a group.

A "specialty" drug, especially in the Sarajevo region, was and still is the mixing of anti-Parkinson medications with beer and other alcoholic beverages to induce a particular change in consciousness. Most do not consider alcohol to be a drug.

Most use drugs in bars, cafes, disco clubs or hidden street/park corners. Parents are the main source of income for purchasing drugs. Other sources of income include working, stealing or selling drugs.

Questionnaire Results - Young People who use drugs

The questionnaire was administered to 212 young people who use drugs: 129 males and 83 females. The following provides a summary of the descriptive data based on the core questions from the questionnaire (n = 212).[20],[21]

- Mean age was 18.2 years.
- Mean age when first used drugs were 15.4 years.
- 67.9% had sexual intercourse.
- 35.3% thought that they were at risk of HIV or other STIs.
- 4.2% had been tested for HIV.

In the past month, the following drugs were used:

- Alcohol 78.8% of respondents;
- Cannabis 52.8%;
- Ecstasy 18.4%;

20. Young people who inject drugs were not included.
21. Percentages were calculated using n=212 as the denominator unless noted otherwise.

- Diazepam 9.4%.
- 50.0% used two or more drugs at the same time.
- 37.7% had sex under the influence of drugs.

Of those who had sexual intercourse (n=144):

- Mean age at first sexual intercourse was 16.3 years.
- 13.9% had no sexual partners in the past year.
- 38.9% had one sexual partner in the past year.
- 40.3% had between 2 and 5 sexual partners in the past year.
- 26.4% “always” used condoms during sex.
- 58.3% “sometimes” or “never” used condoms during sex.
- 7.6% had sex in return for money, drugs, etc.

Reasons for not “always” using condoms during sex:

- Do not like sex with condoms;
- Trust in partners;
- Condoms are difficult to use;
- Embarrassed to purchase condoms.

Where to access information about HIV or other STIs:

- Media;
- School;
- Friends or peers.

Young People who INJECT DRUGS

Heroin is the drug most frequently injected. Often a mixture of drugs is used for injection; heroin and cannabis are the two most common drugs to mix. Other drugs used in combination with heroin include methadone, Tramal, Akineton, Artan, diazepam and Lexaurin. Drugs are easily accessible. The problem is accessing funds to purchase them.

Needles and syringes are easily purchased for the price of 0.20 KM (0.10 EUR).

Table 18 gives a breakdown of the different types of drug and their costs.

TABLE 18

Drug	Unit	Price per Unit (KM)**	Comment
Cannabis	Package	10	
Cannabis	Joint	2	
Heroin			
Lower Quality	1 gram	30 to 40	
Medium Quality	1 gram	40 to 50	
Good Quality	1 gram	70 to 80	
Cocaine	1 gram	150	
Ecstasy	Tablet	8 to 10	Often distributed at rave parties.
Tablets *	Table (10 pieces)	6	
Speed		40	
LSD		25	

* Tablets include Trodon, Tramal, Akineton and Artan.
** 1 KM = 0.51 EUR.

Most participants have shared their drug injecting equipment. Reasons for sharing their equipment include a feeling of belonging to the group, a sign of trust, and fears of overdosing. Many inject at home or in the homes of their friends. Many reported that they gradually lose their sexual drive when under the influence of drugs.

Questionnaire Results - Young People who inject drugs

The questionnaire was administered to 34 young people who inject drugs: 33 males and one female (Table 17). The following provides a summary of the descriptive data based on the core questions from the questionnaire (n = 34).[22]

- Mean age was 21.5 years.
- Mean age when first used drugs was 15.5 years.
- Mean age when first injected drugs was 18.1 years.
- 97.0% had sexual intercourse.
- 52.9% thought that they were at risk of HIV or other STIs.
- 50.0% had been tested for HIV.

In the past month, the following drugs had been used:

- Cannabis 70.6% of respondents;
- Alcohol 67.6%;
- Heroin 64.7%;
- Methadone 58.8%;
- Diazepam 50.0%;
- Analgesics 44.1%;
- Ecstasy 35.2%.
- 64.7% shared drug-injecting equipment.
- 91.2% used two or more drugs at the same time.
- 91.2% had sex under the influence of drugs.

Of those who had sexual intercourse (n=33):

- Mean age at first sexual intercourse was 15.9 years;
- 9.1% had no sexual partners in the past year;
- 15.2% had one sexual partner in the past year;
- 54.5% had between 2 and 5 sexual partners in the past year;
- 21.2% “always” used condoms during sex;
- 69.7% “sometimes” or “never” used condoms during sex;
- 9.1% had sex in return for money, drugs, etc.

Reasons for not “always” using condoms during sex:

- Do not like sex with condoms.
- Trust in partners.
- Embarrassed to purchase condoms.

Where to access information about HIV or other STIs:

- Friends or peers;
- Media;
- Social or health workers.

Young People who DO NOT USE DRUGS

Young people want to experiment. Often they engage in sexual intercourse unprepared and unaware of the potential consequences. Those, who are sexually active and do use condoms, only use them to protect against unwanted pregnancies and not against STIs.

Questionnaire Results - Young People who do not use drugs

The questionnaire was administered to 400 young people who do not use drugs, 175 males and 225 females (Table 17). The following provides a summary of the descriptive data based on the core questions from the questionnaire (n = 400).[23]

- Mean age was 17.3 years.
- 28.5% had sexual intercourse.
- 26.5% thought that they were at risk of HIV or other STIs.
- 3.2% had been tested for HIV.

Of those who had sexual intercourse (n=114):

- Mean age at first sexual intercourse was 17.0 years ;
- 14.0% had no sexual partners in the past year;

22. Percentages were calculated using n=34 as the denominator unless noted otherwise.
23. Percentages were calculated using n=400 as the denominator unless noted otherwise.

- 57.9% had one sexual partner in the past year;
- 24.6% had between 2 and 5 sexual partners in the past year;
- 47.4% "always" used condoms during sex;
- 38.9% "sometimes" or "never" used condoms during sex;
- 6.1% had sex in return for money, drugs, etc.

Reasons for not "always" using condoms during sex:

- Do not like sex with condoms;
- Trust in partners;
- Condoms are not easily available.

Where to access information about HIV or other STIs:

- Media;
- School;
- Family.

Young Men who have Sex with Men

In Tuzla, young MSM form a closed and marginalised group. Most have their first sexual experiences with older partners. Promiscuity is common amongst young MSM. It is not uncommon to have three different sexual partners in one night. Some practise "blind dating" when not knowing the partner does not stop one from engaging in sexual intercourse on the first date.

According to one participant, "Sex with a condom is not sex!"

Mixing drugs is a common trend among young MSM, especially the mixing of alcohol with pills or with cannabis.

Questionnaire Results - Young Men who have Sex with Men

The questionnaire was administered to 30 young MSM. The following provides a summary of the descriptive data based on the core questions from the questionnaire

(n = 30).[24]

- Mean age was 21.3 years.
- 76.7% used drugs.
- Mean age when first used drugs were 17.1 years.
- All had sexual intercourse.
- 70.0% thought that they were at risk of HIV or other STIs.
- 10.0% had been tested for HIV.

Of those who used drugs (n=23), the following drugs had been used in the past month:

- Alcohol 95.7%;
- Diazepam 43.5%;
- Ecstasy 17.4%;
- Cannabis 13.0%.

Of those who used drugs (n=23):

- None had injected drugs.
- 73.9% used two or more drugs at the same time.
- 95.7% had sex under the influence of drugs.

Of those who had sexual intercourse (n=30):

- Mean age at first sexual intercourse was 17.1 years;
- 10.0% had one sexual partner in the past year;
- 46.7% had between 2 and 5 sexual partners in the past year;
- 23.3% had between 6 and 10 sexual partners in the past year;
- 20.0% had more than 10 sexual partners in the past year;
- 6.7% "always" used condoms during sex;
- 93.3% "sometimes" or "never" used condoms during sex;
- 26.7% had sex in return for money, drugs, etc.

Reasons for not "always" using condoms during sex:

- Trust in partners.
- Do not like sex with condoms.

24. Percentages were calculated using n=30 as the denominator unless noted otherwise.

- Difficult to use.

Where to access information about HIV or other STIs:

- Media;
- Friends or peers;
- Family.

Health and Social Consequences

Compared to previous years, there is a noticeable increase in juvenile delinquency under the influence of alcohol. For drug users, the greatest problem is acquiring the money to purchase drugs. Many reported engaging in criminal activities to acquire this money.

In 2000, there were 21 reported cases of both syphilis and gonorrhoea to give a rate of 0.75 cases per 100,000 of the population. It is more than likely the real number of syphilis and gonorrhoea cases is much higher, but the reported number of cases remains low because of poor STI surveillance.

Existing Interventions

Monitoring HIV/AIDS is under the law on Protection of the Population from Infectious Diseases. This law does not, however, conform to the principles of the Convention on Human Rights.

The health care system in FBiH is currently undergoing reform. The goal of the reform is to establish family medicine teams (TOMS) and mental health care centres (CZMZ) that will provide health and mental care services in the various communities. These TOMS and CZMZ are multidisciplinary teams (e.g. dental care, physical rehabilitation, laboratory tests and diagnostics, home health care, etc.) at the primary level of health care.

In FBiH, the health responsibilities are shared between the Federation and Cantonal authorities. In other words, health care is decentralised to the Cantonal level, with the Federation performing a coordinating function.

In 1999, the Sarajevo Canton Ministry of Health and the Government adopted a policy document on the Programme of Primary Prevention and Drug Addiction. The purpose of this document was to streamline the many separate prevention activities relating to drug abuse. In addition, a policy document for a Federation Programme of Alcoholism and Drug and Substance Abuse has also been drafted.

STIs are treated at gynaecological, dermatological and infectological services or hospital wards. Many private physician's offices, clinics and pharmacies also provide STI treatment services.

Injecting drug users reported that the existing treatment conditions on the psychiatric wards are inadequate. Many of them stated that they would accept methadone or community treatment.

Some of the organisations and/or NGOs that provide HIV/AIDS support services to vulnerable young people are listed in Table 19.

TABLE 19

Organisation	HIV Testing	Methadone Therapy	Education Or Support
Infectious Disease Clinics (1) & (2)	✓		
Transfusion Institutes (1)	✓		
Microbiological Laboratories (1)	✓		
Centre for Alcoholism and Substance Abuse (3)			✓
Centre for Prevention & Outpatient Drug Rehab (4)		✓	✓

(1) Depending on the reliability of their testing, test prices vary from 30 KM (15.3 EUR) to 150 KM (76.7 EUR).

(2) Patients are receiving treatment for HIV/AIDS at the clinical centres in Mostar, Sarajevo and Tuzla, but treatment is limited due to the high costs.

(3) Centre is located in Sarajevo.

(4) Centre is located in Mostar and is the only Centre to provide methadone therapy.

Confirmatory HIV testing is not done in FBiH. People are referred to Croatia if they require HIV confirmatory testing.

HIV/AIDS awareness campaigns are often implemented without coordination or a sustainable plan. Each year, the 1 December World AIDS Day awareness campaign is usually implemented by health workers, in partnership with NGOs and the media.

The following international organisations and NGOs address some of the issues concerning young people:

- Post Pesimisti
- Mladi Most
- Emmaus International and Forum of Solidarity
- Mladi Protiv Side - MPS
- International Plan Parenthood - IPPF
- Forum Mladih - SDP

Unfortunately, the efforts of these organisations and NGOs are not coordinated.

Recommendations

The recommendations below are based on the data collected for this RAR Project through questionnaires, interviews, focus groups, existing information, observations and mapping. They have been developed from the key findings, which emerged from the analysis of the RAR data.

Table 20 summarises the recommendations for interventions that are outlined in the RAR Report for the Federation of Bosnia and Herzegovina, 2002.

TABLE 20

Recommendations
• Adopt a National Strategy for the prevention of risk behaviour in Bosnia and Herzegovina.
• Improve the central monitoring and registry for drug addicts and for persons living with HIV/AIDS.
• Ensure a multi-sectoral approach to HIV/AIDS.
• Develop and implement HIV/AIDS risk behaviour prevention programmes. Ensure the participation of young people in the programme development and implementation. Integrate the prevention programmes into the health, education, social care, police and other sectors.
• Support the development and implementation of the community services (i.e. TOMS and CZMZ) and youth counselling.
• Increase public awareness about HIV, Hepatitis B and Hepatitis C testing.
• Increase accessibility to free anonymous HIV testing for certain vulnerable target groups.
• Increase accessibility to Hepatitis B and Hepatitis C testing.
• Distribute needles and syringes.
• Install condom vending machines.

(h2)REPUBLIKA SRPSKA

Republika Srpska comprises 62 municipalities. Similar to FBiH, Republika Srpska has changed its political and economic system from a socialistic one-party system to a pluralistic one. Furthermore, the socialistic industrial sector, characterised by a strong State influence, has been replaced with a form of free market economy. However there continues to be a strong dependency on foreign financial support.

Some socio-economic facts about Republika Srpska:

- 30% of the population are refugees or displaced persons (March 1996 census);
- Unemployment rate continues to grow;
- Strong dependency on foreign financial support remains;
- Literacy is high, 98% in urban populations and 92% in rural populations.

HIV/AIDS in Republika Srpska

The first AIDS case was reported in Republika Srpska (RS) in 1989. Between 1989 and early 2002, a total of 30 cases of HIV infection were reported at the Clinic for Infectious Diseases in Banja Luka. Among the 30 HIV cases, there were 19 cases of AIDS. HIV/AIDS data from other laboratories were not included in the above figures.

Surveillance data on HIV and AIDS are currently unreliable and often filled with discrepancies.

UNICEF RAR Project in Republika Srpska

Professor Dr Srboljub Golubovic was the Entity Coordinator for the RAR Project in RS. He oversaw the overall planning, development and implementation of the project in three cities, Banja Luka, Trebinje and Višegrad.

Dr Radovan Bratic was the Epidemiological Advisor while Mr Miroslav Stijak was the Data Processing, Statistics and Design Expert for the Republika Srpska project.

Table 21 gives the vulnerable target groups for each of the three cities, and the Local Field Coordinators.

TABLE 21

City	Target Group(s)	Local Field Coordinator
Banja Luka	Young People Injecting Drug Users Sex Workers	Dr Natasa Loncarevic
Trebinje	Young People Injecting Drug Users	Dr Stanko Buha
Vi_egrad	Young People Injecting Drug Users Sex Workers	Dr Milka Dmitreska

Some of the drug routes lead through this city. Nearly half of the city's population are refugees or displaced, and struggling with the many socio-economic problems.

Context

As a result of the 1992-1995 conflict, many young people live in "split" families. Today's parents are preoccupied with economic survival and therefore have little time to spend with their children. For this reason, many parents think that schools should share in the care of their children.

Many young people wish to leave RS as soon as possible since they believe they are unable to express their creativity. Their desire to live life as is portrayed in the movies makes them wish even more to escape the disappointing reality.

Drug use in RS is progressively increasing. Drug routes through RS opened up significantly during and after the conflict. Drugs are entering RS from Montenegro, Albania and Bulgaria, and are easily accessed by young people, although the money to purchase them is not as easily accessible.

Prostitution has always existed in Banja Luka, although this was not officially acknowledged until after the fall of the former Yugoslavia.

Risk and Protective Behaviours

TABLE 23

Group	Questionnaires	Interviews	Focus Groups
Young People who USE DRUGS	238	101	77
Young People who DO NOT USE DRUGS	261		
Young People who INJECT DRUGS	17	34	11
SEX WORKERS	26	2	34
Service Providers		25	21
Policy Makers / Community Leaders			
TOTAL:	542	162	143

Note 1: Only questionnaires completed by young people between the ages of 10 and 24 years were included.
Note 2: Conducted 20 focus groups with young people who do/do not use drugs.
Note 3: Conducted 2 focus groups with injecting drug users.
Note 4: Conducted 5 focus groups with sex workers.
Note 5: Conducted 3 focus groups with service providers, including CAB members.
Note 6: Completed a minimum of 13 observations.

Young People who USE DRUGS

Table 23 provides a breakdown of the number of participants by group and data collection method. Questionnaires were administered to 238 young people who use drugs. Interviews were conducted with 101 young people who use/don't use drugs and a total of 77 young people who use/don't use drugs participated in 20 focus groups.

Young people do not consider alcohol or cannabis as drugs. It is thought quite normal for young males to drink. For many, alcohol was first tried in the home. Young people stated that they only used cannabis when desired and that they were not dependent on it.

Questionnaire Results - Young People who use drugs

The questionnaire was administered to 238 young people who used drugs, 112 males and 123 females. The gender of three respondents was unknown. The following provides a summary of the descriptive data based on the core questions from the questionnaire (n = 238).[25],[26]

Many young people have tried alcohol. It is important to remember that alcohol is part of many family customs.

- Mean age was 17.0 years.
- Mean age when first used drugs was 14.4 years.
- 41.6% had sexual intercourse.
- 38.2% thought that they were at risk of HIV or other STIs.
- 4.6% had been tested for HIV.

In the past month, the following drugs has been used:

- Alcohol 87.0% of respondents;
- Cannabis 19.7%;
- Ecstasy 2.1%;
- Diazepam 1.7%.
- 14.3% used two or more drugs at the same time.
- 8.0% had sex under the influence of drugs.

Of those who had sexual intercourse (n=99):

25. Young people who injected drugs were not included.
26. Percentages were calculated using n=238 as the denominator unless noted otherwise.

- Mean age at first sexual intercourse was 15.8 years;
- 2.0% had no sexual partners in the past year;
- 55.6% had one sexual partner in the past year;
- 23.2% had between 2 and 5 sexual partners in the past year;
- 48.5% “always” used condoms during sex;
- 49.5% “sometimes” or “never” used condoms during sex;
- None had sex in return for money, drugs, etc.

Reasons for not “always” using condoms during sex:

- Do not like sex with condoms;
- Trust in partners;
- Difficult to use.

Where to access information about HIV or other STIs:

- Media;
- Friends or peers;
- School;
- Family.

Young people who INJECT DRUGS

Questionnaires were administered to 17 young people who inject drugs (Table 23). Interviews were conducted with 34 young people who inject drugs and a total of 11 young people who inject drugs participated in two focus groups.

It takes between 6 and 8 years for “light” drugs users to develop an injecting drug habit. Many of the young people stated that they used alcohol and cannabis in the first grades of secondary school, long before they began injecting. According to the questionnaire results, none of the young people in secondary schools injected drugs.

If there is trust between injecting partners then the drug injecting equipment is not cleaned. Very few purchase their needles and syringes in pharmacies due to embarrassment, and furthermore, they need a prescription in order to purchase needles and syringes in pharmacies.

Most young people stated that they did not use condoms during sex since they did not perceive themselves as being at any risk.

Questionnaire Results - Young People who inject drugs

The 17 questionnaires were administered to 11 males and six females. The following provides a summary of the descriptive data based on the core questions from the questionnaire (n = 17).[27]

- Mean age was 22.6 years.
- Mean age when first used drugs was 14.5 years.
- Mean age when first injected drugs was 21.1 years.
- 94.1% had sexual intercourse.
- 41.2% thought that they were at risk of HIV or other STIs.
- 29.4% had been tested for HIV.

In the past month, the following drugs has been used:

- Heroin 76.5% of respondents;
- Alcohol 76.5%;
- Cannabis 76.5%;
- Analgesics 52.9%;
- Cocaine None.
- 47.0% shared drug-injecting equipment.
- All used two or more drugs at the same time.
- 94.1% had sex under the influence of drugs.

Of those who had sexual intercourse (n=16):

- Mean age at first sexual intercourse was 17.7 years.
- 43.8% had one sexual partner in the past year.
- 50.0% had between 2 and 5 sexual partners in the past year.
- 6.2% “always” used condoms during sex.
- 93.8% “sometimes” or “never” used condoms during sex.

27. Percentages were calculated using n=17 as the denominator unless noted otherwise.

- 6.2% had sex in return for money, drugs, etc.

Reasons for not "always" using condoms during sex:

- Do not like sex with condoms;
- Trust in partners;
- Difficult to use.

Where to access information about HIV or other STIs:

- Media;
- Friends or peers;
- Family.

Young People who DO NOT USE DRUGS

Many young people stated that their first sexual experiences took place out of curiosity. Condoms were commonly not used. If condoms were used, they were only used to protect against unwanted pregnancies, not against STIs. Table 24 lists the prices of various condoms.

TABLE 24 Condom Brands and Prices, December 2001.

Condom Brand	Number of Condoms Per Package	Price (KM)* in Private Pharmacies	Price (KM)* in State Pharmacies
Durex	3	3.70 to 4.50	3.79
Act Roma	3	1.50	---
Art Sana	3	---	1.50
Romed	3	1.00 to 1.20	1.80
Proms	1	1.00	---
Kamasutra	1	---	0.80
Love Plus	3	2.00	---

*1 KM = 0.511292 EUR

Young males who had many sexual partners were considered "good guys" or "desirable" whereas young females who had many sexual partners were perceived as "promiscuous".

Questionnaire Results - Young People who do not use drugs

The 261questionnaires were administered to 98 males and 162 females. The gender of one respondent was unknown. The following provides a summary of the descriptive data based on the core questions from the questionnaire (n = 261).[28]

- Mean age was 16.3 years.
- 14.9% had sexual intercourse.
- 29.5% thought that they were at risk of HIV or other STIs.
- 2.3% had been tested for HIV.

Of those who had sexual intercourse (n=39):

- Mean age at first sexual intercourse was 16.3 years;
- 71.8% had one sexual partner in the past year;
- 25.6% had between 2 and 5 sexual partners in the past year;
- 48.7% "always" used condoms during sex;
- 53.8% "sometimes" or "never" used condoms during sex;
- None had sex in return for money, drugs, etc.

Reasons for not "always" using condoms during sex:

- Trust in partners;
- Embarrassed to purchase condoms;
- Do not like sex with condoms.

Where to access information about HIV or other STIs:

- Media;

28. Percentages were calculated using n=261 as the denominator unless noted otherwise.

- Family;
- School.

SEX WORKERS

Questionnaires were administered to 26 sex workers (Table 23). Interviews were conducted with two sex workers and a total of 34 sex workers participated in five focus groups.

One sex worker was a member of the RAR Field Team in Banja Luka. This proved invaluable since she was able to persuade other sex workers to participate in the RAR Project.

Sex workers, also referred to as "artistes", "dancers" and "animir dame", are mostly foreign citizens from the Eastern European countries. Many of them have had sex under the influence of alcohol. They can make additional money if they sit with their clients for drinks. Furthermore, some stated that using alcohol helped to make their work easier and more bearable. Many did not perceive alcohol as a drug. Sometimes, clients offered sex workers drugs before sex.

Sex workers working in nightclubs are obligated to ask their clients to use condoms. Some clients, however, are willing to pay more for sex without condoms. Accordingly, many oblige with their clients' requests without notifying the nightclub owners and thus earn extra money. Some stated that they did not use condoms during oral and anal sex.

Although sex workers stated that they did not "always" use condoms because they were expensive or because they were too embarrassed to purchase them, it should be noted that condoms are provided in the rooms of the nightclubs. There is, therefore, really no need to purchase condoms.

All sex workers are regularly tested for HIV.

Questionnaire Results - Sex Workers

The 26 questionnaires were administered to two males and 24 females. The following provides a summary of the descriptive data based on the core questions from the questionnaire (n = 26).[29]

- Mean age was 21.5 years.
- 65.4% had used drugs.
- Mean age when first used drugs was 16.5 years.
- All have had sexual intercourse.
- 84.6% thought that they were at risk of HIV or other STIs.
- 96.2% had been tested for HIV.

Of those who used drugs (n=17), the following drugs had been used in the past month:

- Alcohol all respondents;
- Cannabis 17.6%;
- Heroin 11.8%;
- Analgesics 11.8%.

Of those who have used drugs (n=17):

- 5.9% had injected drugs;
- Mean age when first injected drugs was 21.0 years;
- Of those who injected drugs (n=1), 5.9% shared drug-injecting equipment;
- 23.5% used two or more drugs at the same time;
- 64.7% had sex under the influence of drugs.

Of those who had sexual intercourse (n=26):

- Mean age at first sexual intercourse was 16.7 years;
- 15.4% had between 2 and 10 sexual partners in the past year;
- 3.8% had between 11 and 19 sexual partners in the past year;
- 76.9% had 100 or more sexual partners in the past year;
- 65.4% "always" used condoms during sex;
- 34.6% "sometimes" or "never" used condoms during sex;
- All had sex in return for money, drugs, etc.

Reasons for not "always" using condoms during sex:

- Embarrassed to purchase condoms;
- Do not like sex with condoms;
- Too expensive to purchase.

29. Percentages were calculated using n=26 as the denominator unless noted otherwise.

Where to access information about HIV or other STIs:

- Media;
- School;
- Friends or peers.

Health and Social Consequences

Young People

Young people are more knowledgeable about HIV than STIs. Even so, many do not know where to go for HIV testing. Furthermore, HIV testing is expensive.

Young people stated that they did not think that STIs were present in their town, nor did they think that any of their peers might have STIs. Furthermore, they stated that they were not interested in STIs since "only prostitutes can catch them".

For young people, family was one of the main sources of HIV/AIDS and STD information. The information provided by the family needs to be assessed for its accuracy. The opinion of most young people is that HIV infections occur in the West, not in RS.

An increase in juvenile delinquency has been reported throughout RS.

Young People who inject drugs

Young people stated that they visited the physician only when they were ill. They would visit the physician for abscesses that had developed at injection sites. Most are uninsured and unemployed, making it difficult for them to pay for medical services, including treatment for addictions.

The effect of the drugs they were taking was not constant. They stated that they required higher doses to achieve the same effects as before. They also stated that they were having more "bad trips" than before.

There is an increasing number of young people who are exchanging sex for money so that they can purchase drugs.

Sex Workers

Sex workers stated that they were knowledgeable about HIV/AIDS and STIs. They are aware that they are at risk of HIV, although they are not afraid since they are tested regularly.

Many stated that they felt that they were a stigmatised group and were blamed by the community for the spread of STIs in the region.

Existing Interventions

In RS, health care services are provided on three levels

- Primary Health Care - family medical services include the following: maternal and children health services; health promotion; prevention and treatment of communicable diseases; home care services; general dental services; pharmacy services; emergency medical help; and laboratory diagnostics.
- Secondary Health Care - hospital services; Public Health Institute; and other specialised institutes (Institute for Blood Transfusion, sport medicine, etc.).
- Tertiary Health Care - highly specialised clinical centres oriented towards scientific work, research and education. These specialised clinical centres provide health care services for patients who require medical treatment that is not available at the primary or secondary levels of health care.

Table 25 lists some of the organisations and/or NGOs that provide HIV/AIDS support services to vulnerable young people.

(1) For blood donors, testing is free. Otherwise, the price of the test is between 37 KM (18.9 EUR) and 80 KM (40.9 EUR).

(2) Limited treatment is provided for persons living with HIV/AIDS.

(3) Treatment for STIs is provided.

(4) Treatment is provided for drug users.

(5) NGOs deliver programmes that address the problems of youth.

Near Banja Luka, a therapeutic community, organised by the Catholic Church, provides treatment for drug users.

TABLE 25

Organisation	HIV Testing	Methadon Therapy	Education Or Support
Institutes for Transfusiology (1)	✓		
Clinic for Infectious Diseases (1), (2), (3)	✓		✓
Clinics for Epidemiology (1)	✓		
Clinic for Psychiatry (4)			✓
NGOs – Action Against AIDS, OKC, "Kastel" (5)			✓

Lastly, young people expressed the following views regarding interventions:

- All testing should be free. Information about the various tests should be provided;
- HIV/AIDS, drug and sex education in schools should start in primary school;
- More youth counselling centres are needed;
- More centres where young people could spend their free time are needed;
- Peer education and workshops are the preferred modes for delivering information;
- Condom vending machines should be installed in disco clubs and parking lots;
- More rigorous measures are needed against drug dealers;
- The existing limited system of treatment for drug users needs improving;
- Drug users accept and prefer treatment in communes;
- Injecting drug users prefer methadone therapy.

Recommendations

The recommendations below are based on the data collected for this RAR Project through questionnaires, interviews, focus groups, existing information, observations and mapping. Recommendations were developed from the key findings that emerged from the analysis of the data.

Table 26 summarises the recommendations for interventions that are outlined in the RAR Report for Republika Srpska, 2002. They are presented at two levels, municipal and entity; and the municipal recommendations are further divided according to time frame: short term; medium term; and long term/permanent.

TABLE 26 Recommendations

Recommendations at the Municipal Level – Short Term

- Establish a municipal advisory body, similar to the municipal body in Trebinje, to monitor prostitution.
- Establish and coordinate the HIV/AIDS support services of various NGOs.
- Advocate for local assemblies to pass a decision regarding the operating hours of bars; not to open before 10 am and to close after 10 pm.
- Establish special pharmacy counters for needle exchanges.
- Develop and implement public awareness campaigns about health lifestyles, prostitution, smoking and drinking.

Recommendations at the Municipal Level – Medium Term (within a few months)

- Develop and implement radio and television advertisements about health for young people.
- Establish centres for free HIV testing, Hepatitis testing, STI testing and needle exchange.
- Install condom vending machines at venues frequented by young people (e.g. bars, toilets, schools, bus and train stations, etc.).

Recommendations at the Municipal Level – Long Term/Permanent

- Establish a detoxification centre and safe house for drug users.
- Develop and implement services and treatment for addictions.
- Develop and implement counselling support services for families of drug addicts, for persons living with HIV/AIDS, and for former sex workers.

Recommendations at the Entity Level – Long Term/Permanent

- Establish and enforce stricter penalties for drug trafficking and for the possession of drugs.
- Establish prison-like institutions that also provide counselling for young drug dealers between the ages of 25 and 30 years.
- Legitimise prostitution by having sex workers obtain licenses to work by completing courses in sexual health, hygiene and social etiquette. Sex workers would also have to provide written consent to cooperate with the police.
- Establish and implement rehabilitation services for drug addicts.
- Introduce tax exemptions for companies who employ a certain number of former drug addicts or sex workers.
- Develop and implement a new subject on health promotion in primary and secondary school curricula.

(h2)BRČKO DISTRICT

The area of Brčko District is 493.3 square kilometres, less than 1 per cent of the entire area of Bosnia and Herzegovina (BiH) (51,129 square kilometres). According to the last official census that took place in 1991 before conflict broke out, Brčko has a population of 85,000 people. It is estimated that 18,000 refugees are now living in Brčko, and that another 5,000 individuals have returned since the conflicts ended. Brčko is a multi-ethnic region.

Brčko is situated at one of the main border crossings between Croatia and BiH. There is also a busy east-west route linking Banja Luka and Serbia, so that the area is one of significant economic activity. Since the conflicts, most of this bustling economic activity has been concentrated in a nearby area known as the Arizona market.

Unemployment has always been high in Brčko. The number of unemployed individuals is approximately 27,000. The economy remains in recession. The social and health care infrastructures are good. The political system is fairly stable and is currently monitored by the international community.

HIV/AIDS in Brčko District

According to data from the Department of Transfusiology, there are no reported HIV or AIDS cases in the Brčko District except for two foreign women who came to work as sex workers/dancers. They were immediately deported back to their country of origin, once it was confirmed that they were HIV positive.

UNICEF RAR Project in Brčko

Mr. Miroslav Gavric was the Local Field Coordinator for the RAR Project in Brčko. He oversaw the overall planning, development and implementation of the RAR Project in Brčko.

Dr. Srboljub Golubovic, Entity Coordinator for Republika Srpska, provided technical and administrative support to the Project.

The target groups selected for the RAR Project in Brčko were:

- Young People
- Sex Workers/Striptease Dancers

Reasons for the Selection of Vulnerable Target Groups

Table 27 gives some of the reasons for the selection of particular target groups.

TABLE 27

Target Group	Reason(s) for Selection
Young People	HIV/AIDS education in school curriculum was inadequate.
Sex Workers	High concentration of brothels in the Arizona market area. The Arizona market area was known as the major centre for trafficking in women in the Balkans.

Context

Young People

Drugs are easily available to young people. Cannabis and heroin originate from Albania or the UN Administered Province of Kosovo whereas ecstasy originates from Austria or Germany.

Police data state the following:

- 120 registered drugs users (4 or 5 are women);
- Drugs used most often are cannabis, pills and ecstasy;
- Glue and other inhalants are used to a lesser degree;
- 30 heroin users (5 or 6 inject and the rest use heroin nasally);
- Cocaine is expensive and its use is rare.

Sex Workers

After the conflicts, and especially after the opening of the Arizona market, the many nightclubs that opened were actually brothels, for most of the time. The number of nightclubs (i.e. brothels) peaked in 1999 when the Arizona market area was known as the place for trafficking the most women in the Balkans.

Risk and Protective Behaviours

TABLE 28

Group	Questionnaires	Interviews	Focus Groups
Young People who USE DRUGS	40		9
Young People who DO NOT USE DRUGS	71		50
Service Providers		10	
Policy Makers / Community Leaders		1	
TOTAL:	111	11	59

Note 1: Only questionnaires completed by young people between the ages of 10 and 24 years were included.
Note 2: Conducted 2 focus groups with young people who use drugs.
Note 3: Conducted 6 focus groups with young people who do not use drugs.
Note 4: Completed 7 observations at cafes, discos and parks.

Young People who USE DRUGS

Table 28 provides a breakdown of the number of participants by group and data collection method. Questionnaires were administered to 40 young people who use drugs. A total of 9 young people who use drugs participated in two focus groups.

Young people use drugs for many reasons:

- Curiosity;
- Feeling of being grown up;
- Sense of self-importance.

According to the participants, the most frequently used drugs are alcohol, cannabis and pills (e.g. Artan, Akineton, anlagesics, and ecstasy). Heroin is often used “for correction after a night on ecstasy”, and is usually taken nasally due to a fear of needles. There is a belief that using heroin nasally is less addictive.

Drug use among young people is sporadic because of a lack of money. Table 29 gives a breakdown of the different types of drug and their costs.

TABLE 29 Drug Prices in Br_ko Distric

Drug	Unit	Price per Unit (KM)*	Comment
Cannabis	Matchbox	10	1 matchbox consists of 4 joints
Tablets		5 to 6	
Heroin	1 gram	80 to 100	Good quality heroin.
	_ gram	30 to 50	Less quality heroin.
	_ gram	20 to 25	Less quality heroin.

*1 KM = 0.511292 EUR.

Participants reported that they prefer sex without condoms. Condoms are expensive, and furthermore, they are ashamed to purchase them.

Questionnaire Results - Young People who use drugs

The questionnaire was administered to 40 young people who use drugs, 17 males and 23 females. The following provides a summary of the descriptive data based on the core questions from the questionnaire (n = 40).[30],[31]

- Mean age was 16.7 years.
- Mean age when first used drugs was 14.9 years.
- None had injected drugs.
- 45.0% had sexual intercourse.
- 35.0% thought that they were at risk of HIV or other STIs.
- 5.0% had been tested for HIV.

In the past month, the following drugs had been used:

- Alcohol 67.5% of respondents;
- Cannabis 20.0%;
- Analgesics 10.0%.
- 27.5% used two or more drugs at the same time.
- 20.0% had sex under the influence of drugs.

Of those who had sexual intercourse (n=18):

- Mean age at first sexual intercourse was 15.2 years;
- 33.3% had one sexual partner in the past year;
- 55.6% had between 2 and 5 sexual partners in the past year;
- 16.7% “always” used condoms during sex;
- 83.3% “sometimes” or “never” used condoms during sex;
- 5.6% had sex in return for money, drugs, etc.

Reasons for not “always” using condoms during sex:

- Do not like sex with condoms.
- Trust in partners.
- Condoms too expensive.

Where to access information about HIV or other STIs:

- Media;
- Friends or peers;
- Family.

Young People who DO NOT USE DRUGS

71questionnaires were administered to young people who do not use drugs, a total of 50 young people in six focus groups (Table 28).

Questionnaire Results - Young people who do not use drugs

The 71 questionnaires was administered to 31 males and 40 females. The following provides a summary of the descriptive data based on the core questions from the questionnaire (n = 71).[32]

- Mean age was 15.8 years.
- 9.8% had sexual intercourse.
- 36.6% thought that they were at risk of HIV or other STIs.
- 2.8% had been tested for HIV.

Of those who had sexual intercourse (n=7):

- Mean age at first sexual intercourse was 14.7 years;
- 57.1% had one sexual partner in the past year;
- 28.8% had between 2 and 5 sexual partners in the past year;
- 71.4% “always” used condoms during sex;
- 14.3% “never” used condoms during sex;
- None had sex in return for money, drugs, etc.

Reasons for not “always” using condoms during sex[33]:

- Trust in partners.

30. No young people who inject drugs completed the questionnaires.
31. Percentages were calculated using n=40 as the denominator unless noted otherwise.
32. Percentages were calculated using n=71 as the denominator unless noted otherwise.
33. Only one out of 7 possible participants responded to this question.

Where to access information about HIV or other STIs:

- Friends or peers;
- Media;
- Family;
- School.

Sex Workers

Fieldwork (i.e. data collection) for the RAR Project coincided with the District Prosecutor's campaign against human trafficking and sex workers in the Brčko District. The police were trying to close down the nightclubs, so it was difficult to recruit sex workers to participate in the RAR Project. A RAR Field Team member interviewed one nightclub owner but, unfortunately, he was arrested before the focus group with his sex workers could be conducted.

The Prosecutor's campaign successfully closed all nightclubs, and prostitution organisers and 67 sex workers were arrested.

As a result of the Prosecutor's campaign, sex workers were unable to complete questionnaires or participate in focus groups. Six interviews were conducted with the following individuals: a young male who used the services of sex workers; a waiter who worked in a brothel; the owner of a nightclub; a municipal inspector; a market inspector; and a public prosecutor.

The six interviews and some existing information provided the following key pieces of data:

- Nightclub owners leave the decision on whether to use condoms to the sex workers;
- Sex workers have adequate knowledge of safe sex practices;
- High level of condom use among sex workers;
- Condoms are frequently used with non-regular clients;
- Condoms are less frequently used with regular clients;
- Sex workers who work in nightclubs have monthly medical checkups

Health and Social Consequences

There are no registered cases of drug overdoses. There is an increase in juvenile delinquency. Even so, there is no obvious connection between juvenile delinquency and drug use.

Drugs, sex and HIV/AIDS are taboo topics that are rarely discussed between young people and their parents or teachers. There is poor communication between young people and their parents.

Existing Interventions

The health care system in Brčko is organised through the Department of Health, Public Security and Civil Services. The Department of Health consists of the following:

- Sub-Department for Primary Health Care (includes the Centre for Mental Health, methadone therapy, disease epidemiology)
- Sub-Department for Hospital Health Care (includes the Department of Transfusiology)
- Sub-Department for Social Work

Some of the organisations and/or NGOs that provide HIV/AIDS support services to vulnerable young people are listed in Table 30.

(1) The Department provides HIV testing every year on World AIDS Day (1 December), in cooperation with the Youth Centre Vermont

(2) Counselling on addictive disease is also provided.

(3) Projects involve participation by students from secondary schools. Projects include poster presentations, educative rock concerts, etc.

(4) Therapeutic work with juvenile delinquents who use drugs.

(5) Campaigns to increase HIV/AIDS awareness among the community. Projects implemented include "Say NO to Drugs" and "Sports Against Drugs".

(6) Delivers workshops in schools.

Presently, there is no HIV/AIDS education in the school curriculum.

The government's willingness to work on drug addiction issues is demonstrated by the formation of a Coordination Body for the Eradication of Addictive Diseases.

TABLE 30

Organisation	HIV Testing	Methadone Therapy	Education Or Support
Department of Transfusiology (1)	✓		
Centre for Mental Health (2)		✓	✓
Body for Eradication of Addictive Diseases (3)			✓
Centre for Social Work (4)			✓
Youth Centre Vermont – NGO (5)			✓
Institute for Social Education Proni			✓
CIVITAS (6)			✓

Recommendations

The recommendations below are based on the data collected for this RAR Project through questionnaires, interviews, focus groups, existing information, observations and mapping. They were developed from the key findings that emerged from the analysed data.

Table 31 provides a summary of the recommendations for interventions that are outlined in the RAR Report for Brčko District, 2002, according to vulnerable target group.

TABLE 31

Recommendations for Young People

- Introduce HIV/AIDS, drug and sex education into the school curriculum.
- Deliver workshops to young people to improve their communication skills.
- Develop and implement STI/HIV/AIDS awareness campaigns, and involve the media.
- Organise and conduct public debates to increase STI/HIV/AIDS awareness.
- Establish a working partnership between young people and local NGOs.
- Monitor the cafes near schools for drug use.
- Develop counselling centres within the Centre for Mental Health.
- Establish a system to monitor the indicators of drugs and HIV/AIDS.
- Work in partnership with the Coordination Body for the eradication of addictive diseases.

Recommendations for Sex Workers

- Coordinate the work done by the police, judiciary and District Prosecutor's office at state level.
- Advocate or lobby for improvements in the legislation on prostitution.
- Promote a harm reduction approach.

CROATIA

Croatia is a country in transition. The changeover from a state-owned to a market economy is still taking place. Sweeping social and economic changes are in progress. With an unstable labour market, high unemployment still persists.

The Croatian coast is Mediterranean in style and attracts many tourists.

HIV/AIDS in Croatia

Between 1986 and 2001, Croatia registered 175 AIDS cases and 143 HIV cases. Of these 318 HIV/AIDS cases:

- 244 (76.8%) were male;
- 74 (23.2%) were female;
- 125 (39.3%) were heterosexuals;
- 107 cases (33.6%) were men having sex with men or bisexuals;
- 42 cases (13.2%) were injecting drug users.

It is estimated that there will be 500 persons living with HIV/AIDS in Croatia by the end of 2002.

UNICEF RAR Project in Croatia

Dr Marina Kuzman was the National Coordinator for the RAR Project in Croatia. She oversaw the overall planning, development and implementation of the Project in the four cities, Osijek, Rijeka, Split and Zagreb.

Table 32 lists the target groups selected for each city, and the local field coordinators.

TABLE 32

City	Target Group(s)*	Local Field Coordinator
Osijek	Drug Users Out-of-School Youth	Dr Karlo Kozul
Rijeka	Drug Users Out-of-School Youth	Dr Karla Muskovic
Split	Drug Users Sex Workers	Mr Vedran Mardesic
Zagreb	Drug Users Roma Youth	Mrs Jadranka Mimica

* Drug users included injecting drug users.

Reasons for the selection of cities and vulnerable target groups

Table 33 listed some of the reasons why particular cities and target groups were selected.

Drug users were selected as a target group in all four cities since it remains one of the groups most vulnerable to HIV transmission. Some of the cities focused their RAR on the risk behaviours of young people who take part in the rave culture.

Context

In Osijek, there is an opiate drug problem due to illicit drug markets in the neighbouring counties of Vinkovci and Vukovar (areas bordering FRY and BiH). Furthermore, cannabis is arriving at an increasing rate from the UN Administered Province of Kosovo, and heroin via Hungary.

In Zagreb, the widespread use of mobile phones has added to the invisibility of the drug dealing process. To purchase drugs, a call is placed and the drugs are delivered to the home. Open drug dealing on the city streets is rare.

TABLE 33

City	Target Group(s)*	Reason(s) for Selection
Osijek	Drug Users Out-of-School Youth	The majority of research data on drug use and sexual behaviour has been collected on young people in school or university, hence the focus on out-of-school youth.
Rijeka	Drug Users Out-of-School-Youth	The majority of research data on drug use and sexual behaviour has been collected on young people in school or university, hence the focus on out-of-school youth.
Split	Drug Users Sex Workers	Lack of research on sex work in Croatia.
Zagreb	Drug Users Roma Youth	Young people are very much interested in the rave culture. There is an increased use of synthetic drugs. Ignorance of the cultural and sociological factors that influence risk behaviour in the Roma population.

*Drug users include injecting drug users.

The heroin epidemic is no longer increasing in Split and Zagreb, although it is still increasing in Osijek and Rijeka.

Prostitution is illegal in Croatia.

Risk and Protective Behaviours

Young People

Young people do not perceive alcohol as posing any type of risk. Furthermore, they do not perceive drugs as having any significant influence on either the frequency of their sexual relations or on their use of condoms. Even so, accidental or unplanned sexual relations often happen under the influence of drugs when "one does what one otherwise would not". Most of these times, condoms are not used.

Condoms are perceived as an obstacle to closeness and thus their use is often avoided. If condoms are used, they are used to only protect against unwanted pregnancies and not against STIs.

In Rijeka it is considered very "in" for girls to have sexual relations with foreigners, such as sailors.

Drug Users and Injecting Drug Users

Table 34 provides a breakdown of the number of participants by group and data collection method. Questionnaires were administered to 220 drug users. Interviews were conducted with 33 of them and a total of 97 drug users and injecting drug users participated in 9 focus groups.

TABLE 34

Group	Questionnaires	Interviews	Focus Groups
DRUG USERS	147	33	97
INJECTING DRUG USERS	73		
Service Providers		22	
Policy Makers / Community Leaders		6	
TOTAL:	220	61	97

Note 1: Only questionnaires completed by young people between the ages of 10 and 24 years were included.
Note 2: Conducted 9 focus groups with drug users and injecting drug users.
Note 3: In Zagreb, no focus groups were conducted with drug users due to their lack of trust.
Note 4: Completed observations at parks, cafes, disco clubs, health centres and on the Internet.

The RAR Project confirmed that the use of synthetic drugs, especially ecstasy, is increasing among young people. Ecstasy is often consumed during the weekends at disco clubs or rave parties. It is felt that young people are using less opiate type drugs and more synthetic drugs.

Cannabis is often consumed in large group settings. Girls often consume drugs with their partners.

Questionnaire Results - Drug Users

The questionnaire was administered to 147 drug users, 105 males and 41 females. There was one respondent whose gender was unknown. The following provides a summary of the descriptive data based on the core questions from the questionnaire (n = 147).[34],[35]

- Mean age was 19.5 years.
- Mean age when first used drugs was 15.5 years.
- 89.8% had sexual intercourse.
- 58.1% thought that they were at risk of HIV or other STIs.
- 5.4% had been tested for HIV.

In the past month, the following drugs had been used:

- Alcohol 91.8% of respondents;
- Heroin 76.2%;
- Ecstasy 34.7%;
- Amphetamines 38.4%.
- 80.3% used two or more drugs at the same time.
- 70.1% had sex under the influence of drugs.

Of those who had sexual intercourse (n=132):

- Mean age at first sexual intercourse was 16.4 years.
- 2.3% had no sexual partners in the past year.
- 38.6% had one sexual partner in the past year.
- 51.5% had between 2 and 5 sexual partners in the past year.
- 15.2% “always” used condoms during sex.
- 86.4% “sometimes” or “never” used condoms during sex.
- 1.5% had sex in return for money, drugs, etc.

Reasons for not “always” using condoms during sex:

- Do not like sex with condoms.
- Trust in partners.
- Condoms too expensive to purchase.

Where to access information about HIV or other STIs:

- Media;
- Friends or peers;
- School;
- Family.

Injecting Drug Users

Often the first experience with injecting drugs was gained through the older more experienced IDUs since new IDUs do not possess their own drug injecting equipment. Long term IDUs often inject alone. Many of the participants did not like purchasing their needles and accessories from pharmacies since they were often “looked at below the eye”.

Questionnaire Results - Injecting Drug Users

The questionnaire was administered to 73 young people who were injecting drugs, 48 males and 25 females. The following provides a summary of the descriptive data based on the core questions from the questionnaire (n = 73)[36].

- Mean age was 21.4 years.
- Mean age when first used drugs was 15.0 years.
- Mean age when first injected drugs was 17.6 years.
- All have had sexual intercourse.

34. Young people who injected drugs were not included in this sample.
35. Percentages were calculated using n=147 as the denominator unless noted otherwise.
36. Percentages were calculated using n=73 as the denominator unless noted otherwise.

- 57.5% thought that they were at risk for HIV or other STIs.
- 58.9% had been tested for HIV.

In the past month, the following drugs had been used:

- Cannabis 72.6 % of respondents;
- Alcohol 68.5%;
- Heroin 63.0%;
- Diazepam 38.4%;
- Methadone 37.0%.
- 72.6% shared drug-injecting equipment.
- 86.3% used two or more drugs at the same time.
- 98.6% had sex under the influence of drugs.

Of those who had sexual intercourse (n=73):

- Mean age at first sexual intercourse was 15.7 years;
- 31.5% had one sexual partner in the past year;
- 54.8% had between 2 and 5 sexual partners in the past year;
- 11.0% “always” used condoms during sex.
- 89.0% “sometimes” or “never” used condoms during sex.
- 5.5% had sex in return for money, drugs, etc.

Reasons for not “always” using condoms during sex:

- Do not like sex with condoms.
- Trust in partners.
- Do not think of using condoms.

Where to access information about HIV or other STIs:

- Media;
- Friends or peers;
- Family.

Sex Workers

Table 35 provides a breakdown of the number of participants by group and data collection method. Questionnaires were administered to seven sex workers. Interviews were conducted with four sex workers and a total of six sex workers participated in one focus group.

TABLE 35

Group	Questionnaires	Interviews	Focus Groups
SEX WORKERS	7	4	6
Service Providers		6	
Policy Makers / Community Leaders		3	
TOTAL:	7	13	6

Note 1: Only questionnaires completed by young people between the ages of 10 and 24 years were included.
Note 2: Conducted one focus group with sex workers.
Note 3: In Split, it was difficult to recruit sex workers who were aged between 10 and 24 years, and also willing to complete the questionnaire.
Note 4: Completed 4 observations at parks, a café and in a local street.

Most of the participants were aware of the risks of HIV infection, although they still did not use condoms if clients did not want to. Sex workers charged more for sexual services without condoms. Most practiced oral sex without condoms. Female drug users often prostituted themselves in exchange for drugs.

In Split, the sex workers received free condoms from the Association “Help” (an NGO). Condoms were too expensive to be purchased.

Questionnaire Results - Sex Workers

The questionnaire was administered to seven sex workers, three males and four females. The following provides a summary of the descriptive data based on the core questions from the questionnaire (n = 7)[37].

- Mean age was 21.8 years.
- All have used drugs.
- Mean age when first used drugs was 16.6 years.
- All have had sexual intercourse.
- 85.7% thought that they were at risk of HIV or other STIs.
- 57.1% had been tested for HIV.

Of those who used drugs (n=7), the following drugs had been used in the past month:

- Cannabis 85.7%;
- Alcohol 87.5%;
- Heroin 87.5%;
- Diazepam 57.1%.

Of those who have used drugs (n=7):

- 85.7% had injected drugs;
- Mean age when first injected drugs was 18.7 years;
- Of those who injected drugs (n=6), all had shared drug-injecting equipment;
- 71.4% used two or more drugs at the same time;
- All had sex under the influence of drugs.

Of those who had sexual intercourse (n=7):

- Mean age at first sexual intercourse was 16.1 years;
- 28.6% had between 2 and 5 sexual partners in the past year;
- 42.9% had between 6 and 10 sexual partners in the past year;
- 14.3% “always” used condoms during sex;
- 85.7% “sometimes” or “never” used condoms during sex;
- All had sex in return for money, drugs, etc.

Reasons for not “always” using condoms during sex:

- Do not like sex with condoms;
- Trust in partners;
- Use other types of contraception.

Where to access information about HIV or other STIs:

- Friends or peers;
- Media;
- Social or health workers.

Out-of-School Youth and Roma Youth

Table 36 provides a breakdown of the number of participants by group and data collection method. Questionnaires were administered to 37 out-of-school or Roma youth. Interviews were conducted with four of them and a total of 22 participated in five focus groups.

TABLE 36

Group	Questionnaires	Interviews	Focus Groups
OUT-OF-SCHOOL / ROMA YOUTH	37	4	22
Service Providers		1	
Policy Makers / Community Leaders			
TOTAL:	37	5	22

Note 1: Only questionnaires completed by young people between the ages of 10 and 24 years were included.
Note 2: Conducted 5 focus groups with out-of-school or Roma youth.

37. Percentages were calculated using n=7 as the denominator unless noted otherwise.

Note 3: List of completed observations was not available.

Many of the participants reported that they did not often go out to disco clubs or cafes due to a lack of money. Rather, they usually gathered in open public spaces. Furthermore, they did not often purchase condoms because they were too expensive.

In the Roma culture, young people begin sexual relations at an early age since they often marry at an early age. Furthermore, there is a high degree of tolerance for men who have extramarital affairs, whereas for women this would not be tolerated.

Questionnaire Results - Out-of-School Youth and Roma Youth

The questionnaire was administered to 37 out-of-school youth or Roma youth, 24 males and 13 females. The following provides a summary of the descriptive data based on the core questions from the questionnaire

(n = 37).[38]

- Mean age was 18.8 years.
- 62.2% had used drugs.
- Mean age when first used drugs was 15.0 years.
- 83.8% had sexual intercourse.
- 62.2% thought that they were at risk of HIV or other STIs.
- 13.5% had been tested for HIV.

Of those who used drugs (n=23), the following drugs had been used in the past month:

• Alcohol	All respondents;
• Cannabis	82.6%;
• Heroin	56.5%;
• Methadone	43.5%;
• Ecstasy	34.8%.

Of those who used drugs (n=23):

- 52.2% had injected drugs;
- Mean age when first injected drugs was 18.1 years;
- Of those who injected drugs (n=12), 75.0% had shared drug-injecting equipment;
- 91.3% used two or more drugs at the same time;
- All had sex under the influence of drugs.

Of those who had sexual intercourse (n=31):

- Mean age at first sexual intercourse was 15.4 years;
- 25.8% had one sexual partner in the past year;
- 58.1% had between 2 and 5 sexual partners in the past year;
- 9.7% “always” used condoms during sex;
- 93.5% “sometimes” or “never” used condoms during sex;
- 3.2% had sex in return for money, drugs, etc.

Reasons for not “always” using condoms during sex:

- Do not like sex with condoms.
- Trust in partners.
- Cannot be bothered to use condoms.

Where to access information about HIV or other STIs:

- Media;
- Friends or peers;
- Family.

Health and Social Consequences

The less at-risk population of young people (i.e. those who do not inject drugs or who have fewer sexual partners) have a higher perception of the risks associated with HIV or STIs than the more at-risk young people. Regardless, an increasing number of young people are engaging in various risk behaviours:

- Increasing number of traffic accidents involving young people under the influence of alcohol;
- Increasing number of overdose cases;
- Increasing number of Hepatitis C cases;

38. Percentages were calculated using n=37 as the denominator unless noted otherwise.

- Increasing number of pregnant women who are addicted to drugs.

One of the major risks of consuming ecstasy is the potential for dehydration. It is thus essential to consume considerable amounts of liquid when using ecstasy. Club owners often intentionally turn off the water taps in washrooms, thereby making it almost impossible to access free water. Young people must then purchase drinks at the bar instead.

Young people have considerable knowledge about HIV/AIDS, syphilis and gonorrhoea. However, they have very little knowledge about other STIs, such as herpes and chlamydia, or about Hepatitis B and C.

STI/HIV/AIDS information is mainly accessed through the media and friends. Girls ranked their families as an important source for information. This may indicate that there is good communication between mothers and their daughters.

Existing Interventions

Croatia has adopted and implemented various documents and programmes related to HIV/AIDS:

- The Office of Drug Addictions has been established within the government;
- The Croatian Institute for Prevention of Addictions has been established under the Psychoactive Drug Abuse Control Act;
- The National Strategy for the Prevention of Drug Abuse provides the framework for activities relating to the prevention and treatment of drug abuse;
- The National Programme of Health Protection from AIDS regulates the implementation of measures aimed at preventing the spread of HIV infection and ensures that medical and social care is provided for persons living with HIV/AIDS and their families; and
- The National Committee on AIDS is responsible for implementing the above National Programme.

Some of the organisations and/or NGOs that provide HIV/AIDS support services to vulnerable young people are listed in Table 37. It is important to note that treatment is mandatory for minors who are caught in the possession of psychoactive drugs.

TABLE 37

Organisation	HIV Testing	Methadone Therapy	Education Or Support
In Rijeka:			
Centre for Prevention & Treatment of Addictions		✓	✓
Rijeka Clinical Hospital Centre (1)	✓		✓
Terra Society	✓	✓	✓
Life is More Association (2)			✓
Institute of Public Health (3)			✓
In Split:			
Institute for Addictive Diseases (4)	✓		✓
San Lorenzo (5)			✓
New Life Association			✓
League for Fight Against Narcomania (6)			✓
Bridge Association (7)			✓
Help Society	✓	✓	✓
In Zagreb:			
Sestre Milosrdnice Teaching Hospital			✓
Vrapce Psychiatric Hospital		✓	✓
Childrens Hospital Zagreb			✓
Dr. Fran Mihaljevic Infectious Disease Clinic	✓		
Institute for Transfusion Medicine	✓		
Croatian Red Cross Harm Reduction Centre		✓	✓
Spica Association (8)			✓

(1) A 6-bed detoxification unit at the Psychiatric Clinic will be opened shortly.

(2) Counselling services for drug users and their families.

(3) Institute's School Health Service provides STI/HIV/AIDS prevention education to children and young people.

(4) Institute is located outside of town and difficult to access (i.e. outside of public transport lines). Outpatient detoxification also available at the Institute.

(5) Provides support for parents of drug users.

(6) Organises prevention activities in schools and initiates projects for young people.

(7) Provides psychosocial support for vulnerable young people.

(8) Provides water and fruits to young people at rave parties to help prevent dehydration from the use of ecstasy.

Methadone is administered by general practitioners. Problems exist with the administration of methadone because local clinics do not have organised services over the weekends and general practitioners can dispense methadone at their discretion. A comprehensive evaluation of the methadone programme in Croatia is needed.

In Split, the needle exchange programme (Association Help) is ideally located in the town centre. The needle exchange is easily accessible yet also secluded enough so as not to provoke stigmatisation. The staff at the needle exchange have built up a good rapport with the IDU community.

In Zagreb, the Croatian Red Cross operate the needle exchange programme (Harm Reduction Centre). The needle exchange is located in an area that is not frequented by IDUs, making it difficult for IDUs to access it for clean needles and syringes. Furthermore, it only operates within limited hours, from 14:00 to 17:00 hours.

Recommendations

The recommendations below are based on the data collected for this RAR Project through questionnaires, interviews, focus groups, existing information, observations and mapping. They were developed from the key findings that emerged from analysis of the RAR data.

Table 38 provides a summary of the recommendations for interventions that are outlined in the RAR Report for Croatia, 2002. They are grouped at three levels: policy; national or local; and individual.

TABLE 38

Recommendations at the Policy Level

- Continue with the implementation of the National Programme for Protection from AIDS for the Republic of Croatia. The Programme ensures medical and nursing care to persons living with HIV/AIDS.
- Strengthen the current health promotion programmes.
- Continue implementing organised measures under the National Strategy for Drug Prevention and Control.

Recommendations at the National or Local Level

- Improve civil society's response to HIV/AIDS related issues.
- Improve the collaboration between young people and institutions.
- Increase the number of harm reduction programmes targeted at injecting drug users.
- Expand needle exchange and outreach programmes.
- Increase accessibility to free HIV testing.
- Educate health care workers regarding the confidentiality of HIV testing.
- Reduce the price of condoms thus making condoms more accessible to young people.
- Install condom vending machines at venues where young people frequent (e.g. , disco clubs, concert halls, etc.). Ensure that condoms are price affordably.
- Develop and implement awareness campaigns that are targeted to young people or their parents, and involve the media.
- Improve sex education in the school curriculum.
- Revise health education and awareness programmes with interactive "peer education". Explore possibilities for using the Internet for peer education.
- Develop and distribute IEC materials about STI/HIV/AIDS, drugs and condom use.
- Improve the administration of methadone therapy programmes by educating physicians, evaluating methadone programmes, and improving accessibility to methadone at weekends.
- Develop programmes targeted at sailors or seamen.
- Establish Youth Friendly Centres.
- To avoid dehydration after taking ecstasy, ensure that bottled water is available for purchasing at bars, clubs and rave parties, and that the income from sales of bottled water be taxed at a lower rate than sales of alcoholic drinks.
- Establish dialogue between the police and young people. The police drug laboratory could inform young people about the composition of impounded tablets by posting the drug compositions on the Internet.
- Conduct further research on the risk behaviours of out-of-school youth.
- Conduct further research on sex workers.

Recommendations at the Individual Level

- Deliver education about STI/HIV/AIDS and healthy sexuality to young people.
- Provide counselling to persons living with HIV/AIDS and their families.
- Develop and distribute information and prevention messages about condom use to clients of sex workers.

FEDERAL REPUBLIC OF YUGOSLAVIA (Excluding Kosovo)

The Federal Republic of Yugoslavia (FRY) comprises two republics, Serbia and Montenegro, and one province, the UN administered Province of Kosovo.

As mentioned earlier, a RAR on psychoactive substance use in young people was completed in Kosovo in April and May 2001. This regional report presents only a summary of the original RAR reports for Serbia and Montenegro. Copies of all RAR reports are available from the appropriate UNICEF office.

As a result of the past ten years of regional conflict in the Balkans and the imposed sanctions, FRY has been deeply isolated from the international community. The country's overall economy can be described as low in production, dominated by state or social ownership, inefficient with monopolies, and outdated in its technologies.

HIV/AIDS in FRY

There is currently no effective mechanism for reporting on HIV and AIDS in FRY. There is reporting of persons testing positive for HIV only in Belgrade. AIDS cases, in contrast, are reported for all of FRY. The data on reported AIDS cases are separately maintained from the HIV data.

The first two AIDS cases were reported in FRY in 1985. According to the most recently published data (December 2001), there is a cumulative total of 922 reported AIDS cases in FRY. Of these 922 cases:

- 691 cases (75%) are deceased;
- 894 cases (97%) are from Serbia, and more specifically, 738 cases (80%) are from Belgrade;
- 433 cases (47%) are injecting drug users;
- 175 cases (19%) are heterosexuals.

The World Health Organisation estimates that there are 10,000 HIV positive cases in FRY.

SERBIA

The transition from childhood to youth, for a child growing up in Serbia after 1990, coincided with a very difficult period in the country's development. Many of the structural amenities that a community should provide for a young person, like family and school, were either denied or compromised. Under conditions of aggressive conflict propaganda with constant images of human suffering and continuous exposure to violence and crime, a young person was often left with minimal support, no role models, and only vague values for what was right and wrong.

According to the Economic Institute in Belgrade, the official unemployment rate is 26%. This is thought to be inaccurate. In Serbia, per capita spending has fallen from US$ 240 (260 EUR) (1989) to US$ 59 (64 EUR) in 2001. Not surprisingly, over 50% of young people want to leave the country and 85% wish for a better life than that of their parents (UNICEF 2000).

HIV/AIDS in Serbia

There is no effective mechanism for reporting of HIV and AIDS in FRY. HIV cases are reported only in Belgrade, although AIDS cases are reported for the whole of FRY. According to the most recently published data (December 2001), 738 cases of AIDS have been reported in Belgrade since 1985. According to the Federal Institute of Public Health, there is a cumulative total of 1,234 reported HIV cases in Belgrade since 1987. Twenty-one of these cases are under 18 years old.

UNICEF RAR Project in Serbia

Professor Dr Viktorija Cucic was the Republic Coordinator for the RAR Project in Serbia. She oversaw the overall planning, development and implementation of the RAR Project in four cities, Belgrade, Kragujevac, Nis and Novi Sad.

Table 39 lists the vulnerable target groups in each city, and the Local Field Coordinators.

TABLE 39

City	Target Group(s)*	Estimated Size of Target Group(s)	Local Field Coordinator
Belgrade	Drug Users Young MSM Sex Workers	20,000 drug users 3,000 sex workers	Dr Vesna Bjegovic
Kragujevac	Drug Users Sex Workers		Dr Dragana Ignjatovic
Nis	Drug Users Young MSM		Dr Bojana Ilic
Novi Sad	Drug Users Young MSM		Mr Vladimir Beara

* Drug users included injecting drug users

Reasons for the Selection of Cities and Vulnerable Target Groups

Table 40 lists some of the reasons why certain cities and target groups were selected.

TABLE 40

City	Target Group(s)*	Reason(s) for Selection
Belgrade	Drug Users Young MSM Sex Workers	Lack of sufficient and relevant information on the three target groups. Inadequate prevention initiatives provided for the three target groups.
Kragujevac	Drug Users Sex Workers	Each of the four cities has a major university and therefore a high concentration of young people.
Nis	Drug Users Young MSM	Drug trafficking routes intersect in the cities of Nis and Novi Sad.
Novi Sad	Drug Users Young MSM	Cannabis and poppyheads are grown near Novi Sad.

* Drug users included injecting drug users

Context

Drug Use

Factors that are contributing to the increasing use of drugs include the following:

- Years of conflict in the Balkans;
- Devastated social and environmental conditions created by the years of conflict;
- Large supplies of inexpensive drugs.

Sex Work

Prostitution is illegal in Serbia. There are no reliable data on the estimated number of sex workers in Serbia. Provoked by the onset of AIDS, a movement for the legalisation and decriminalisation of sex work emerged in the early 1990s. Unfortunately, the movement was unorganised and lacked the support of professionals. Nonetheless, it was the first time that sex work was given a public voice.

Trafficking in women began 10 to 15 years ago in Serbia. Women from nearby countries, unable to find jobs in their homeland, work in Serbia as sex workers.

Most of the sex workers live independently in rented apartments although some still live with their parents who are unaware of their activities. The main reason for prostituting oneself is money. The decision to enter prostitution is often made under the influence of a friend or a former boyfriend who is involved in prostitution.

There are three distinct levels of sex work:

- Low level sex work takes place in various hot spots around town. It involves sex workers standing about, closely watched by their pimps, waiting for potential clients. The clients are usually from lower socio-economic backgrounds. The sexual services are performed in parks, cars or homes.
- Mid level sex work takes place through escort agencies. These agencies do not require any medical documentation of the health of their sex workers. The agencies operate from rented apartments in the city centre.
- High level sex work services wealthy clients in plush hotels. The sex workers work for agencies, and serve as business escorts in addition to providing sexual services. Clients are generally businessmen.

Young Men who have Sex with Men

According to federal legislation in Serbia, homosexuality was liable for punishment up until 1994, although not a single case of prosecution has ever been recorded. Much animosity and discrimination still exists towards MSM.

Gay activism was non-existent in Serbia until the break-up of the former Yugoslavia. Gay activism was founded at the same time as the struggles for civil initiatives and human rights. The first Conference on Sexual Minorities was held in Novi Sad in January 2000, attended by representatives from various nations. The Conference proceeded without any incident unlike the Gay Parade in June 2001. During the Parade, many participants were brutally attacked. Discrimination, severe threats and physical perils are still very common at most organised gatherings.

Risk and Protective Behaviours

Drug Users

Table 41 provides a breakdown of the number of participants by group and data collection method. Questionnaires were administered to 464 drug users and injecting drug users. Interviews were conducted with 142 drug users/injecting drug users and a total of 147 drug users/injecting drug users participated in 16 focus groups.

TABLE 41

Group	Questionnaires	Interviews	Focus Groups
DRUG USERS	138	142	147
INJECTING DRUG USERS	326		
Service Providers		170	107
Policy Makers / Community Leaders		24	50
Other		38	103
TOTAL:	464	374	407

Note 1: Only questionnaires completed by young people between the ages of 10 and 24 years were included.
Note 2: Conducted 16 focus groups with drug users and injecting drug users.
Note 3: Conducted 6 focus groups with service providers.
Note 4: "Other" includes prisoners, students, journalists, teachers, club owners, parents, etc.
Note 5: Completed observations at cafes, parks, public toilets, parties, streets, etc.

Psychology-pedagogy staff (i.e. counsellors) at secondary schools reported the following:

- Marked aggression among young people;
- Cannabis use is increasing;
- Age of onset of sexual activity is decreasing and protection (i.e. use of condoms) is almost never used;
- Cooperation between parents and teachers is almost non-existent.

Young people used drugs for many reasons:

- Sense of emptiness;
- Boredom;
- Feeling that life makes no sense;
- Liberation from constant anxiety and tension;
- Positive group dynamics;
- Sense of acceptance;
- Partying without alcohol or drugs cannot be fun;
- "common cause".

Many young people use alcohol and cannabis during their everyday outings and weekend fun at cafes. Cannabis is often the first drug used. On average, the move to harder drugs usually occurs between one and three years after the initial use of cannabis. Reasons for taking harder drugs include the following:

- Fear of "cold turkey withdrawal" or "entering paranoia";
- Diminishing effects with cannabis;
- Urge to explore other states of consciousness.

Very seldom does a young person perceive herself/himself as ever having a drug problem.

There are no regular meeting places for drug users. A group of hard core drug users will often gather at one person's apartment and wait for the dealer to bring the drugs or gather at the dealer's place to purchase the drugs first. Usually the price of drugs drops considerably if a large quantity is purchased. For this reason, drug users often pool their money together to purchase drugs.

Usually wealthy individuals use cocaine, although others will often use cocaine during major celebrations such as the New Year since it is usually cheaper and more readily accessible.

Table 42 gives a breakdown of the different types of drugs and their costs.

TABLE 42

Drug	Unit	Price per Unit (DM)*	Comment
Cannabis	1 gram	1.5 to 2	Domestically grown or imported from Albania.
Heroin	_ gram	15 to 20	Either swallowed, snorted or injected.
	_ gram	30	
	1 gram	60	
	5 grams	200	
Cocaine	1 gram	70 to 120	Often consumed by wealthy individuals.
Ecstasy	1 tablet	10 to 15	Often distributed at rave parties.
Opium Poppy Tea	1 small bag	10 to 15	
Methadone	20 tablets	70 to 90	Substitution for heroin

* 1 DM = 0.511292 EUR

To snort heroin, a new banknote is rolled into a pipe then inserted into the nasal cavity. Due to its sharp edges, the new banknote may cause bleeding in the nasal cavity. If this blood-tainted banknote is then used by another individual, this could be a mode of transmission for HIV.

Benzodiazapines, Trodon and anti-Parkinson medications are sold in private pharmacies. Since the sale of these drugs is not regulated by the Law on Psychoactive Drugs Trafficking, the private pharmacies have used this loophole to sell these drugs without prescription. These drugs are often consumed with alcohol or cannabis.

Many young rave partygoers, in states of unaltered consciousness, have sexual intercourse often without using condoms.

According to drug addicts, there is nothing that one perceives in reality that is more valuable than drugs and absolutely nothing can replace drugs. Often one's entire life cycle and daily rhythm is tightly interconnected with using drugs. As one drug addict stated, "I have no alternative to drugs".

Questionnaire Results - Drug Users

The questionnaire was administered to 138 drug users, 85 males and 51 females (Table 41). Gender was unknown for two respondents. The following provides a summary of the descriptive data based on the core questions from the questionnaire (n = 138).[39],[40].

- Mean age was 20.3 years.
- Mean age when first used drugs was 16.2 years.
- 94.9% had sexual intercourse.
- 69.6% thought that they were at risk of HIV or other STIs.
- 34.0% had been tested for HIV.

In the past month, the following drugs had been used:

- Cannabis 81.2% of respondents;
- Alcohol. 73.2%;
- Ecstasy 42.8%;
- Heroin 26.8%;
- Analgesics 23.9%.
- 79.7% used two or more drugs at the same time.

39. Drug users who injected drugs were not included.
40. Percentages were calculated using n=138 as the denominator unless noted otherwise.

- 80.4% had sex under the influence of drugs.

Of those who had sexual intercourse (n=131):

- Mean age at first sexual intercourse was 18.5 years;
- 2.3% had no sexual partners in the past year;
- 20.6% had one sexual partner in the past year;.
- 42.0% had between 2 and 5 sexual partners in the past year;
- 23.7% "always" used condoms during sex;
- 75.6% "sometimes" or "never" used condoms during sex;
- 13.0% had sex in return for money, drugs, etc.

Reasons for not "always" using condoms during sex:

- Trust in partners;
- Do not like sex with condoms;
- Difficult to use.

Where to access information about HIV or other STIs:

- Friends or peers;
- Media;
- Family.

Injecting Drug Users

The choice to begin injecting drugs is often connected to an idol, close friend or acquaintance, and it is usually a close friend or an acquaintance who introduces the young person to the ritual of injecting drugs.

Preparing the drug for injecting may be a source of HIV transmission. Furthermore, the steps involved in drug preparation are alarmingly unhygienic.

Heroin is boiled with tap water in a common spoon. Boiling of the drug in a dirty bottle cap was also observed. The boiled drug is then filtered through a cotton ball with a shared needle into a shared gun and then into other syringes. The cotton balls are not wasted. They are routinely stored in a box. At a time when there is no drug available, these stored cotton balls are boiled again in an attempt to drain the last droplets of heroin out. To clean drug injecting equipment, it is either boiled in water, rinsed with alcohol, bleach or dish washing liquid.

(RAR Report for Serbia, 2002)

Insulin syringes are seldom sold in pharmacies.

Questionnaire Results - Injecting Drug Users

The 326 questionnaires were administered to 228 males and 98 females (Table 41). The following provides a summary of the descriptive data based on the core questions from the questionnaire (n = 326).[41]

- Mean age was 21.4 years.
- Mean age when first used drugs was 15.7 years.
- Mean age when first injected drugs was 18.2 years.
- 97.5% had sexual intercourse.
- 81.9% thought that they were at risk of HIV or other STIs.
- 56.7% had been tested for HIV.

In the past month, the following drugs had been used:

- Cannabis 81.9% of respondents;
- Heroin 81.9%;
- Alcohol 77.3%;
- Analgesics 49.1%;
- Diazepam 43.9%;
- Ecstasy 34.4%.
- 57.0% shared drug-injecting equipment.
- 92.0% used two or more drugs at the same time.
- 95.1% had sex under the influence of drugs.

Of those who had sexual intercourse (n=318):

- Mean age at first sexual intercourse was 15.6 years;
- 1.2% had no sexual partners in the past year;
- 16.0% had one sexual partner in the past year;

41. Percentages were calculated using n=326 as the denominator unless noted otherwise.

- 51.2% had between 2 and 5 sexual partners in the past year;
- 14.8% "always" used condoms during sex;
- 84.3% "sometimes" or "never" used condoms during sex;
- 13.8% had sex in return for money, drugs, etc.

Reasons for not "always" using condoms during sex:

- Do not like sex with condoms;
- Trust in partners;
- Condoms are too expensive to purchase.

Where to access information about HIV or other STIs:

- Media;
- Friends or peers;
- Family.

Young Men who have Sex with Men

Table 43 provides a breakdown of the number of participants by group and data collection method. Questionnaires were administered to 299 young MSM. Interviews were conducted with 94 young MSM and a total of 100 young MSM participated in 25 focus groups.

TABLE 43

Group	Questionnaires	Interviews	Focus Groups
Young MSM	299	94	100
Service Providers		49	10
Policy Makers / Community Leaders		1	
TOTAL:	299	144	110

Note 1: Only questionnaires completed by young people between the ages of 10 and 24 years were included.
Note 2: In Belgrade, the Field Team also interviewed 113 young MSM via the Internet <www.gay-serbia.com>. This figure is not included in the above table.
Note 3: Conducted 25 focus groups with young MSM.
Note 4: Conducted 2 focus groups with service providers.
Note 5: Completed observations at cafes, parks, public toilets, parties, streets, etc.

Many of the participants had still not informed their parents of their sexual orientation. They were apprehensive of their parents' potential aggressive reaction. Those participants who had informed their parents of their sexual orientation, claimed that their parents' acceptance was merely verbal as evidenced by their lack of willingness to communicate on the issue. One third of the participants had informed their heterosexual friends of their sexual orientation. In turn, their friends, particularly their female friends, had responded in a positive manner. Among heterosexual females, it is often considered cool to have a gay friend.

Participants often described their mothers as the dominant individual whereas their fathers were the negative or passive individuals.

The first sexual partner was usually the same age or slightly older. He was often a neighbour or an Internet acquaintance. Condoms were rarely used unless the partner insists.

More than half of the participants stated that they were in a steady relationship. Even so, in addition to their steady partner, they had had five to seven different sexual partners in the past year. Internet chat and personal web pages were the most popular methods of meeting sexual acquaintances. Other methods included friends' recommendations, and frequenting parks and other gay hangouts. Those who frequented parks and public lavatories to meet other young MSM to engage in quick anonymous sexual intercourse were often less educated and from lower socio-economic levels. These young MSM had between three and five different sexual partners per week.

Usually both anal and oral sex were performed during a sexual encounter. Very few engaged in only oral sex. Approximately one third of participants ejaculated in their partners' mouths during oral sex. Almost no one used condoms during oral sex. All HIV positive men used condoms during anal sex.

Very few participants could distinguish the difference between condoms that are used for anal sex and those that are used for oral sex. Most purchase the cheaper thinner condoms. The price of Durex Extra Safe condoms is between 95 dinars (1.5 EUR) and 105 dinars (1.7 EUR) whereas the thinner condoms are 28 dinars (0.4 EUR). Oil-based lubricants are often used since water-based lubricants are not available in Serbia.

Questionnaire Results - Young Men who have Sex with Men

The questionnaire was administered to 299 young MSM. The following provides a summary of the descriptive data based on the core questions from the questionnaire

(n = 299).[42]

- Mean age was 21.0 years.
- 31.1% had used drugs.
- Mean age when first used drugs was 16.2 years.
- 67.9% had sexual intercourse.
- 75.6% thought that they were at risk of HIV or other STIs.
- 40.8% had been tested for HIV.

Of those who used drugs (n=93), the following drugs were used in the past month:

- Alcohol 84.9% of respondents;
- Cannabis 75.3%;
- Ecstasy 29.0%;
- Analgesics 15.1%;
- Diazepam 14.0%.

Of those who used drugs (n=93):

- 17.2% had injected drugs;
- Mean age when first injected drugs was 17.2 years.
- Of those who injected drugs (n=16), 43.8% shared drug-injecting equipment;
- 60.2% used two or more drugs at the same time;
- 62.4% had sex under the influence of drugs.

Of those who had sexual intercourse (n=203):

- Mean age at first sexual intercourse was 16.5 years;
- 3.4% had no sexual partners in the past year;
- 12.8% had one sexual partner in the past year;
- 37.9% had between 2 and 5 sexual partners in the past year;
- 18.7% had between 6 and 10 sexual partners in the past year;
- 7.9% had more than 10 sexual partners in the past year;
- 61.1% “always” used condoms during sex;
- 86.2% “sometimes” or “never” used condoms during sex;
- 19.2% had sex in return for money, drugs, etc.

Reasons for not “always” using condoms during sex:

- Do not like sex with condoms;
- Trust in partners;
- Condoms are too expensive to purchase.

Where to access information about HIV or other STIs:

- Media;
- Friends or peers;
- School.

42. Percentages were calculated using n=299 as the denominator unless noted otherwise.

Sex Workers

Table 44 provides a breakdown of the number of participants by group and data collection method. Questionnaires were administered to 116 sex workers. Interviews were conducted with 25 sex workers and a total of 36 sex workers participated in focus groups.

TABLE 44

Group	Questionnaires	Interviews	Focus Groups
SEX WORKERS	116	25	36
Service Providers		13	8
Policy Makers / Community Leaders		1	24
Other		9	27
TOTAL:	116	48	95

Note 1: Only questionnaires completed by young people between the ages of 10 and 24 years were included.
Note 2: Conducted 14 focus groups with sex workers, service providers, and others.
Note 3: "Other" includes prisoners, students, journalists, teachers, club owners, parents, etc.
Note 4: Completed observations at cafes, parks, public toilets, parties, streets, etc.

Female participants stated that they were indifferent to having male and female sexual clients whereas male participants made a distinction between having only male sexual clients or both. All participants noted that they rarely kissed their clients. The number of clients varied from 12 clients per week to 5 to 10 clients per day.

Sex workers could be categorised according to their sexual behaviour and risk of HIV infection:

- Female sex workers who are addicted to drugs exchange sex for money. The money is then used to purchase drugs. Often these sex workers do not use condoms during sex.
- Roma sex workers, unaware of risk behaviours, often agree to have sex without condoms if their clients are willing to pay more for it.
- Sex workers who sometimes use condoms.
- Male sex workers who are on "top" are more concerned about using condoms during sex than male sex workers who are on the "bottom".
- Sex workers who are aware of risk behaviours and are working to support their families use condoms most of the time.

Questionnaire Results - Sex Workers

The 116 questionnaires were administered to 12 males and 104 females. The following provides a summary of the descriptive data based on the core questions from the questionnaire (n = 116).[43]

- Mean age was 21.1 years.
- 56.9% used drugs.
- Mean age when first used drugs was 16.7 years.
- All had sexual intercourse.
- 75.9% thought that they were at risk of HIV or other STIs.
- 50.9% had been tested for HIV.

Of those who used drugs (n=66), the following drugs had been used in the past month:

- Alcohol 89.4% of respondents;
- Cannabis 86.4%;
- Heroin 51.5%;
- Ecstasy 40.9%;
- Analgesics 37.9%.

Of those who used drugs (n=66):

- 39.4% had injected drugs;
- Mean age when first injected drugs was 17.2 years.
- Of those who injected drugs (n=26), 84.6% shared drug-injecting equipment;

43. Percentages were calculated using n=116 as the denominator unless noted otherwise.

- 86.4% used two or more drugs at the same time;
- All had sexual intercourse;
- 98.5% had sex under the influence of drugs.

Of those who had sexual intercourse (n=116):

- Mean age at first sexual intercourse was 15.4 years;
- 9.5% had a sexual partner in the past year;
- 9.5% had between 6 and 10 sexual partners in the past year;
- 2.6% had between 11 and 19 sexual partners in the past year;
- 60.3% had 100 or more sexual partners in the past year;
- 60.3% “always” used condoms during sex;
- 39.6% “sometimes” or “never” used condoms during sex;
- 96.6% had sex in return for money, drugs, etc.

Reasons for not “always” using condoms during sex:

- Clients pay more for sex without using condoms;
- Condoms are too expensive to purchase;
- Trust in partners.

Where to access information about HIV or other STIs:

- Media;
- Friends or peers;
- Social or health workers.

Health and Social Consequences

Years of living under stress and in a trauma-ridden environment have brought about depression, a sense of hopelessness, confused values, distrust in what the future holds, and a general negligence towards one’s health.

Drug Users

Most drug users reported feeling stigmatised and rejected by society, family, friends, and by the health care system that is expected to provide them with treatment and care. Only other drug users understood them. Many reported that during a crisis they would not know to whom to turn.

Depression, anxiety, lack of concentration, impaired nervous system, and constant fears all contribute to drug addicts being strung out on a permanent craving for drugs, which, in turn, causes them to live alone and scrounge for money. Furthermore, more than half of the participants had engaged in crime to gain money for their drugs.

Participants reported that medical staff often treated them as crooks or law offenders who have only themselves to blame for their predicament.

Twelve participants, who had used LSD, had had flashbacks. Twelve participants, who had used Trodon, had suffered epileptic fits. More than one third of participants had experienced drug overdoses.

Heroin addicts, who were not in permanent relationships, did not have several sexual partners. Their decreased sexual urge is most likely to be attributable to depression.

Young Men who have Sex with Men

Most participants consider themselves stigmatised by society and can sense various degrees of homophobia. This stigmatisation can lead to anxiety and depression.

Young MSM fear that their sexual orientation will be exposed or that they will be stigmatised if they seek health care. For this reason, they seek help from private physicians, especially gay-friendly physicians, with the expectation that their sexual orientation will be kept confidential.

Many have serious doubts about the anonymity of HIV testing.

Sex Workers

Female sex workers take care of their health and appearance while male sex workers exercise to keep their bodies looking fit. All participants claimed to be well informed about STIs.

Some participants stated that they have been incarcerated overnight by the City Police and released once they've paid the mandatory fine. A few participants stated that the police sexually abused them while in jail.

Most would like STI and HIV testing to be more accessible.

Existing Interventions

Ten years of conflict and imposed sanctions have left most of the health facilities in Serbia in poor condition. Drugs and medical supplies have been difficult to procure and provide to patients.

Of the participants who had been treated at the Institute for Addictive Diseases, ALL have reported negative experiences at the Institute:

- Unfair rules as to who is admitted or not admitted for treatment;
- Communication with physicians and nurses is perceived to be cold and official;
- Patients are made to feel like discarded members of society rather than human beings with drug problems to treat;
- Low physician to patient ratio which can compromise the quality of treatment;
- If a patient is caught using drugs, he/she is discharged from the Institute and cannot be re-admitted for at least another six months;
- Methadone dosages are incorrectly prescribed;
- Sexual intercourse does take place in the Institute. No condoms are, however, available.

Participants did, however, praise Dr Vesna Fridman as the only professional at the Institute who works hard and with enthusiasm. Unfortunately, Dr. Fridman has left the Institute.

Table 45 lists some of the organisations and/or NGOs that provide HIV/AIDS support services to vulnerable young people.

TABLE 45

Organisation	Methadone Therapy	Education Or Support
Institute for Addiction Diseases (1)	✓	✓
St. Sava High School (2)		✓
13th Gymnasium – Group 484 (3)		✓
GOD (Generation Answers to Drugs)		✓
ALEXO (4)		✓
Belgrade Open Club (5)		✓

(6) Methadone therapy is only available to persons living with HIV/AIDS who abuse drugs, or to persons who have abused drugs for more than 15 years.

(7) Project "Talking Makes Us Happy"

(8) Project "Escape to Dead-End Street". Addiction Prevention Programme in the form of workshops.

(9) Increase awareness and support for social justice and medical protection for persons living with HIV/AIDS.

(10) An Internet counselling service www.savetovaliste.org.yu.

Additional prevention measures (e.g. education of teachers by the Ministry of Interior Officers, various forms of peer education, lectures by JAZAS Youth, etc.) are often sporadic and uncoordinated. Most often, the teachers or school services initiate the request for prevention education themselves.

Heroin addiction has ruined the careers of many rock musicians. Many of the musicians are interested in participating in prevention activities, although they do not know where to start. They require assistance with organising and coordinating prevention activities.

Presently, there are no targeted interventions for young MSM or sex workers. Hopefully, the RAR findings will provide opportunities to develop and implement interventions for these vulnerable groups.

Recommendations

The recommendations below are based on the data collected for this RAR Project through questionnaires, interviews, focus groups, existing information, observations and mapping. The recommendations were developed from the key findings that emerged from the analysis of the collected data.

Table 46 provides a summary of the recommendations for interventions that were outlined in the RAR Report for Serbia, 2002. They are presented according to the various vulnerable target groups.

TABLE 46

Recommendations for Drug Users

- Develop and deliver education to young people. Use peer education.
- Develop and deliver education to teachers and counselling staff to help them recognise the problem of drug use in young people.
- Develop and deliver education to journalists to help them understand drug addictions so that they will report more accurately with less sensationalism.
- Develop and implement HIV/AIDS awareness campaigns throughout the year.
- Coordinate the efforts of the various Ministries (Health, Education and Interior) to develop a long-term plan for prevention programmes.
- Improve communications with the police regarding the disclosure of information about drug trafficking routes.
- Improve access to health care for drug users.
- Install condom vending machines in various downtown places.
- Introduce and enforce more severe fines to pharmacists who sell non-prescribed drugs.
- Develop and implement standardised therapy protocols for the treatment of drug addictions.
- Establish counselling clinic services for drug addicts and their families.
- Establish rehabilitation centres for drug addicts.
- Coordinate the efforts of the police, the Narco-Centre services, and the Social Work Centre.
- Improve access and availability of needles and syringes.

Recommendations for Young Men who have Sex with Men

- Introduce and adopt laws to eliminate discrimination that is based on faith, ethnicity and sexual orientation.
- Eliminate all negative references to homosexuality from textbooks and the media.
- Develop and implement HIV/AIDS awareness campaigns throughout the year.
- Develop and implement a media campaign to encourage tolerance and appreciation of diversities.
- Establish counselling services.
- Establish a support group for parents of gay children.
- Establish an SOS phone service network to provide support to those in crises.
- Install condom vending machines in hot spot areas.
- Ensure anonymous HIV testing.
- Develop and deliver education to health care professionals to sensitise them to the issues and concerns of the gay community.

Sex Workers

- Develop strategies to access sex workers.
- Develop and deliver education to sex workers about risk behaviours and HIV/AIDS.
- Explore the decriminalisation then legalisation of prostitution.
- Explore the feasibility of registering escort and sexual service agencies.

MONTENEGRO

Montenegro has not been in conflict with another country since the break-up of the former Yugoslavia. Nonetheless, there have been changes to the political and economic systems over the past ten years that have influenced living conditions in Montenegro.

- Conflicts in the Balkans;
- Increasing numbers of refugees and displaced persons;
- Emigration of many young experts;
- Economic isolation and deterioration;
- Loss of faith in the family system;
- Poor educational system;
- Increasing crime;
- Trafficking in drugs and human beings.

Visa requirements have been relaxed to enter Montenegro. It is possible to move easily into and out of Montenegro and most passport holders can obtain visas at the border. During the tourist season, there are more than 200,000 visitors to Montenegro, some of who may have an indirect negative influence on young people living in Montenegro (e.g. in summer 2000, one tourist was found to be in possession of ecstasy pills).

The open borders facilitate illegal entry into Montenegro. Montenegro is a transit point for trafficking in drugs and humans, although it is not known whether any of these drugs stay in Montenegro.

Presently, the ruling parties are pro-independence and pro-European. Their policies orientate towards a capitalist system and the development of private property. The economy is orientated towards tourism, trade, shipbuilding, naval transportation and agriculture, and towards small and mid size businesses.

HIV/AIDS in Montenegro

There is no effective mechanism at present for reporting on both HIV and AIDS in FRY. AIDS cases are reported for the whole of FRY. The database on reported AIDS cases is kept separate from the data on the reported HIV cases.

The first AIDS case was reported in Montenegro in 1989. Since 1989 there has been a cumulative total of 42 reported AIDS cases, of which 19 (45%) have died.

Presently, there are 12 reported AIDS cases and 12 HIV cases. Most of these people are sailors, otherwise they work in tourism or catering.

It is estimated that there are between 100 and 400 HIV cases in Montenegro.

UNICEF RAR Project in Montenegro

Dr Boban Mugosa was the Republic Coordinator for the RAR Project in Montenegro. He oversaw the overall planning, development and implementation of the RAR Project in two cities, Bar and Podgorica. Dr Andja Backovic was the RAR Advisor for the RAR Project in Montenegro.

Table 47 lists the vulnerable target groups studied in each city, and the Local Field Coordinators.

TABLE 47

City	Target Group(s)	Local Field Coordinator
Bar	Young People, Sailors	Dr Ljiljana Jovicevic
Podgorica	Young People, Drug Users*	Ms Natasa Terzic

* Drug users included injecting drug users.

Reasons for the Selection of Cities and Vulnerable Target Groups

Table 48 lists some of the reasons why certain cities and target groups were selected.

TABLE 48

City	Target Group(s)	Reason(s) for Selection
Bar	Young People Sailors	Young people have carefree attitudes about drugs and sex. Bar has a port, and sailors represent more than 10% of reported HIV/AIDS cases. .
Podgorica	Young People Drug Users*	Capital city. Young people have carefree attitudes about drugs and sex, and many of them are using drugs.

* Drug users included injecting drug users.

Context

Young People

The basic institutions of society, school and family have lost their traditional importance. The weakened institutions of family and school and distorted value systems are major obstacles for young people trying to form a healthy self-identity in the process of socialisation.

The living motto for many young people has become “live fast, try everything and take risks”, which has led to the earlier onset of sexual experiences, more liberal sexual behaviours and an increase in the use of drugs.

Drug Users

The latest research findings (2001) indicate the following:

- Increase in drug use among young people;
- Decrease in age when drugs are first used;
- New types of drug are on the market.

Drug use among young people is spreading towards middle class families. Young people in the senior grades of elementary school are beginning to use drugs.

It is known that Montenegro is a transit country for trafficking in drugs, although it is not known whether any of these drugs stay in Montenegro.

Sailors

The typical lifestyle of a sailor makes him potentially vulnerable to HIV infection. When away from home for several months, sailors often visit brothels, have different sexual partners, and use alcohol and other drugs.

Risk and Protective Behaviours

TABLE 49

Group	Questionnaires	Interviews	Focus Groups
Young People who USE DRUGS	47	4	13
Young People who INJECT DRUGS	9		
Young People who DO NOT USE DRUGS	270	12	54
SAILORS	50	4	26
Service Providers		20	
Policy Makers / Community Leaders		4	
TOTAL:	376	44	93

Note 1: Only questionnaires completed by young people between the ages of 10 and 24 years were included.
Note 2: Conducted 3 focus groups with young people who use drugs/inject drugs.
Note 3: Conducted 7 focus groups with young people who do not use drugs.
Note 4: Conducted 2 focus groups with sailors and one focus group with hostesses aboard ships.
Note 5: Completed over 40 observations at schools, cafes, night clubs, bars and parks.

Young People who USE DRUGS

Table 49 provides a breakdown of the number of participants by group and data collection method. Questionnaires were administered to 47 young people who use drugs. Interviews were conducted with four young people who use/inject drugs, and a total of 13 young people who use/inject drugs participated in 3 focus groups.

Young people were often unaware of the passive social pressure to use drugs as evidenced by such statements as “everyone tried it” or “most young people are using drugs”. Drugs were initially received as a present. Providing drugs for another person was understood as an expression of “solidarity”. The initial use of drugs was not due to peer pressure but due to “solidarity” within the group and the curiosity to experience something new.

Young people used drugs to help overcome unpleasant realities.

The participants did not feel that using cannabis would damage their health or lead to the use of harder drugs. Cannabis is easily accessible. It is sold on the streets, in cafes and around schools. Cannabis is often consumed in public places, although as drug use becomes more severe (e.g. using heroin), the most common place for using drugs is the home. It usually takes about two years to go from using cannabis to heroin.

Other light tranquillisers are available from pharmacies.

Many of the participants felt that drug use led to an earlier onset of sexual intercourse. Alcohol was a must at parties and celebrations to help with relaxation. Sexual intercourse under the influence of drugs was better but riskier. Most of the male participants only had short relationships with sexual partners. The steady girlfriend was usually not the most frequent sexual partner.

Participants reported that they could recognise a “safe” partner by his/her tidy looks. Most did not use condoms with their steady partner or their “safe” partner. If a condom was used, it was usually for the purpose of contraception rather than for protection against STIs.

Condoms were not openly discussed and were often not used because of shame. They can be purchased at pharmacies.

Questionnaire Results - Young People who use drugs

The questionnaire was administered to 47 young people who use drugs, 35 males and 12 females. The following provides a summary of the descriptive data based on the core questions from the questionnaire (n = 47).[44,45]

- Mean age was 19.7 years.
- Mean age when first used drugs was 16.3 years.
- 91.5% had sexual intercourse.
- 44.7% thought that they were at risk of HIV or other STIs.
- 8.5% had been tested for HIV.

In the past month, the following drugs had been used:

- alcohol 74.5% of respondents;
- cannabis 66.0%;
- diazepam 21.3%;
- analgesics 8.5%.
- 59.6% used two or more drugs at the same time.
- 66.0% had sex under the influence of drugs.

Of those who had sexual intercourse (n=43):

- Mean age at first sexual intercourse was 15.9 years;
- 20.9% had one sexual partner in the past year;
- 65.1% had between 2 and 5 sexual partners in the past year;
- 25.6% “always” used condoms during sex;
- 72.1% “sometimes” or “never” used condoms during sex;
- 14.0% had sex in return for money, drugs, etc.

Reasons for not “always” using condoms during sex:

- Do not like sex with condoms;
- Trust in partners;
- Difficult to use.

Where to access information about HIV or other STIs:

- Friends or peers;
- Media;
- Family.

Questionnaire Results - Young People who inject drugs

The questionnaire was administered to nine young people who inject drugs, eight males and one female. The following provides a summary of the descriptive data based on the core questions from the questionnaire (n = 9).[46]

- Mean age was 18.9 years.
- Mean age when first used drugs was 15.3 years.
- Mean age when first injected drugs was 17.3 years.
- 88.9% had sexual intercourse.
- 55.6% thought that they were at risk of HIV or other STIs.
- 55.6% had been tested for HIV.

In the past month, the following drugs had been used:

- Cannabis 77.8%;
- Alcohol 55.6%;
- Cocaine 55.6%;
- Heroin 44.4%;
- Diazepam 33.3%;
- Ecstasy 33.3%.
- 66.7% shared drug-injecting equipment.
- All used two or more drugs at the same time.
- 88.9% had sex under the influence of drugs.

Of those who had sexual intercourse (n=8):

- Mean age at first sexual intercourse was 15.3 years;
- 66.7% had between 2 and 5 sexual partners in the past year;
- 12.5% “always” used condoms during sex;
- 77.8% “sometimes” or “never” used condoms during sex;
- 33.3% had sex in return for money, drugs, etc.

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44. Young people who inject drugs were not included.
45. Percentages were calculated using n=47 as the denominator unless noted otherwise.
46. Percentages were calculated using n=9 as the denominator unless noted otherwise.

Reasons for not "always" using condoms during sex:

- Condoms are expensive to purchase;
- Do not like sex with condoms;
- Condoms are not easily available.

Where to access information about HIV or other STIs:

- STI counselling services;
- Family;
- Media.

Young People who DO NOT USE DRUGS

Questionnaires were administered to 270 young people who do not use drugs (Table 49). Interviews were conducted with 12 of these young people and a total of 54 young people who do not use drugs participated in seven focus groups.

The participants reported that the most common reason for the first experience of sexual intercourse was a desire to maintain the relationship. Two to three weeks after their first meeting, the elder partner would insist on sexual intercourse as a condition for maintaining the relationship. Young females were more exposed to such pressures than young males.

Questionnaire Results - Young People who do not use drugs

The 270 questionnaires were administered to 127 males and 143 females. The following provides a summary of the descriptive data based on the core questions from the questionnaire (n = 270).[47]

- Mean age was 17.7 years.
- 35.2% had sexual intercourse.
- 38.9% thought that they were at risk of HIV or other STIs.
- 1.1% had been tested for HIV.

Of those who had sexual intercourse (n=95):

- Mean age at first sexual intercourse was 16.1 years;
- 46.3% had one sexual partner in the past year;
- 40.0% had between 2 and 5 sexual partners in the past year;
- 50.5% "always" used condoms during sex;
- 50.5% "sometimes" or "never" used condoms during sex;
- 7.3% had sex in return for money, drugs, etc.

Reasons for not "always" using condoms during sex:

- Trust in partners;
- Do not like sex with condoms;
- Embarrassed to ask partners to use condoms.

Where to access information about HIV or other STIs:

- Media;
- Friends or peers;
- Family.

SAILORS

Questionnaires were administered to 50 sailors (Table 49). Interviews were conducted with four sailors and a total of 26 sailors/hostesses participated in 3 focus groups.

Sailors reported that they were more afraid of malaria than AIDS. The STI/HIV/AIDS information that they received in their regular studies was inadequate. Before boarding ship, sailors would have liked more information on STI/HIV/AIDS.

There was a sense that the majority of sailors use alcohol and drugs due to boredom. Most thought that it would be easy to stop using cannabis. Furthermore, many considered cannabis a light drug.

Questionnaire Results - Sailors

The 50 questionnaires were administered 42 males and eight females. The following provides a summary of the descriptive data based on the core questions from the questionnaire (n = 50). [48]

47. Percentages were calculated using n=270 as the denominator unless noted otherwise.

- Mean age was 20.2 years.
- 28.0% had used drugs.
- Mean age when first used drugs was 17.6 years.
- 80.0% had sexual intercourse.
- 50.0% thought that they were at risk of HIV or other STIs.
- 6.0% had been tested for HIV.

Of those who used drugs (n=14), the following drugs had been used in the past month:

- Alcohol 92.8%;
- Cannabis 92.8%;
- Cocaine 14.3%.

Of those who used drugs (n=14):

- None had injected drugs;
- 42.8% used two or more drugs at the same time;
- 35.7% had sex under the influence of drugs.

Of those who had sexual intercourse (n=40):

- Mean age at first sexual intercourse was 17.0 years;
- 47.5% had one sexual partner in the past year;
- 42.5% had between 2 and 5 sexual partners in the past year;
- 36.6% “always” used condoms during sex;
- 63.4% “sometimes” or “never” used condoms during sex;
- 10.0% had sex in return for money, drugs, etc.

Reasons for not “always” using condoms during sex:

- Do not like sex with condoms;
- Trust in partners.

Where to access information about HIV or other STIs:

- Media;
- Friends or peers;
- Family.

Health and Social Consequences

Most young people are living recklessly. There is a culture of going out late and staying out until dawn.

Drug addiction is viewed as a “family problem” and thus as the problem of drug abuse worsens there is a tendency to keep the problem within the home instead of seeking treatment.

There has been an increase in the number of Hepatitis B and Hepatitis C cases. It is, however, difficult to determine whether this increase is due to better diagnosis or an actual increase in the number of cases.

Existing Interventions

The programmes about young people’s health that have been adopted by the government ministries have not been consistent. The Ministry of Health adopted the document entitled “Health Policy in the Republic of Montenegro till Year 2002” which requires schools to introduce programmes that advocate healthy lifestyles. The Ministry of Education and Science adopted a document entitled the “Book for Changes”, but there is “not a single word” in it that advocates health lifestyles for young people.

The main obstacles to accessing health care services include:

- Lack of discretion;
- Long waiting lines;
- Mistrust;
- “Resentment” of health care professionals to the problems of drug addiction and HIV/AIDS

In 2001, the government adopted the Programme for the Prevention of Addiction-Related Illnesses that will treat addiction-related illnesses as the “number one enemy of young people’s health”. Since the formal adoption of this Programme, not much has been done in terms of actual implementation.

Health services for young people in the fields of reproductive and mental health are inaccessible and insufficient. Furthermore, there is a lack of interest in the community to address the reproductive and

48. Percentages were calculated using n=50 as the denominator unless noted otherwise.

mental health problems of young people. There is also a lack of available health care services that address the issues of drugs and HIV/AIDS. Hospitals do not offer adequate treatment for drug users. There are no harm reduction programmes operating. Neither anonymous HIV testing nor pre- and post-test counselling is available.

Injecting drug users can purchase needles and syringes in pharmacies without a prescription.

Table 50 lists some of the organisations and/or NGOs that provide HIV/AIDS support services to vulnerable young people.

TABLE 50

Organisation	Education Or Support
Primary Schools (1)	✓
Red Cross (2)	✓
CAZAS (3)	✓

(11) Drug and HIV/AIDS prevention programmes exist in primary schools, but not in high schools or faculties. In high schools and faculties, one-off lectures may be offered.

(12) The Red Cross has programmes for the prevention of drug use and HIV/AIDS, and for reproductive health. These are peer education programmes.

(13) CAZAS (Montenegrin Association for Fight Against AIDS) provides peer education in high schools.

Over the past two years, the number of NGOs in Podgorica has significantly increased, although very few of the NGOs provide support services targeted at young people. Drug and HIV/AIDS education in the schools is poor. The media does deliver information about drugs and HIV/AIDS, but in a sensational manner that lacks accurate relevant information.

Recommendations

The recommendations below are based on the data collected for this RAR Project through questionnaires, interviews, focus groups, existing information, observations and mapping. They have been developed from the key findings that emerged from the analysis of the project data.

Table 51 summarises the recommendations for interventions that are outlined in the RAR Report for Montenegro, 2002. They are presented at three levels, individual, local community, and national.

TABLE 51

Recommendations at the Individual Level

- Incorporate education about STIs and drug use in the school curriculum.
- Deliver lectures on HIV/AIDS, STIs and drugs throughout the school year.
- Deliver HIV/AIDS, drug and sex education to parents and teachers.
- Develop and implement peer education programmes in schools.

Recommendations at the Local Community Level

- Develop and implement a media campaign to increase awareness about HIV/AIDS and drug use
- Establish a counselling centre for young people that will address the issues of reproductive health, healthy lifestyles, STIs, HIV/AIDS, psychosocial support and prevention of drug addictions.
- Assist in the creation of family associations.
- Assist local NGOs in the development of prevention programmes and awareness campaigns.
- Install condom vending machines at venues frequented by young people (e.g. disco clubs, bars, pedestrian zones, boats, etc.).
- Organise ambulances in marine centres so that they can provide services to sailors prior to departure and on arrival by ship.
- Distribute condoms aboard ships via pharmacies.
- Increase accessibility to sports and culture by developing and implementing after-school activities for young people.

Recommendations at the National Level

- Develop an HIV/AIDS national plan.
- Increase monitoring of private pharmacies with regard to the sale of narcotics and the dispensing of narcotics without a physician's prescription.
- Improve HIV/AIDS surveillance activities by establishing registries in medical institutions for drug addicts and for persons living with HIV/AIDS.
- Increase accessibility to free anonymous HIV testing.
- Establish institutions that specialise in the treatment of drug addictions.
- Introduce healthy lifestyles as a new subject in the school curriculum.
- Enforce legislation relating to the production, distribution and use of drugs.
- Develop and implement a programme to educate sailors about STIs and drug use.

FORMER YUGOSLAV REPUBLIC OF MACEDONIA

The 1999 Kosovo crisis brought more than 250,000 refugees to FYR Macedonia, further burdening the country's already fragile economy. The 2001 crisis between ethnic Macedonians and the Albanian minority created social, political and economic disruption. There are still military troops present in the country. The current political situation and economic circumstances give rise to violence, sexual abuse, promiscuity and drug use.

Some socio-economic facts about FYR Macedonia:

- Unemployment is high (41.7% in 1997);
- Most of the unemployed are under the age of 30 years;
- Many people work in the grey economy to overcome poverty;
- Average salary is 10,639 denars (175.2 EUR);
- More than 80% of an individual's income is spent on food (2001);
- Much of the talented and highly qualified labour force has left the country.

In 1999/2000, there were 89,775 students enrolled in secondary education. On average, approximately 5% of secondary students withdraw from school.

HIV/AIDS in FYR Macedonia

The first reported AIDS case in FYR Macedonia was in 1989, while the first reported HIV case was in 1987. Since reporting began until 31 December 2001, the cumulative total of reported AIDS cases is 43, whereas the cumulative total for reported HIV cases is 16.

Of these reported HIV/AIDS cases:

- 37 (86%) have died;
- 4 haemophiliacs have been infected with HIV from imported blood products;
- 3 have been infected with HIV by vertical transmission

Heterosexual intercourse remains the main mode of HIV transmission among the adult population. Some male HIV cases with unknown risk factors are suspected to have resulted from men having sex with men.

To date, there has been no national study conducted to establish HIV prevalence in FYR Macedonia.

UNICEF RAR Project in FYR Macedonia

Dr Vesna Velik-Stefanovska was the National Coordinator for the RAR Project in FYR Macedonia. She oversaw the overall planning, development and implementation of the RAR Project in five cities, Skopje, Kumanovo, Strumica, Prilep and Ohrid.

Table 52 lists the vulnerable target groups to be studied in the RAR Project and the Local Field Coordinator for each city.

Vulnerable Target Groups by City

Each of the Local Field Coordinators was assigned to one target group. The assigned target group may be studied in more than one city. The target groups and cities selected for the RAR Project represented the overall mosaic of young people in FYR Macedonia.

The city of Skopje was selected as it is the capital of FYR Macedonia and nearly one third of the country's total population lives there.

Table 53 gives the target groups and the cities in which they were studied.

TABLE 52

Target Group	Local Field Coordinator
Young People in Secondary Schools, aged 14 to 19 years	Dr Vladanka Andreeva
Injecting Drug Users, aged 10 to 24 years	Mr Vanja Dimitrievski
Young MSM or Bisexuals *	
Children and Adolescents deprived of parental care, aged 10 to 18 years	Dr Jaroslav Karadjinski
Juvenile Delinquents in Correctional Institutions, aged 10 to 18 years	Dr Vladimir Mikik

*This target group was included in the RAR Project during data collection and through triangulation and induction, and includes female bisexuals.

TABLE 53

Target Group	Skopje	Kumanovo	Strumica	Prilep	Ohrid
Young People	✓	✓	✓	✓	
Injecting Drug Users	✓	✓	✓		
Young MSM or Bisexuals *	✓				
Deprived of Parental Care	✓				
Juvenile Delinquents	✓			✓	✓

* This target group included female bisexuals.

Reasons for the Selection of Vulnerable Target Groups

Table 54 gives some of the reasons why particular target groups were selected.

TABLE 54

Young People
FYR Macedonia is a country in transition. This has led to a loss of traditional values that, in turn, gives rise to feelings of insecurity and rootlessness among young people. Today's parents are completely preoccupied with economic survival so they spend less quality time with their children.

Injecting Drug Users
Injecting drug users are still heavily stigmatised and discriminated against by both the general public and medical staff. IDUs do not know where to access health care when needed.
Young Men who have Sex with Men or Bisexuals *
Through observations and initial qualitative findings (i.e. triangulation and induction), there was an indicated need to study this target group of young people. The activities of this target group are still very much hidden and take place in closed circles.

Deprived of Parental Care
In institutions, children exchange STI/HIV/AIDS information. The information they exchange is not, however, accurate.

Juvenile Delinquents
Since FYR Macedonia's independence, there has been a steady presence of juvenile delinquency. Due to the struggle for economic survival, many families take part in the black market. Children are often included in these black market activities that, in turn, often lead to juvenile delinquency. Connections between juvenile delinquency, drug use and sexual abuse do exist.

* This target group includes female bisexuals.

Reasons for the Selection of Cities

The cities were selected with the aim of achieving greater coverage and assessment of the selected target groups.

Table 55 gives some additional reasons why certain cities were selected.

TABLE 55

Skopje, Kumanovo, Strumica, and Prilep	Most of the secondary schools are located in these cities: Skopje – 29 schools; Kumanovo – 4 schools; Prilep – 5 schools; and Strumica – 3 schools. There are a total of 96 secondary schools in Macedonia, of which 41 schools participated in the RAR Project.
Skopje, Kumanovo and Strumica	Many of the injecting drug users live in these cities.
Skopje	The institutions for children deprived of parental care are located in Skopje.
Skopje, Prilep and Ohrid	At the beginning of the RAR Project, one of the institutions for juvenile delinquents was located in Prilep, however, midway through the fieldwork, this institution moved back to Skopje. Another institution for juvenile delinquents was located in Ohrid.

At the beginning of the RAR Project, one of the institutions for juvenile delinquents was located in Prilep, however, midway through the fieldwork, this institution moved back to Skopje. Another institution for juvenile delinquents was located in Ohrid.

Context

Young People

Many of the young people spend their free time with their classmates or informal groups of neighbourhood children playing billiards, surfing the Internet or attending weekend parties. After school, the older youth hang out in cafes and at the weekends they hang out in cafes, discos or private parties.

Half-truths or misinformation are often created during discussions with peers.

Injecting Drug Users

FYR Macedonia is positioned at one of the main crossroads on the drug trafficking route connecting the countries of Turkey and Bulgaria to the West. Furthermore, opium poppy, hemp, fruits used to prepare alcoholic drinks and medicinal plants are grown in FYR Macedonia for various purposes such as remedies, recreation and trade.

By the mid 1970s, the country began treating drug addicts. Even so, the number of drug users has been steadily increasing to reach alarming levels in the past five years. It is estimated that the number of persons using some type of psychotropic substance, excluding alcohol and tobacco, is between 20,000 and 30,000. The estimated number of heroin users is between 5,000 and 8,000.

According to the Ministry of Internal Affairs National Register, the number of registered drug abusers has increased from 337 to 4,569 between 1990 and 2000.

Young Men who have Sex with Men

In the past few years of independence, discussions regarding sexual orientation have become more open and free. Nonetheless, the general population still perceives young MSM or bisexuals as “freaks” or “immoral persons”. These groups of individuals remain heavily stigmatised and discriminated against.

Some of the RAR participants stated that they lived in two worlds, one that was “open” and the other was “hidden”. The “open” world was where they lived their so-called normal lives whereas the “hidden” world was where they were happy to live the way they wanted without restraints.

Most young MSM firmly believe that they are genetically predisposed to their sexual orientation.

Young People Deprived of Parental Care

The reasons why children and adolescents are admitted into institutions that provide care for young people who are deprived of parental care include the following:

- They have no parents;
- Their parents are divorced;
- Their parents are unable to provide satisfactory care or to fulfil their parental duties;
- Their parents cannot provide them with an education because of poverty;
- A court decision has removed them from their parents.

Young people are admitted to these institutions by the Social Work Centres that act as guardian bodies. The wardship arrangement is in effect until the parents are deemed capable of caring for their children again. The RAR Project focused on two institutions, 11 Oktomvri and 25 Maj.

The 11 Oktomvri provides care for young people (aged 3 to 18 years old) who are deprived of parental care. It is housed in a modern 3-storey building in central Skopje and is in the immediate vicinity of a big shopping centre where young people gather all year round. The city transport network enables young people to move about town easily. The institution can accommodate 144 young people.

The 25 Maj also provides care for young people (aged 7 to 18 years) who are deprived of parental care. However, this institution caters to young people who also have emotional or behavioural problems and/or educational neglect. It is located away from the city centre, on the northern periphery of Skopje. The area around the institution has no lighting so it is often used for illegal activities, including sex work. Directly in front of the institution is a road where expensive cars are often parked for short periods of time. Some of the children from the institution are seen talking with persons from these expensive cars.

Juvenile Delinquents

According to the law, a juvenile delinquent is an offender who is under 18 years of age. Juvenile delinquency falls within the jurisdiction of the police, the courts, the Ministry of Justice, Social Work Centres, the Ministry of Labour and Social Policy and the Institutions that provide care for delinquent minors.

The RAR Project focused on four correctional institutions for juvenile delinquents: two institutions in Skopje; one institution originally located in Prilep which moved to Skopje near the end of the RAR project; and one institution in Ohrid.

Most of the juvenile delinquents in these correctional institutions come from large dysfunctional families, often with histories of crime or alcohol abuse. Many of them did not complete primary education. They are a stigmatised group and are often referred to as “urchins”.

There are no formal leaders in the correctional institutions, although the most respected is usually the person who has spent the most time in the institution and is also the strongest.

Risk and Protective Behaviours

Table 56 provides a breakdown of the number of participants by group and data collection method. Questionnaires were administered to 1,755 young people. Interviews were conducted with 9 young people and a total of 154 young people participated in 20 focus groups.

TABLE 56

Group	Questionnaires	Interviews	Focus Groups
Young People who USE DRUGS	163	9	154
Young People who DO NOT USE DRUGS	1,592		
Service Providers		8	
Policy Makers / Community Leaders		1	
TOTAL:	1,755	18	154

Note 1: Only questionnaires completed by young people between the ages of 10 and 24 years were included.
Note 2: Conducted 20 focus groups.
Note 3: Completed 10 observations at secondary schools and 22 observations at cafes, disco clubs, shopping centres and private homes.

Young People who USE DRUGS

The law prohibits the serving of alcohol to minors. Even so, participants confirmed that they could easily purchase alcohol almost anywhere. Most participants had used alcohol. Common responses regarding alcohol included "drinking alcohol is normal" and "it's part of family traditions". Some girls drank alone at home to see how much they could drink since "it is shameful to embarrass yourself in a café or at a party".

Many had used cannabis and firmly believed that it was not harmful when used occasionally. The main reasons for trying cannabis included curiosity and "because my friend told me it was great". Cannabis is easily accessible.

Most participants were not yet sexually active. They stated that when they did become sexually active that they would use condoms. Most of them, however, did not know how to use condoms properly.

Of the participants who were sexually active, most stated that they were aware of the need for safer sex and thus used condoms regularly. Their responses on the questionnaires stated otherwise.

Questionnaire Results - Young People who use drugs

The questionnaire was administered to 163 young people who use drugs: 86 males and 76 females. There was one questionnaire for which the respondent's gender was unknown. The following provides a summary of the descriptive data based on the core questions from the questionnaire (n = 163).[49],[50]

- Mean age was 17.0 years.
- Mean age when first used drugs was 15.4 years.
- 54.6% had sexual intercourse.
- 63.2% thought that they were at risk of HIV or other STIs.
- 4.3% had been tested for HIV.

In the past month, the following drugs had been used:

- Alcohol 91.4%;
- Cannabis 69.3%;
- Ecstasy 12.3%;
- Diazepam 12.3%;
- Analgesics 11.0%.
- 48.8% used two or more drugs at the same time.
- 20.2% had sex under the influence of drugs.

Of those who had sexual intercourse (n=89):

- Mean age at first sexual intercourse was 15.7 years;
- 44.9% had ONE sexual partner in the past year;
- 36.0% had between 2 and 5 sexual partners in the past year;
- 42.7% "always" used condoms during sex;
- 60.7% "sometimes" or "never" used condoms during sex;
- 7.9% had sex in return for money, drugs, etc.

Reasons for not "always" using condoms during sex:

- Do not like sex with condoms;
- Unaware of the benefits of using condoms;
- Trust in partners.

Where to access information about HIV or other STIs:

- Media;
- School;
- Friends or peers.

49. Young people who inject drugs were not included.
50. Percentages were calculated using n=163 as the denominator unless noted otherwise.

Questionnaire Results - Young People who do not use drugs

The questionnaire was administered to 1,592 young people who do not use drugs, 569 males and 1,007 females (Table 56). There were 16 questionnaires for which the respondent's gender was unknown. The following provides a summary of the descriptive data based on the core questions from the questionnaire (n = 1,592).[51]

- Mean age was 16.3 years.
- 19.4% had sexual intercourse.
- 61.7% thought that they were at risk of HIV or other STIs.
- 5.7% had been tested for HIV.

Of those who had sexual intercourse (n=309):

- Mean age at first sexual intercourse was 15.3 years;
- 43.0% had one sexual partner in the past year;
- 39.8% had between 2 and 5 sexual partners in the past year;
- 59.9% "always" used condoms during sex;
- 49.2% "sometimes" or "never" used condoms during sex;
- 7.8% had sex in return for money, drugs, etc.

Reasons for not "always" using condoms during sex:

- Do not like sex with condoms;
- Unaware of the benefits of using condoms;
- Trust in partners.

Where to access information about HIV or other STIs:

- Media;
- School;
- Family.

Injecting Drug Users

Table 57 provides a breakdown of the number of participants by group and data collection method. Questionnaires were administered to 109 injecting drug users. Interviews were conducted with 16 injecting drug users and a total of 40 injecting drug users participated in nine focus groups.

TABLE 57

Group	Questionnaires	Interviews	Focus Groups
INJECTING DRUG USERS	109	16	40
Service Providers		15	
Policy Makers / Community Leaders		2	
TOTAL:	109	33	40

Note 1: Only questionnaires completed by young people between the ages of 10 and 24 years were included.
Note 2: Conducted 9 focus groups.
Note 3: Completed 9 observations at school playgrounds, a detoxification department, during a methadone therapy session, during needle and syringe sharing, and at the home of an IDU.

Participants began using drugs out of curiosity and often in the company of more experienced drug injectors. Heroin was the most frequently injected drug. Other drugs which were injected included methadone, sedatives (e.g. Apaurine, diazepam), cocaine and other drugs that are in liquid form.

Preparing heroin for injecting may be a source of HIV transmission.

In almost all cases when the heroin is taken in a group, it is done so by using one injection kit. The heroin is mixed with water and lemon in a utensil, which is heated and cooked until the content melts (i.e. mixes). The utensil that is most frequently used for this purpose, the so-called "cooker", is usually a spoon, a bottle cap, a cutout bottom of a tin can, etc. If a utensil is not available in which to prepare the heroin then

51. Percentages were calculated using n=1,592 as the denominator unless noted otherwise.

someone else's cooker is used (i.e. one that is previously used, borrowed or found). The water should be distilled but often it is water from a tap, from a pond, from a toilet, saliva, etc. The prepared heroin is extracted from the cooker with a needle and syringe through a piece of cotton or cigarette filter that helps to clear the impurities. The heroin solution is now ready for distribution.

(FYR Macedonia RAR Report, 2002)

Once the heroin solution has been prepared, each person pulled up a dose with his/her own syringe. In some instances, all members of the group used the same needle and syringe. Some IDUs were insulted when another IDU refused to use the same needle and syringe. Close relatives and intimate partners often shared the same needles and syringes.

Since a small portion of the drug is retained in the filter, used filters were kept and re-cooked during times of crisis. IDUs who had no money often visited the places where drugs were injected to collect and re-cook the discarded filters.

Prepared drugs in syringes that were ready for injecting could be purchased in Skopje. New needles and syringes could be obtained either at the needle exchange programme or purchased at pharmacies.

Shooting galleries were only accessible to individuals who knew the security personnel or the correct password. Needles and syringes were often shared in shooting galleries, and drugs could also be purchased there.

Table 58 gives a breakdown of the different types of drugs and their costs.

TABLE 58

Drug	Unit	Price per Unit (Denars)*	Comment
Cannabis	1 cigarette	100	
	1 matchbox	300 to 450	Matchbox is package of 3 to 4 grams.
Heroin	1 dose	500	
Methadone	1 dose	800 to 1,500	

* 100 Denar = 1.64725 EUR.

Condoms were not regularly used when having sex. Changing sexual partners was a common occurrence as was the exchange of sex for money or drugs. Some participants have had sex with more than one partner at a time without using condoms.

Questionnaire Results - Injecting Drug Users

The questionnaire was administered to 109 young people who inject drugs, 83 males and 26 females. The following provides a summary of the descriptive data based on the core questions from the questionnaire (n = 109).[52]

- Mean age was 21.0 years.
- Mean age when first used drugs was 16.0 years.
- Mean age when first injected drugs was 17.3 years.
- 94.5% had sexual intercourse.
- 78.9% thought that they were at risk of HIV or other STIs.
- 64.2% had been tested for HIV.

In the past month, the following drugs had been used:

- Methadone 67.9%;
- Cannabis 62.4%;
- Alcohol 57.8%;
- Heroin 56.9%;
- Diazepam 46.8%;
- Analgesics 34.9%;
- Cocaine 23.8%.
- 63.3% shared drug-injecting equipment.
- 79.8% used two or more drugs at the same time.
- 86.2% had sex under the influence of drugs.

52. Percentages were calculated using n=109 as the denominator unless noted otherwise.

Of those who had sexual intercourse (n=103):

- Mean age at first sexual intercourse was 16.8 years;
- 19.4% had one sexual partner in the past year;
- 50.5% had between 2 and 5 sexual partners in the past year;
- 13.6% "always" used condoms during sex;
- 88.3% "sometimes" or "never" used condoms during sex;
- 25.2% had sex in return for money, drugs, etc.

Reasons for not "always" using condoms during sex:

- Do not like sex with condoms;
- Trust in partners;
- Unaware of the benefits of using condoms.

Where to access information about HIV or other STIs:

- Media;
- Friends or peers;
- Social or health workers.

Young Men who have Sex with Men

Table 59 provides a breakdown of the number of participants by group and data collection method. Questionnaires were administered to 33 young MSM. Interviews were conducted with 11 young MSM and a total of 26 young MSM participated in five focus groups.

TABLE 59

Group	Questionnaires	Interviews	Focus Groups
YOUNG MSM / BISEXUALS	33	11	26
Service Providers		11	
Policy Makers / Community Leaders			
TOTAL:	33	22	26

Note 1: This target group did not complete the core questionnaires since they were included near the end of the data collection phase. Instead, a different questionnaire was administered.
Note 2: This target group includes female bisexuals.
Note 3: Conducted 5 focus groups.
Note 4: Completed 17 observations at cafes, disco clubs, a private gay party and on the Internet.

All female participants included in this target group were bisexuals. Most bisexual females reported that their male partners were aware of their sexual activities with other females. According to one female participant, "men are excited by this and ultimately they always insist on having sex with the two women". The females started having same sex relations for reasons of curiosity, experimentation and genetic predisposition.

In attempts to hide their gay identity, many bisexual men often have female partners for public appearance.

In Skopje, there is an extensive network of young MSM and bisexuals. They all seem to know each other. There are gay clubs. Even so, they mostly meet at private home parties. These parties are usually hosted by individuals who are financially well off (e.g. foreigners). The parties are well organised with catering, strippers, entertainers, etc. Minors are sought to attend these parties. In the absence of minors, young MSM are hired to provide sexual services at high prices. Impoverished adolescent boys can be very tempted to exchange sex for money.

In addition to parties, sexual contacts are often established on the Internet. At a cost of 300 Denars (4.90 EUR), contact services will provide the telephone number of a person who will render sexual services in exchange for money.

For many of the RAR participants, their first sexual experience was with a person of the opposite gender. It was not until later that sexual contacts were with someone of the same gender.

"Active" sex is the position assumed by the penetrator whereas "passive" sex is the position assumed by the person who is being penetrated. Only a few opt to be exclusively "active" or "passive". Most prefer to

practice both positions. For females having sex with females, sex is limited to oral sex performed on one another. Sometimes, sex toys are used to simulate the male sex organ.

Participants stated that promiscuity was fairly common. One-night stands were frequently practiced (21% reported that they had had 3 to 7 one night stands). Having sex with two or three partners at the same time was not uncommon.

Awareness about the various types of condoms and how to use them properly was low. Condoms were never used during group sex. According to one participant, group sex would be pointless if condoms were used.

Participants reported only using alcohol and cannabis.

Young People Deprived of Parental Care

Table 60 provides a breakdown of the number of participants by group and data collection method. Questionnaires were administered to 61 young people deprived of parental care. Interviews were conducted with 12 youths and a total of 89 youths participated in 13 focus groups.

TABLE 60

Group	Questionnaires	Interviews	Focus Groups
DEPRIVED OF PARENTAL CARE	61	12	89
Service Providers		10	
Policy Makers / Community Leaders		3	
TOTAL:	61	25	89

Note 1: Only questionnaires completed by young people between the ages of 10 to 24 years were included.
Note 2: Some of the respondents in this target group found the questionnaires difficult to understand and thus did not complete them.
Note 3: Conducted 13 focus groups.
Note 4: Completed 8 observations at nearby schools, neighbourhoods, during focus groups and within the institutions.

Beer and wine were consumed most frequently since they are inexpensive. Drugs aroused the curiosity and interest of the younger participants. They viewed drugs as a game and did not consider smoking cannabis or glue sniffing to be dangerous. Both the young people and the educators stated that they could not recognise many of the different types of drugs.

Some of the female participants obtained drugs through their boyfriends who lived outside the institutions. When they were in the presence of their boyfriends and other drug users, they often used drugs since this was the group rule. Usually it was a joint of cannabis or hashish that was passed around within the group. Other times, it was injecting heroin within the group using one needle and syringe. These female participants stated that they were certain that they would be able to stop using drugs once they broke up with their boyfriends.

During the interviews, many of the participants avoided talking about their first sexual experiences. Some of the girls, however, did reveal that they were forced into their sexual experiences. Similarly, some of the boys stated that they were forced into sexual acts with other men as their first sexual experiences.

Neither the boys nor girls wanted emotional relationships with someone in the institution. All preferred to have relationships with individuals outside of the institution. Many of the boys stated that they frequently used the services of sex workers.

It was very common for the girls to have unprotected sex. The prevailing view was that condoms were the boy's responsibility. The boys stated the following rule: "If the girl's clean, there is no reason for using a condom".

Although there were many reasons listed for not using condoms, the prevailing impression was that there seemed to lack any habit of using condoms.

Questionnaire Results - Young People deprived of parental care

The questionnaire was administered to 61 young people deprived of parental care: 23 males and 38 females. The following provides a summary of the descriptive data based on the core questions from the questionnaire

(n = 61).[53]

- Mean age was 15.2 years.
- 9.8% had used drugs.
- Mean age when first used drugs was 14.8 years.
- 42.6% had sexual intercourse.
- 65.6% thought that they were at risk of HIV or other STIs.
- 4.9% had been tested for HIV.

Of those who used drugs (n=6), the following drugs had been used in the past month:

- Cannabis 66.7%;
- Alcohol 50.0%;
- Cocaine 33.3%;
- Heroin 16.7%.

Of those who used drugs (n=6):

- 16.7% had injected drugs;
- Mean age when first injected drugs was 16.0 years;
- The one person who had injected drugs had shared drug-injecting equipment;
- 33.3% used two or more drugs at the same time.
- None had sex under the influence of drugs.

Of those who had sexual intercourse (n=26):

- Mean age at first sexual intercourse was 13.2 years;
- 11.5% had one sexual partner in the past year;
- 26.9% had between 2 and 5 sexual partners in the past year;
- 26.9% “always” used condoms during sex;
- 65.4% “sometimes” or “never” used condoms during sex;
- 3.8% had sex in return for money, drugs, etc.

Reasons for not “always” using condoms during sex:

- Embarrassed to purchase condoms.
- Unaware of the benefits of using condoms.
- Do not like sex with condoms.

Where to access information about HIV or other STIs:

- School;
- Media;
- Friends or peers.

Juvenile Delinquents

Table 61 provides a breakdown of the number of participants by group and data collection method. Questionnaires were administered to 67 juvenile delinquents. Interviews were conducted with 6 juvenile delinquents and 67 juvenile delinquents participated in 13 focus groups.

TABLE 61

Group	Questionnaires	Interviews	Focus Groups
JUVENILE DELINQUENTS	67	6	67
Service Providers		12	
Policy Makers / Community Leaders		4	
TOTAL:	67	22	67

53. Percentages were calculated using n=61 as the denominator unless noted otherwise.

Note 1: Only questionnaires completed by young people between the ages of 10 to 24 years were included.
Note 2: Conducted 13 focus groups.
Note 3: Completed 11 observations at nearby schools, neighbourhoods, during focus groups and within the institutions.
Note 4: During fieldwork (i.e. data collection), there were no female juvenile delinquents in the correctional institutions.

Most participants stated that they started drinking alcohol at an early age. Most drank in group settings, rarely alone. The main reason for drinking was to be "accepted by the group". Cannabis was the most commonly used drug since it was easily accessible and inexpensive.

Few participants had injected drugs. Of those who had injected, heroin was the drug most often injected. Reasons for injecting included curiosity, friends and an escape from problems. The transition from lighter to heavier drugs is characteristic for most injecting drugs users in correctional institutions. They would start with cannabis then begin smoking heroin joints, followed by heroin foil and finally injecting heroin. The period of transition from cannabis to injecting is between 6 months to 1.5 years. Heroin is easily accessible and inexpensive, however, the quality is poor and often mixed with other substances.

According to the participants, they did not talk about drugs and drug use with their educators at the correctional institutions. Participants rarely talked to the educators at all.

Talking about sex was taboo. Some talked about sex with their closest friends but it was never discussed with the educators in the correctional institutions. Even so, there did not appear to be a tendency for young people to compare their sexual experiences with others. Most of the youth (75%) in the correctional institutions reported that they were sexually active. One participant stated that "good sex is almost always accompanied by alcohol".

There was a belief that condoms were only to be used with "unknowns". It was expected that females were using birth control pills. Sexual opportunities were often linked with free weekends (i.e. away from the correctional institutions). Young men often had sex with sex workers during these free weekends.

Questionnaire Results - Juvenile Delinquents

The questionnaire was administered to 67 male juvenile delinquents. The following provides a summary of the descriptive data based on the core questions from the questionnaire

(n = 67).[54]

- Mean age was 17.1 years.
- 38.8% had used drugs.
- Mean age when first used drugs was 14.2 years.
- 74.6% had sexual intercourse.
- 61.2% thought that they were at risk of HIV or other STIs.
- 23.9% had been tested for HIV.

Of those who used drugs (n=26), the following drugs had been used in the past month:

- Cannabis 46.2%;
- Alcohol 30.8%;
- Analgesics 23.1%;
- Methadone 23.1%;
- Diazepam 15.4%.

Of those who used drugs (n=26):

- 38.5% injected drugs;
- Mean age when first injected drugs was 14.5 years;
- Of those who injected drugs (n=10), 50.0% shared drug-injecting equipment;
- 53.8% used two or more drugs at the same time;
- 57.7% had sex under the influence of drugs.

Of those who had sexual intercourse (n=50):

- Mean age at first sexual intercourse was 14.3 years;
- 14.0% had one sexual partner in the past year;
- 26.0% had between 2 and 5 sexual partners in the past year;
- 20.0% "always" used condoms during sex;
- 80.0% "sometimes" or "never" used condoms during sex;

54. Percentages were calculated using n=67 as the denominator unless noted otherwise.

- 8.0% had sex in return for money, drugs, etc.

Reasons for not "always" using condoms during sex:

- Trust in partners;
- Do not like sex with condoms;
- Unaware of the benefits of using condoms.

Where to access information about HIV or other STIs:

- Media;
- Friends or peers;
- School.

Health and Social Consequences

The official STI data show a decline in STIs. There is a sense, however, that STI prevalence is actually 3 to 4 times higher than the official data. Weak surveillance activities may contribute to this discrepancy.

Young People

There are reported stories of unwanted pregnancies and abortions, although the RAR Project was unable to confirm these stories. One possible reason why pregnancies and abortions are kept secret is that according to the law, pregnant students must withdraw from regular schooling.

Girls did not visit the gynaecologist in order to avoid the embarrassment of "everybody would know that I have had sex".

Young people were well informed about HIV/AIDS, but they were not as well informed about other STIs.

Young people did not discuss with their parents subjects related to sex, contraception, HIV/AIDS and drugs. Many would turn to their older siblings or their best friends for advice. Half-truths and misinformation were often created during discussions with peers.

Injecting Drug Users

Between 1 January 1999 and 30 September 2001, 254 overdose cases were successfully treated, using urgent medical intervention and toxicology, at the clinic in the Faculty of Medicine in Skopje.

The number of IDUs testing positive for Hepatitis C is quickly increasing. Of the participants in the RAR Project, 51.5% reported testing for Hepatitis C and of those tested, 13% reported testing positive for Hepatitis C.

Some participants stated that they sold drugs in order to secure drugs for themselves. Many stated that they had lost hope of a brighter future. Some, however, still hoped that they could be cured of their dependency on drugs and start again.

Young Men who have Sex with Men

Most young MSM were not well informed about STI/HIV/AIDS. Many stated that they were reluctant to openly talk with their physicians due to the stigma attached to being gay or bisexual.

Participants who were interviewed gave the appearance of being happy doing what they were doing, however, as the interview progressed many allowed their sadness to surface. They were fully aware of the stigma that attached to their sexual orientation.

Young People deprived of care

Most participants stated that they did not have sufficient STI/HIV/AIDS information. Information is accessed through friends or the media, then from family, schools and health workers. Many of the younger participants received information from the older participants in the institution.

Girls rarely seek out information about their own reproductive health. Moreover, they do not know who and where to ask. According to official information, there have been a number of unwanted pregnancies in the institutions, all of which were terminated with the support of the institutions. Furthermore, there have been a number of officially registered cases of STIs.

Juvenile Delinquents

Juvenile delinquents do not have sufficient information about STI/HIV/AIDS and drug abuse. In the focus groups, it was revealed that the girlfriends of three of the participants had abortions to terminate unwanted pregnancies. Furthermore, other participants revealed that they have had STIs.

Free time in the correctional institutions was unorganised and monotonous. The participants spent their free time sleeping, watching television or playing some sport activity. One youth stated that “even sleeping is boring here”.

Most of the serious criminal acts were committed under the influence of drugs or were committed to obtain money to purchase drugs.

Existing Interventions

The transition of FYR Macedonia into an independent country created the need for a centralised health care system. For this reason, the Ministry of Health was established in 1991. Many of the health care institutions are in relatively new buildings, although much of the medical equipment and many vehicles are outdated or poorly maintained.

The Drug Commission, in operation since 1991, functions under the Ministry of Health. Various other Commissions working on various aspects of drug use and abuse have been established in different ministries. A State Inter-Department Commission has been established to coordinate these various Commissions.

Young People

The topics of HIV/AIDS and drug use are included in the school curriculum, although they are not fully addressed.

Participants stated that they were impressed when popular individuals were seen wearing red ribbons (eg. on MTV Music Awards) to show their support in the fight against HIV/AIDS.

Injecting Drug Users

IDUs were not satisfied with the working hours or the location of the needle exchange programme in Skopje. Furthermore, they did not like the attitudes of the pharmacy personnel.

Young People deprived of care

Educators in the institutions stated that they needed more information about STI/HIV/AIDS and drugs. Furthermore, they needed information on what to do when it was evident that young people in the institutions were using drugs. At the request of both the youth and the educators, MIA (a local NGO) distributed STI/HIV/AIDS information to the institutions, after the fieldwork was completed.

The institutions have a regularly employed nurse. Even so, young people have stated that they were not provided with adequate health care and that there was a lack of trust towards them.

Juvenile Delinquents

In one of the correctional institutions, medical examinations were conducted on all newcomers. The correctional institutions consulted with outside physicians when methadone therapy was required for young people who are injecting drugs. Even so, there is no monitoring available for these young people while they are on methadone therapy.

In one of the correctional institutions, there were vocational workshops with skilled instructors.

Some of the organisations and/or NGOs that provide HIV/AIDS support services to vulnerable young people are listed in Table 62.

(14) A variety of therapeutic programmes, including methadone therapy, are used to treat drug addicts. Methadone therapy is also provided at hospitals in Strumica and Stip.

(15) Local NGOs in Skopje deliver interactive HIV/AIDS lectures in school using the peer education format. Most of these local NGOs also have their own web site that provides STI/HIV/AIDS information, manage SOS telephone lines, distribute appropriate HIV/AIDS information and implement World AIDS Day campaigns each 1 December.

TABLE 62

Organisation	Needle Exchange	Methadone Therapy	Education Or Support
In Skopje:			
Psychiatric Hospital (1)		✓	
NGOs – Doverba, HOPS, MIA, and HERA (2) & (3)			✓
NGO – HOPS	✓		
Centre for Dependencies in Kisela Voda (4)		✓	
Institute of Toxicology at the Medical Faculty		✓	
In Strumica:			
NGO – Izbor (5)		✓	✓
Medical Centre		✓	
In Kumanovo:			
Medical Centre – Treatment of Dependencies (6)		✓	✓
In FYR Macedonia:			
Ministry of Health (7)			✓
Health Institutions			✓
Ministry of Education and Science (8)			✓
Ministry of Interior (9)			✓

(16) The NGOs are also providing counselling and support to young MSM and bisexuals, drug users and their families and PLWHA, and conducting pre- and post- testing counselling.

(17) The Centre works in prevention and treatment of drug abuse.

(18) This out-patient department also provides counselling services. The NGO is also developing programmes for re-socialisation and rehabilitation of drug addicts.

(19) In addition to dry detoxification, the Centre organises lectures in local schools.

(20) Every year, the Ministry implements a programme entitled “Protection of the Population in the Republic of Macedonia from HIV/AIDS” which includes lectures that are held in some secondary schools.

(21) Topics such as HIV/AIDS, protection against alcohol abuse, drugs and tobacco are presented in short lecture format as part of the school curriculum. From time to time, these topics are discussed during homeroom periods. Each year, on 1 December (i.e. World AIDS Day), school students receive HIV/AIDS information.

(22) The Sector for Illicit Drug Trade at the Ministry organises lectures for students in primary and secondary schools.

Recommendations

The recommendations below are based on the data collected for this RAR Project through questionnaires, interviews, focus groups, existing information, observations and mapping. They have been developed from the key findings, which emerged from the analysis of the RAR data.

Table 63 provides a summary of the recommendations for interventions that were outlined in the RAR Report for FYR Macedonia, 2002.

Also included in the FYR Macedonia’s RAR report are recommendations for interventions for the various vulnerable target groups (Table 64).

TABLE 63

Recommendations at the National Level

- Incorporate the findings and recommendations from this RAR Project into the National HIV/AIDS Strategy for the FYR Macedonia.
- Establish multi-sector cooperation between governmental institutions and non-governmental organisations to provide HIV/AIDS prevention services for young people.
- Develop and train staff who work with vulnerable young people within government institutions on HIV/AIDS.

Recommendations at the Non-Governmental Level

- Enhance working networks between the various NGOs who provide HIV/AIDS support services. Also, encourage interested young people, lobby groups, private businesses, local government, and the media to work with NGOs.
- Distribute information about HIV/AIDS and contemporary ways of working with young people to the various NGOs.

TABLE 64

Recommendation for Young People

- Introduce sex education into the elementary and secondary school curricula.
- Encourage parents to actively participate on school boards and to develop health education for their children.
- Promote the concept of responsible parenthood that includes more open communication with children.
- Provide teachers with additional training in communication skills.
- Establish working networks between the Ministry of Education and Science, the various institutions and local NGOs to develop and implement a peer education programme to enhance young people's self esteem and decision making skills.
- Develop and implement frequent educational campaigns about HIV/AIDS, drugs and contraception.
- Develop and implement a condom awareness campaign.
- Monitor the quality and price of condoms.
- Monitor compliance with the legal regulations regarding the sale of alcohol to minors.

Recommendations for Injecting Drug Users

- Develop and implement various targeted awareness campaigns about HIV/AIDS.
- Develop and implement drug awareness campaigns.
- Change legal provisions to enforce sanctions on drug users.
- Establish a working group to improve the services that are provided by the various Ministries, NGOs and health centres in the areas of HIV/AIDS and drugs.
- Decentralise, with support from the Ministry of Health, the programme for distributing methadone therapy.
- Enhance the support services provided by NGOs who work with IDUs.
- Provide professional counselling to IDUs and their family members.
- Establish needle exchange outreach programmes or extend the hours of operation for existing needle exchange programmes.
- Improve access to needles and syringes in pharmacies.

Recommendations for Young Men who have Sex with Men or Bisexuals

- Develop and implement a public awareness campaign to reduce the stigma associated with MSM.
- Provide support to NGOs that provide STI/HIV/AIDS information to young MSM.

Recommendations for Young People Deprived of Care

- Enhance working networks between the Ministry of Labour and Social Policy, Social Work Centres and the institutions for young people deprived of parental care to provide quality care and education to these youth admitted into these institutions.
- Provide logistical and professional support to these institutions as they prepare the "Health Education Strategy" which will include education about HIV/AIDS and drugs.
- Incorporate the STI/HIV/AIDS and drug support services provided by NGOs into the "Health Education Strategy".
- Explore the feasibility of providing institutionalised young people with outside psychological consultations.
- Provide appropriate staff in the institutions with the medical training and equipment to respond properly to incidents of drug abuse.

Recommendations for Juvenile Delinquents

- Develop and deliver education about STI/HIV/AIDS and drugs to youth and staff in these institutions.
- Improve the health services available in these institutions. Ensure institutionalised IDUs receive proper care while on methadone therapy.
- Establish or revise the educational programme that will allow juvenile delinquents to complete their primary education prior to their discharge from the institutions.
- Distribute condoms to young people before their weekend discharges.
- Provide support to juvenile delinquents and their parents during their re-entry into society upon discharge.
- Provide juvenile delinquents with vocational courses during their stay in the institutions. Encourage them to complete courses to earn a diploma.
- Establish working networks between Ministries, NGOs and institutions to enhance the re-socialisation of juvenile delinquents once they are discharged.

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APPENDIX A

Vulnerable Target Groups Studied

COUNTRY	CITY	TARGET GROUP(S)
ALBANIA	Korca	Mobile Population
	Shkodra	Drug Users
	Tirana	Drug Users
	Vlora	Sex Workers
BOSNIA AND HERZEGOVINA Federation of Bosnia and Herzegovina	Mostar	Drug Users Young People
	Sarajevo	Drug Users Young People
	Tuzla	Drug Users Young People Young MSM
BOSNIA AND HERZEGOVINA Republika Srpska	Banja Luka	Young People Injecting Drug Users Sex Workers
	Trebinje	Young People Injecting Drug Users
	Višegrad	Young People Injecting Drug Users Sex Workers
BOSNIA AND HERZEGOVINA Brčko District	District Brcko	Young People Sex Workers
CROATIA	Osijek	Drug Users Out-of-School Youth
	Rijeka	Drug Users Out-of-School Youth
	Split	Drug Users Sex Workers
	Zagreb	Drug Users Roma Youth

FEDERAL REPUBLIC OF YUGOSLAVIA Serbia	Belgrade	Drug Users Young MSM Sex Workers
	Kraguye-vac	Drug Users Sex Workers
	Nis	Drug Users Young MSM
	Novi Sad	Drug Users Young MSM
FEDERAL REPUBLIC OF YUGOSLAVIA Montenegro	Bar	Young People Sailors
	Podgorica	Young People Drug Users
FORMER YUGOSLAV REPUBLIC OF MACE-DONIA (Target groups were studied in various cities. For more details refer to FYR Macedonia's RAR summary report.)	Kumanovo	Young People
	Ohrid	Injecting Drug Users
	Prelip	Young MSM or Bisexuals
	Skopje	Youth Deprived of Parental Care
	Strumica	Juvenile Delinquents

APPENDIX B

Summary of UNICEF/WHO Regional Training Workshop on RAR

1. Background Experts from the field of Rapid Assessment and Response (RAR) provided RAR training to Core Teams from seven locations (Albania, Croatia, FYR Macedonia, FBiH, RS, FRY Serbia, and FRY Montenegro) over five days.

2. Workshop Participants Each Core Team was comprised of the National/Entity Coordinator and the Local Field Coordinators. The UNICEF Focal Point for each of the Core Teams also attended the Training Workshop. In total, there were approximately 45 workshop participants. The professional backgrounds of the participants ranged from medical doctors, epidemiologists, statisticians, to those who work for non-governmental agencies or do research in social medicine.

3. Workshop Format Each morning, a summary of the previous day's workshop was provided followed by a brief summary of the participants' feedback on the evaluation forms they had completed. The remainder of the day alternated between presentations and group work.

4. Evaluation At the end of each day, the workshop participants were asked to complete an evaluation form on what went well or what could have been improved during that day. The evaluations forms were immediately reviewed each night and revisions to the next day's workshop were made if possible.

5. What Worked Well

- Starting each day with a summary of the previous day and feedback from the evaluation forms provided participants with a quick recall of what they've learned thus far.
- Core Teams working on their Assessment Protocols throughout the five days. The Assessment Protocol is their "roadmap" to what they will be doing in the next three months.
- A sub-working group was established to develop the compulsory questions for the survey. Each of the Core Teams nominated one member to participate on the sub-working group.
- One trainer was allocated to each of the Core Teams. This trainer remained with the same Core Team for the five days during the group work sessions.
- The participants enjoyed the presentation by the two guests from Bulgaria on their experience with RAR. It was a concrete example that was appropriate and relevant.

6. Areas for Improvement

- The participants commented that the presentations were too long. The trainers attempted to shorten their presentations, although this meant that many of the concrete examples were not used. A better balance between presentations and use of examples was needed.
- The participants wanted examples that were relevant and appropriate. They preferred examples from Kosovo and Bulgaria rather than examples from Africa or Asia.

7. Training Certificates On the last day, each participant received a training certificate to acknowledge their completion of the Training Workshop.

8. Next Steps In November, the Core Teams will be delivering Training Workshops to their field team members at each of the seven locations. Once these workshops are completed, the field teams will begin to collect data.

APPENDIX C

Summary of UNICEF/OSI Regional Action Plan Workshop

1. Background The goal of the 3-day Workshop was to provide participants with the knowledge and skills to develop and implement an action plan. Technical experts from the field of developing and implementing interventions introduced the range of interventions that are specific for different target groups, especially young people, drug users including injecting drug users and sex workers.

2. Workshop Participants There were 4 participants from each of the 7 RAR locations (Albania, FBiH, RS, Croatia, Serbia, Montenegro and Macedonia): the National/Republic/Entity Coordinator; the UNICEF Focal Point; and the other 2 participants were either actively involved in the development/implementation of interventions or with an NGO that provides support services to vulnerable young people. In addition, 2 participants from the Kosovo RAR project attended the Workshop. In total, there were approximately 40 participants.

3. Workshop Format On the first day, each RAR location presented their RAR experience and their key findings, followed by a presentation identifying an action plan. The second day alternated between presentations and group work on the action plan grids. The third day focused on the next steps in the RAR process with an emphasis on the "Response".

4. Evaluation Participants were asked to complete a 1-page evaluation form on the last day of the Workshop.

5. Report The proceedings of the Workshop was prepared as a formal document and is available from UNICEF Sarajevo

6. What Worked Well

- Inviting trainers from various technical backgrounds to contribute to the Workshop.
- Moderated discussion on the obstacles and possible solutions for implementing interventions.

7. Areas for Improvement

- There was not enough time during the group work sessions to complete the action plan grids. The participants, however, did work through the thinking process for completing the grids.

8. Next Steps The National/Republic/Entity Coordinator will complete the Country/Republic/Entity RAR report, in English, and submit it to the UNICEF Area Office by no later than 26 February 2002. The action plans will be further developed at city level before being discussed with the Community Advisory Boards in each city. Advocacy and social mobilisation will take place to seek funding to implement the interventions. UNICEF Focal Points will provide some support through this process.

APPENDIX D

Core Questions for Questionnaire

Questionnaire Identification Number: □□□□□□□□

City:

Place of interview:

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

Completed by: (initials only)

Checked by: (initials only)

Data Entered 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 survey?

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

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.

3. How old were you when you FIRST used drugs?

years old

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

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

a) ☐ bars / cafés / clubs

b) ☐ home

c) ☐ street

d) ☐ parks

e) ☐ schools

f) ☐ toilets

g) ☐ other place (please specify)

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

a) ☐ alcohol

b) ☐ cannabis / marijuana

c) ☐ diazepam or other benzodiazepines (local name)

d) ☐ ecstasy

e) ☐ glue or inhalant

f) ☐ amphetamines

g) ☐ LSD

h) ☐ heroin

i) ☐ methadone

j) ☐ cocaine

k) ☐ poppy tea

l) ☐ analgesics (local name)

m) ☐ other drugs (please specify)

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

a) ☐ yes

b) ☐ no

In Question 7, we define "sexual intercourse" as oral, vaginal and anal penetrative sex.

7. Have you ever had sexual intercourse under the influence of any of the drugs mentioned in Question 5?

a) ☐ yes

b) ☐ no

8. How old were you when you FIRST injected drugs?

years old

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

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. Have you ever shared drug-injecting equipment?

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.

10. 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

11. Do you think that you are at risk for HIV or other Sexually Transmitted Infections?

a) ☐ yes

b) ☐ no

12. 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

We are asking some questions about sexual behaviour. We realise 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.

13. 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.

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

15. 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 17.

16. 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)

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

a) ☐ yes

b) ☐ no

18. 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

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.

(h1) Notes