

MAPPING AND COMMUNITY BASED RESEARCH STUDY ON MOST AT-RISK ADOLESCENTS TO HIV/AIDS/STI

December, 2007

The assessment is conducted by the team of researchers from the Institute of Ethnology and Anthropology, the University ‘Sts. Cyril and Methodious’ Skopje.

Chief Researcher:

Ass. Prof. Ljupco S. Risteski, PhD, the Institute of Ethnology and Anthropology

Assistant Researchers:

Davorin Trpeski, MA, Grad. Ethnologist, the Institute of Ethnology and Anthropology

Marija Toseva, Grad. Social Worker, NGO HOPS, Skopje

Vanja Dimitrievski, Grad. Ethnologist, the Institute of Ethnology and Anthropology

Field Research Mentors:

Zoran Jordanov, NGO EGAL, Skopje

Svetlana Vojnovska, Grad. Social Worker, the Institute of Social Work and Social Policy, Skopje

Vlatko Dekov, Grad. Social Worker, NGO HOPS, Skopje

Field Researchers:

Zoran Jordanov, EGAL, Skopje

Katerina Partinova, NGO HOPS, Skopje

Mila Carovska, NGO HOPS, Skopje

Froska Nanova, NGO Izbor, Strumica

Biljana Miceva, NGO Izbor, Strumica

Stevo Dimusevski, NGO HOPS, Skopje

Nikola Nedeski, Grad. Social Worker, NGO HOPS, Skopje

Kiril Penov, medical doctor, NGO HOPS, Skopje

Aleksandar Sitnikovski, Grad. Social Worker, NGO HOPS, Skopje

Robert Jovanovski, NGO HOPS, Kumanovo

Sonja Aleksievska, Grad. Psychologist, NGO HOPS, Kumanovo

Petar Petreski, NGO HELP, Gostivar

Ivan Stojanoski, Grad. Social Worker, NGO HELP, Gostivar

Project Administrator:

Elizabeta Pavkovik, Grad. Ethnologist, the Institute of Ethnology and Anthropology, Skopje

International consultant engaged for design of the research study, review of the draft report and writing up of the executive summary and recommendations:

Joanna Busza, Lecturer, Centre for Population Studies, London School of Hygiene and Tropical Medicine, London, UK

Research Supervisory Committee:

D-r Gordana Kuzmanovska, Epidemiologist, Republic Institute for Health Protection

D-r Sandra Kuzmanovska, Ministry of Health, Manager of the project supported by the Global Fund for HIV/AIDS, Tuberculosis and Malaria

Prof. Vesna Dimitrievska, PhD, Sociologist, Institute for Sociology

Slavica Sekutkovska, President, Association of Social Workers of the City of Skopje

Katerina Miovska, President, NGO HERA –Health Education and Research Association

Nora Stojanovik, Macedonian Harm Reduction Network

Miodraga Stefanovska, NGO Macedonian Interethnic Association

D-r Silvana Onceva, Local Auditor of the project supported by the Global Fund for HIV/AIDS, Tuberculosis and Malaria

D-r Igor Veljkovik, Project officer, UNICEF Office, Skopje

This assessment was commissioned by the United Nations Children’s Fund (UNICEF) Skopje office, with financial support from the SIDA (Swedish International Development Agency) and the DCI (Development Cooperation of Ireland). The statements in this publication are the views of the author(s) and do not necessarily reflect the policies or the views of UNICEF. The publication is not edited to UNICEF standards.

EXECUTIVE SUMMARY OF THE REPORT

INTRODUCTION

In recent years, concern has grown within the FYR of Macedonia¹ that while the country's HIV epidemic remains concentrated within specific marginalised populations engaging in at-risk behaviours such as injecting drug use, the exchange or sale of sex, and unprotected male-to-male anal intercourse, adolescents (defined by WHO as aged 10-18) and young people (10-24) may be particularly neglected and under-served by targeted prevention and treatment services. In order to identify potential gaps in service provision for the youngest members of at-risk groups and characterise their needs, UNICEF commissioned formative research into the situation of most-at-risk-adolescents in Macedonia, defined as young people under the age of 18 who have engaged in at least one of the following activities known to increase risk of HIV acquisition and transmission: injecting drug use (IDU), sex work (SW), and unprotected same-sex behaviour among males (MSM).

Review of previous studies demonstrated that significant information existed on structural factors that could put young people at risk (denial of health insurance and specific harm reduction services to those under 18), as well as on some of the norms and attitudes that affect their choices. Most previous research, however, started from the perspective of health service provision, and focused on knowledge or use of services and did not include information based on MARA's own perceptions that might broaden understanding of their local environment and social networks, how and why they make certain decisions, and what their needs are from their own point of view. This study was thus designed as a community-based qualitative exploration of risk-taking among MARA and their attitudes and behaviours related to prevention of HIV and other adverse health outcomes.

The study was coordinated by the Institute of Ethnology and Anthropology of the University "Ss. Cyril and Methodius" from Skopje, in collaboration with a range of national public health and research institutions and non-governmental organisations (NGO) with extensive community-based experience of working with drug users, sex workers, and men who have sex with men.

STUDY OBJECTIVES

The primary aims of the mapping and the community based research study for MARA to HIV/AIDS/STIs in Macedonia were as follows:

1. To produce knowledge on the existence of MARA and describe their locations, behaviours, social context and the problems they face.
 - To locate different MARA sub-groups and collect information on their experiences at individual level, at community level and structural level with information from the community itself.
2. To identify case studies illustrating how legal frameworks, social programmes, public authorities, and available harm reduction initiatives facilitate or pose barriers to optimal use of appropriate services for MARA.
 - To analyse the information gathered from MARA that reflect all the factors influencing their individual risky behaviour and health-seeking or preventive measures.

METHODS

As the main priority of the study was to provide good quality formative research on MARA that could document and describe how they fit within larger categories of adolescents and specific high-risk groups, qualitative methods were selected to help explore MARA's lifestyles, relationships, and concerns. The emphasis was on eliciting participants' own perspectives and world-views.

¹ The country was admitted to the United Nations under designation of "the Former Yugoslav Republic of Macedonia". For simplicity, herein after, the country is referred to as "Macedonia".

Sampling & Recruitment

The main target group for the research were MARA, defined by UNICEF as adolescents involved in one or more of the following behaviours:

- adolescent males that have sex with men (MSM), with a special emphasis on those who have unprotected sex with men;
- adolescents who offer sexual services (AOSS);
- adolescents injecting drug users (AID).

In Macedonia, UNICEF uses a working definition of adolescents to refer to young people aged 13 to 18. However, as this age groups is difficult to identify (and may be even less willing to admit to illegal or stigmatised activities), the study also recruited slightly older members of at-risk communities (aged 19 to 22) who could give retrospective information on their own experiences when younger, or might provide data on younger friends and contacts from the same peer group. Other key informants (KI) recruited to the research included taxi drivers, pimps, NGO fieldworkers, and staff from hotels and cafés. These individuals were selected on the basis of some contact or involvement with MARA.

Researchers recruited participants through (1) Venue Based Sampling, in which locations where risk-taking activity is known to occur are identified, mapped, and treated as individual sampling units. Each venue was visited at several times to observe the kinds of people and activities present, and participants directly approached and invited to join the study; and (2) Snowball Sampling, in which initial informants from the target groups (often known to NGO outreach workers) were asked to refer other MARA from within their social networks for recruitment into the study.

Research Sites

The research was conducted in the following locations:

MARA Groups	Cities
Adolescents who offer sexual services (AOSS)	Skopje, Strumica
Adolescents injecting drug users (AID)	Skopje, Gostivar, Kumanovo
Adolescent males that have sex with men (MSM)	Skopje, Strumica, Gostivar, Tetovo

Sites were selected to reflect locations with sizable populations of the target groups and evidence that the research team would be able to identify and make contact with MARA; this usually relied on the presence of an NGO working with the target group that had established good rapport and trust with hard-to-reach communities. Most NGOs are active in the capital Skopje, and while most have initiated some programmes in the interior of Macedonia, these are often on a smaller scale and rely on the availability of funding.

Tools

A range of qualitative methods were used to collect data in order to maximise the depth and coverage of research and to triangulate findings across settings and between different types of informants:

- (1) *Mapping*: In each study site, locations where each risk-taking activities are known to occur were identified, mapped and visited. Sites were characterised according to what kinds of people visited them, what interactions took place, and the demographic composition of community members.
- (2) *Fieldworker note taking*: During data collection, fieldworkers recorded the location in which research took place, the types of participants and their activities, the availability and conditions of facilities, the time of data collection, and the emotional state/ mood of participants.
- (3) *In-depth interviews*: MARA and other key informants were invited to participate in in-depth interviews lasting between 1-2 hours. With participants' permission, interviews were recorded with digital voice recorders, and later transcribed and entered into Atlas.ti for analysis.
- (4) *Group discussions*: Where possible, peer groups of MARA were brought together for informal discussions to give additional contextual information in which to frame individual experiences elicited through interviews.

The following table summarises the data collected:

MARA behaviour	Interviews w/ target group	Key informant interviews	Observations & Mapping notes	Group discussions	Registers check
Adolescent males who have sex with men (MSM)	36	1	5	1	
Adolescents who offer sexual services (AOSS)	21	11	1	3	5
Adolescents injecting drugs (AID)	33	2	3		
SUBTOTAL	90	14	9	4	5
				TOTAL	122

Ethics

Ethical approval was obtained from the Institute of Ethnology and Anthropology at the University “Ss. Cyril and Methodius” in Skopje, which is an accredited education and scientific institution, and authorised to provide permission for applied research. Under Macedonian law, other permission was not required as the study did not collect biological specimens or include a clinical component.

Informed consent procedures were carefully explained to participants, particularly that their access to available services and the quality of care received would not be affected should they refuse to participate in the study. Throughout the study, both confidentiality and anonymity were maintained, with no identifying information recorded. All participants were compensated for their time with Macedonian Denar 150 (about Euro 2.40).

KEY FINDINGS

Adolescent males who have sex with men (MSM)

In the context of HIV prevention, the term *MSM* is most frequently used in reference to sexual acts between men, particularly those that pose high-risk for disease transmission such as unprotected anal intercourse. From an epidemiological perspective, MSM behaviours are not differentiated between those that accompany a self-identified sexual identity (often labelled gay, homosexual, bisexual or transsexual) from those engaged in by men who may consider themselves to have a heterosexual orientation. For this study, young people’s own associations with MSM behaviours were asked about, without predetermined assumptions about sexual identity or orientation.

Same-sex sexual contact was illegal in Macedonia until 1996, and remains a highly stigmatised behaviour. As such, this is a particularly difficult group to reach, with adolescents potentially even more hidden and unwilling to acknowledge MSM activity. The study was nonetheless able to recruit twenty seven informants MSM 13-18 and then interviewed a further ten from the more adult group.

The MSM population in Macedonia meet each other through a range of venues, including “virtual” gay-friendly locations:

- » Internet (sites such as Gaymacedonia)
- » Gay clubs and gay-friendly clubs;
- » “Cruising” sites;
- » Through friends
- » At private houses/apartments where MSM live and socialise

Most respondents kept their sexual behaviour secret and did not tell their family or their friends for fear of discrimination or, in some cases, severe reprisals. Where young people felt able to disclose having a gay identity, this was usually to a trusted sibling or other close relative (although not parents). All respondents had either directly experienced adverse circumstances when their sexual behaviour was discovered or had heard about such instances from friends. The police were heavily implicated in discriminatory harassment.

Young MSM tended not to report meeting sexual partners at cruising sites, preferring venues such as clubs or parties. They engaged in sex with multiple partners, and in some cases reported that they adopted only one role during sex, either exclusively *active* (the penetrating partner) or only *passive* (the receptive partner) during anal sex, although the majority are *uni* (willing to be receptive or penetrative). Those who most frequently defined themselves as either exclusively *passive* or *versatile* or *uni* were also more likely to identify themselves as part of the lesbian, gay, bisexual and transgender population (LGBT), while those reporting that they practice solely the active role in sex did not consider MSM sexual acts to reflect sexual orientation.

Respondents reported that their first sexual experience occurred between the ages of 9 and 18 and in most cases this was with a male partner. In some cases, mostly from the Roma community, the first MSM sexual experience was violent, forced by a relative (such as a cousin) or friend of similar age, in the other cases it was voluntary. A few respondents had their first sexual experience with a woman. Most MSM in this study reported having had some sexual experience with women.

Knowledge of HIV and how it is transmitted was generally high, although MSM exhibited poorer understanding of other STI and how they are contracted. The majority reported almost always using condoms during anal sex, with use dropping off once they have been with the partner for longer time. Condoms are not used for oral sex. Findings from this study population did not suggest extensive use of either alcohol or drugs, nor the influence of these substances on sexual behaviour and risk-taking.

Generally, young MSM were wary of using any health or prevention services, out of a reluctance to reveal MSM behaviour. At the moment three NGO work with the MSM population in Skopje. Those are EGAL (Equality of Gay and Lesbian), CCHR (Center for Civil and Human Rights) and MASSO (Macedonian Associated for Free Sexual Orientation). MSM had heard of some of these, primarily MASSO, then EGAL, although CCHR was not mentioned at all. This is likely to be related to the fact that MASSO is often represented in the media, and EGAL acts directly through field workers who distribute condoms and lubricants and sexual health education. Levels of awareness regarding condoms and lubricants and how to use them depend more on MSM's educational, and social and economic background, rather than current exposure to health promotion messages. There appeared to be a difference between respondents of Macedonian origin, who exhibited higher knowledge, and MSM from the Roma community. Even with adequate knowledge, however, participants reported that they do not like condoms, saying they reduce pleasure.

Adolescents who offer sexual services (AOSS)

Twenty-one respondents (5 male and 16 female) were interviewed for this study, with four giving extensive life narrative accounts. The majority of those interviewed in Skopje were purposively sampled from the Roma community, as previous research suggested significant participation in sex work associated with local poverty, low educational attainment, and poor economic opportunities.

One respondent was forced to start providing sexual services, three initiated sex work to obtain drugs for either themselves or a partner, and the remaining 17 began engaging in sex work in order to earn money for themselves or their family, in some cases to fulfil basic household needs and in others to be able to afford consumer goods such as clothes and cosmetics, and pay for leisure activities. Two male sex workers reported that they served male clients, and did so voluntarily in order to increase their incomes. They did not associate with an MSM or gay identity and reported that there was no pleasure in their involvement in sex work.

Sex work was provided in a range of locations including on the street (near rail stations, in parks, under bridges), in private apartments, and in venues such as cafes, bars, restaurants and hotels. Clients also reflected tremendous diversity: businessmen, foreigners, local residents, drivers, soldiers etc. Arrangements for meeting clients and negotiating payment differed across cities and forms of sex work; in Skopje, women reported working alone and were connected to one person who was both a partner/ boyfriend to whom they were emotionally attached, but who also served as a middle-man who finds and arranges clients, protects the sex worker by waiting close by when the AOSS is with the client, and shared the earned money.

On the other hand, in Strumica, the respondents separated their emotional partner/boyfriend from the role of middle-man. There, a sex worker did not necessarily disclose to an emotional partner how she earned money and would work separately with a middle-man who would find and arrange clients for compensation, but would not serve as a protector nor receive the majority of earnings. In Strumica generally, sex work was more informally organized. AOSS often decided to start sexual exchange, working together, and only used "pimps" if they wished find clients more easily. The pimp kept AOSS' telephone numbers and when contacted by an interested client he would call an AOSS and forward the client's number or appoint the place and the time of the meeting. The clients would pay the AOSS, who paid the pimp later. Pimps did not protect sex workers, although they might punish them if clients were not happy and this could range from ignoring the sex worker, i.e. not passing on new clients, through verbal attacks, to physical attacks including beating, tearing hair or slapping.

Some AOSS worked in groups for personal security and in avoid looking suspicious to various authorities, and provided alibis for one another, including to their parents when they went out late. Most groups formed spontaneously from among friends who decided to start exchanging sex for compensation, or one girlfriend persuaded the other, but there were also groups established by third parties for profit, and who received some percentage for brokering and protection. These groups could be as small as two individuals, up to ten girls or boys.

Migration formed an integral part of sex work. AOSS from Roma settlements in Skopje would travel to Gostivar, Tetovo, Kicevo and Ohrid, for more money and customers, or because they did not want anyone from Skopje to know how they were earning money. AOSS working in other cities would often take jobs in restaurants or bars as waitresses or dancers and at the same time offer sexual services, staying from several days to 6 months. Often they would travel several times in a cyclical pattern, telling their communities at home that they work as waitresses. There was also evidence of migration between Macedonia and Bulgaria on a nightly basis, in both directions over the border.

In terms of risks to health, sex workers experienced significant levels of violence. AOSS from Skopje reported particularly severe problems with violent clients, including experiences of rape, beating and robbery. AOSS working on the street were most vulnerable. While respondents did not want to talk about violence from partners and pimps, NGO field workers who served as key informants reported seeing evidence of abuse from sex workers' personal and business contacts.

Sex workers displayed very good knowledge of condoms and where to obtain them, stating that availability was not a problem. Most got free condoms from NGO or bought them in kiosks and pharmacies. The participants in this study claimed to use condoms with clients, although 8 of the 14 female respondents had experienced a pregnancy, suggesting low use of contraception or condoms in some situations. As was the case with MSM, AOSS were more likely to use condoms with commercial partners than with partners with whom they shared an emotional relationship; this was partly an explicit strategy to separate their professional from their personal lives.

There is only one organization providing services specifically for sex workers, HOPS – Options for Healthy Life, based in Skopje. The services focus on harm reduction in sex work, not only for prevention of HIV/AIDS and other STIs, but also targeting violence, use of drugs and alcohol, stigma, and discrimination. Due to legal differentiations between selling sex as an adult (18 and over) and as a minor (under 18), there are no programs and support systems designed to meet adolescents' needs.

In this study, there was mixed evidence on sex workers' use of available services. Three respondents had sought help for drug use (two with assistance of HOPS) and three for mental disorders (anorexia/bulimia and depression, anxiety and neurosis, psychosis). Others would visit ordinary health services for minor afflictions such as colds and injuries, while others never go to a doctor. Young sex workers noted a difference between private and state owned health institutions, claiming that they had more confidence in the private sector, and trusted that treatment would be of better quality there. All respondents were also somewhat familiar with services available from health promotion NGO (information, condoms, print materials, advice and testing, assistance in receiving personal papers and health insurance, gynaecological examinations) and for most, these organizations were the only places where they could speak openly and honestly about issues of importance to them, and receive help and support without feeling judged.

When asked about the need for specialised health services intended only for people who exchange sexual services, respondents were divided between those who felt it was a good idea because they could attend without shame and would obtain information and treatment directly related to their work, and others who felt it would be discriminatory and did not want to be set apart and made to feel different from other patients.

Adolescents injecting drugs (AID)

Adolescents who inject drugs represent a specific group among injecting drug users more generally (IDUs). They have initiated injecting drug use early, and in Macedonia, are particularly vulnerable as a result of existing legislation that limits possibilities for implementing best practice harm reduction programs to protect their health.

Thirty-three injecting drug users were interviewed for this study, of whom almost all (30) completed primary education and 3 reached university enrolment. About half (17) completed secondary school, 6 were currently secondary school students, and 4 discontinued their education during secondary school as a direct result of teaching staff's attitudes to drug taking. Most lived with their parents, and a few lived with one parent, a guardian or siblings.

Twenty-four respondents initiated injecting drugs under the age of 18 years. Dugs were reported as easily available and could be bought in many locations throughout cities. During shortages in the supply, IDU usually would travel to surrounding villages or seek drugs from neighbouring cities. Young people reported that although drug dealing locations were discrete, hidden from the police and other citizens, they were known and accessible to adolescents using drugs, who communicated availability through the use of mobile telephones. Locations where young people inject drugs were also secret, and included AID's homes when parents were out, friends' homes, and discreet venues such as deserted buildings, basements, cars, parks, and dealers' homes. Chronic fear of the police caused AID to regularly change injection locations. Most stated that they wished for permanent and legal places in which they could freely and safely inject drugs, somewhere private and free from police abuse, where they could obtain sterile syringes and needles, advice and necessary medical care and social services.

Currently, AID procured injection equipment from pharmacies and through needle exchange programmes, but the practice of using previously used needles and syringes was not uncommon. Respondents knew the potential risks of lending or borrowing injecting equipment, although they perceived the need to inject drugs as stronger than fear over the consequences. Drug taking took place within social networks, and AID felt their shared injecting drug use forged companionship and peer groups that were maintained in other situations and activities. Injecting in a company of two or more AID was seen as a social interaction, and this appeared to be associated with joint preparation of drugs.

When asked about health-seeking, respondents gave examples of other IDU who had been denied medical assistance, although none of them had personally experienced such discrimination. Many AID had no information about organisations that give services and support to drug users, nor did they expect such services. Those who did know about NGOs working on drug issues had limited knowledge about what was available besides harm reduction and counselling. Use of existing services among AID is very low, primarily due to the legal age limits for service delivery, but also because many AID did not identify themselves as problem drug users. Furthermore, repressive measures by the police cause AID to hide themselves and fear any contact with authorities, including prevention programmes for HIV/AIDS, Hepatitis B and C and other health risks.

CONCLUSIONS

Among the groups most-at-risk of HIV transmission in Macedonia, identified as men who have unprotected sex with men, people selling sex, and injecting drug users, adolescents co-exist with older community members and both share many of the same experiences and vulnerabilities, as well as exhibit some specific to their age group. Across MARA, however, there do seem to be particular barriers to accessing appropriate preventive and remedial care that are related to both legislative restrictions on service provision to adolescents, and the caution with which harm reduction organisations working with at-risk groups operate in order to avoid being criticised of exploitation or abuse of young people. These barriers are further framed by prevailing social attitudes that demonise MARA and marginalise them for their participation in stigmatised activities. Repressive police activity – which may feel particularly threatening to younger individuals, especially if different laws apply to them as minors – will further discourage adolescents from admitting their potential risks and seeking assistance. It will also push MARA into hidden social spaces where they can not be easily reached, and make them increasingly hostile to any contact with authorities.

RECOMMENDATIONS

Relations with police:

All three MARA groups experience significant police harassment. Violent and discriminatory repression by the police is counter-productive for effective national harm reduction efforts, and only serves to increase vulnerability to HIV and other adverse outcomes. There is no evidence that restrictive police activity reduces the extent of illegal behaviours such as drug use or sex work; rather it is likely to push such activity “underground” where it can no longer be monitored. Agreement should be reached between HIV prevention authorities and the criminal justice system to encourage tolerance where appropriate, and active cooperation with community-based and outreach health promotion projects (needle exchanges, condom distribution, drop-in centres). NGO should try to develop productive partnerships with local police authorities and should assist individuals in taking legal action against police harassment, particularly in the case of harassment of MSM, as the police can have no legal basis for this.

Harm reduction versus community mobilization approaches:

Not all members of high risk groups share the same level of vulnerability or have the same needs. This study made clear that among MSM, there is a difference between young men who *identify* as sexually attracted to men, and those who engage in male-to-male sex without considering it part of their sexual orientation. It is likely that many of the first group may wish to support the efforts of organisations working with LGBT, which are likely to have an agenda supporting increased awareness of same-sex relationships, advocacy for human rights, and activism for equal participation in society. The capacity of these organisations should be strengthened to encourage them to reach younger men who might be experimenting with different sexual activities and need support; currently, some LGBT organisations in the region are wary of actively seeking young people as beneficiaries lest they get accused of “promoting homosexuality” or exploiting young people.

In the case of men who do *not* self-identify as MSM, access to STI information and testing, condoms and lubrication, VCT, need to be made available in locations and communities where MSM is known to exist (including prisons and juvenile detention centres) within a harm reduction framework and not linked to promotion of a specific sexual identity or association with a social MSM “community”.

Similarly, sex workers clearly expressed a difference between those who perceived a need for services specific to those who sell sex, and others who did not want to be singled out from the general population. This may also reflect a difference between (1) individuals who identify themselves as selling sex, and, in this study, expressed appreciation for those NGO that offered a venue for them to meet, discuss their priorities, and access services in a non-judgmental environment and (2) those who may exchange sex occasionally to supplement their income but do not consider it their primary occupation or the context in which they make friends and relationships. It may be that there should be a divide between making condoms and health checks easily available (in work places, through mobile clinics, at “sex worker” friendly primary health care facilities) and providing more comprehensive facilities for sex workers (drop-in centres, counsellors, availability of showers and laundry, self-help groups, skills building etc). Some attention must also be given to any sex workers identified as in coercive or exploitative circumstances.

MARA participation

As some experiences and needs of adolescents involved in risk-taking may differ from older groups (due to relations with parents, poorer understanding of risks and service availability, different daily schedules among those still in school, etc), MARA should be enlisted to assist in the development and adaptation of planned interventions to ensure they are appropriate and attractive. Where contact through existing organisations has been established, MARA could be contacted and asked to contribute as volunteers, paid staff, peer recruiters, etc. If snowball sampling was seen as an effective means of reaching MARA through research, this same method could be applied to informing communities about new services, building trust and rapport, and encouraging attendance. Social events (such as organised parties) can also be an effective way of introducing new services or facilities to at-risk groups. If MARA have their own clear social networks, these can be used to gain support among smaller groups and strengthen the intervention approach before extending coverage further.

Advocacy for legal change

Legislative change can be a long and arduous process. However, this research makes clear that legal age restrictions on access to clinical services such as harm reduction centres, will only exacerbate HIV susceptibility among the most vulnerable. Pressure should be brought to bear to change this law, through the use of case studies and public exposure of the harm the current legal framework can cause. In the meantime, wherever legally feasible, service providers should avoid recording patients’ ages in order to serve according to need.

CONTENTS

EXECUTIVE SUMMARY OF THE REPORT	3
CONTEXT AND METHODOLOGY OF MAPPING AND COMMUNITY BASED RESEARCH STUDY ON MOST AT-RISK ADOLESCENTS	11
Context.....	12
Objectives and Subject of the Mapping and the Research	12
Methodology.....	13
Methods and Techniques for Collecting Information	17
Fieldworker Note-taking	18
Ethics	18
Advantages and Disadvantages of the Methodology.....	20
ADOLESCENT MALES THAT HAVE SEX WITH MEN (MSM)	21
Introduction	22
General demographic information on the researched MSM population.....	22
Description of the scene.....	24
Individual Characteristics and Community Influences on the HIV/AIDS and STI risk among MSM	24
Institutions offering services to MSM population.....	30
Legislation in Macedonia related to the MSM risky behaviour	30
ADOLESCENTS WHO OFFER SEXUAL SERVICES (AOSS)	32
Introduction	33
General demographic information on the researched AOSS population	35
Description of the scene.....	37
Individual Characteristics and Community Influences on the HIV/AIDS and STI risk among AOSS	42
Institutions offering services to AOSS population	46
Legislation in Macedonia related to the AOSS risky behaviour.....	48
ADOLESCENTS INJECTING DRUG USERS (AID)	49
Introduction	50
General demographic information on the researched AID population	50
Description of the scene.....	53
Individual Characteristics and Community Influences on the HIV/AIDS and STI risk among AID	53
Institutions offering services to AID population	57
Legislation in Macedonia related to the AID risky behaviour.....	58
References	59
Acronyms	62
History of the project	63

CONTEXT AND
METHODOLOGY OF
MAPPING AND COMMUNITY
BASED RESEARCH STUDY
ON MOST AT-RISK
ADOLESCENTS

CONTEXT

Due to recent political transitions in the region and subsequent social and economic upheaval, Macedonia is one of the countries that has been identified as at potential risk of a significant epidemic of HIV and other STI. While available data does not indicate an impending crisis, there is also a lack of adequate information on populations that are most at risk within the country, including on their behaviour, social context, and the structural factors that may enhance their vulnerability (Ministry of Health, 2003-2006).

Preliminary research and project evaluations suggest that among populations most at-risk from HIV infection, the greatest percentage comprise young people. In particular, young people who sell sex, inject drugs, or engage in unprotected male-to-male sex have been considered to be at particular risk within the Macedonian context. Among young people, adolescents (aged 13-18) may experience the greatest degree of risk as they are less likely to have access to appropriate information and services to reduce their vulnerability. Furthermore, this category of most at-risk adolescents (MARA) have not been included as a separate target group in the second generation behavioural and serological surveillance for HIV/AIDS. (Ministry of Health, 2005; 2006)

UNICEF therefore selected MARA as a priority group for their HIV and STI prevention measures and thus commissioned the study "Mapping and community based research on MARA to HIV/AIDS/STIs in Macedonia" in order to provide in-depth information on MARA including their risk-taking behaviour, social environment and networks, and health-seeking with a view to contributing to the development of appropriate risk-reduction intervention activities.

Previous research on MARA in Macedonia

Some basic literature exists on the three target groups in Macedonia (Choneva 1994; Arnaudovski and others., 1996; Choneva 1994; Angeleski 1994; Trajkovski 2003; Jovev 2002; Tomovski 1994; Tulevski 1997; Veljanov – Kunovska 1996; Todorovska –Gjurcevska 1996; Gajdasic-Knezevik and others 2003; Tulevski – Shekutkovska 2004). These studies demonstrate that interest in marginalised populations as a topic of social science investigation has grown in recent years, partly due to the recent emergence of international and nongovernmental organisations responding to social and political changes in Macedonia since the dissolution of Yugoslavia.

Some international health institutions (UNICEF, WHO) have further focused their research on specific sub-populations among those considered to be at risk, such as adolescents (UNICEF, 2002). Formative research has offered a general picture of the context in which HIV is transmitted in Macedonia and the effectiveness of the national response. For instance, in 2006 an evaluation was conducted of services available to young people, including a basic assessment of the availability and quality of health and social services target at MARA (UNICEF, 2006).

However, until now, research has primarily taken a "health services" approach and has not considered HIV/STI from a community-based perspective that could give a broader understanding of the social context in which risk occurs and the factors that protect or exacerbate vulnerability. These previous studies did not actively elicit information from the community members themselves.

OBJECTIVES AND SUBJECT OF THE MAPPING AND THE RESEARCH

The research targeted most at-risk adolescents (MARA) in respect to contracting HIV/AIDS and STIs in Macedonia, within the age range 13 to 18. As this target group was assumed to be particularly hard-to-reach, recruitment into the study included some young people aged 19-22 engaged in the specified risk-taking behaviours, as they could provide retrospective information on their experiences. They were also likely to be part of the same social networks as MARA. Key informants (KI) were also sought out for each sub-group, regardless of age and sex. In keeping with UNICEF's wider project focus, MARA were defined as:

- a. adolescent males that have sex with men (MSM), with a special emphasis on those who have *unprotected* sex with men;
- b. adolescents who offer sexual services (AOSS);
- c. adolescents injecting drug users (AID).

The basic aims of study were:

1. To produce knowledge on the existence of MARA and describe their locations, behaviours, social context and the problems they face.
 - To locate different MARA sub-groups and collect information on their experiences at individual level, at community level and structural level with information from the community itself.
2. To identify case studies illustrating how legal frameworks, social programmes, public authorities, and available harm reduction initiatives facilitate or pose barriers to optimal use of appropriate services for MARA.
 - To analyse the information gathered from MARA that reflect all the factors influencing their individual risky behaviour and health-seeking or preventive measures.

The overall goal of the research was to translate the findings into feasible recommendations for the Macedonian context that could inform the development of appropriate policies and programmes for HIV and STI prevention among adolescents, including:

- Identification of appropriate intervention strategies for HIV and STI prevention among MARA;
- Adoption of relevant policy change and/or legislative reform to create an enabling environment for optimal use of HIV and STI related services by MARA;
- Advocacy to raise public awareness on local levels of HIV/AIDS and STI risk;
- Strengthening the capacity of stakeholders and partners to implement appropriate “best practice” approaches to HIV/AIDS and STI prevention for MARA.

METHODOLOGY

Study Design

Due to a lack of information on adolescents' participation in the behaviours of interest and poor access to their social networks, the only feasible research approach was to conduct exploratory, formative research that would establish initial contact with MARA. Qualitative methods are particularly appropriate for generating new knowledge on neglected topics, and for initiating links to marginalised populations for which it is not possible to establish a sampling frame for quantitative surveys. In addition, qualitative methods draw on the “emic” perspective from anthropology, which privileges the knowledge and outlook of “insiders” within a given community and aims to distil a holistic understanding of their own attitudes, behaviours and interpretation within a specific context (Neuman Lawrence, 2003: 140; Kristin G. Esterberg, 2002). This can offer insight into social and cultural processes and positions individuals within a wider social framework consisting of relationships, networks, and structural parameters that shape behaviour. Although not statistically representative of the population under study, qualitative data provides a basic understanding of a given situation that can then direct subsequent quantitative investigation, if required (Neuman Lawrence, 2003: 145-146; Kristin G. Esterberg, 2002: 4-22).

Research locations

All available information on AID, AOSS and MSM populations was reviewed in order to identify potential regional variations in composition and behaviour of MARA, as this could have influenced selection of study sites. However, the experience of nongovernmental organizations did not indicate significant diversity between populations. As a result sites were selected to reflect locations with sizable populations of target groups and evidence that the research team would be able to identify and make contact with MARA; this usually relied on the presence of an NGO working with the target group that had established good rapport and trust with hard-to-reach communities. Most NGOs are active in the capital Skopje, and while most have initiated some programmes in the interior of Macedonia, these are often on a smaller scale and rely on the availability of funding. Furthermore, NGO contact with each sub-group varies according to location.

Most HIV/AIDS and STI prevention programmes for young people focus on drug use, particularly injecting drug use (i.e. in Skopje, Kumanovo, Strumica, Gostivar). Organizations that work with Adolescents who offer sexual services are concentrated in Skopje, although there are NGO in other cities such as Strumica that do not have special services for sex workers but have initiated contact with some members of the community through related work. Organizations working with the MSM population, especially in relation to HIV/AIDS and STIs prevention are almost non-existent in the interior of Macedonia.

In order to maximise access to the study populations, therefore, and to ensure that research findings could be feasibly translated into interventions and capacity building activities for local service providers, the research was limited to sites with established contact. As a result, this study does not provide new evidence on MARA in cities or rural areas that do not currently have NGO activity working with these specific hard-to-reach populations, and findings can not be generalised throughout Macedonia.

The study was conducted in the following sites:

MARA Groups	Cities
Adolescent males that have sex with men (MSM)	Skopje, Strumica, Gostivar, Tetovo
Adolescents who offer sexual services (AOSS)	Skopje, Strumica
Adolescents injecting drug users (AID)	Skopje, Gostivar, Kumanovo

Sampling and Recruitment

As mentioned previously, the hidden nature of the study populations, the choice of qualitative study design, and the targeted site selection within Macedonia all precluded achievement of a *representative sample*. Instead, the study employed *purposive sampling* guided by the concept of *theoretical representativeness*, whereby respondents are selected to contribute a diverse range of experiences based on known or hypothesised differences in characteristics (sex, ethnicity, socio-economic background, choice of drugs, social network, residence, use of services, etc.). These categories remain flexible throughout the research and can be adapted as new information is gained.

During the development of the study protocol, there was concern that it might be particularly difficult to reach adolescents aged 13-18 within the target populations. Younger members of at-risk communities often feel particularly vulnerable, particularly as their legal status as “minors” can put them in an additionally marginalised position with police and other authorities. This apprehension can translate into a reluctance to participate in research, which can be perceived as an attempt to identify illegal activity for prosecution or mandatory contact with social services. The sampling strategy therefore extended eligibility for participation through age 21, with the justification that slightly older respondents could (1) provide retrospective information on their experiences a few years earlier, (2) share many of the same behaviours, perceptions and traits of younger peers, and (3) facilitate access to adolescents in their social networks.

Field researchers were selected from among NGO staff who had been working among the target population long enough to have established contact and rapport, and were thus able to recruit respondents directly. In some cases, former IDU were employed as fieldworkers and were also able to access potential respondents. The initial study protocol anticipated the use of Venue-Based Sampling, involving careful mapping of locations frequented by MARA, repeat visits to observe the nature of activity, types of people congregating, and differences throughout the day. However, as fieldworkers already had “privileged access” to the target populations, this formal approach to locating respondents proved unnecessary in most sites. Direct requests for participation in the study was complemented with “snowball sampling” whereby respondents were asked to refer their peers and social contacts to the study. The majority of study participants were recruited through this chain referral method. This ensured access to group members without recent contact with services or outreach workers and may have helped limit the bias introduced by working with a convenience sample of individuals already known to the NGO, although qualitative research experience shows that respondents often refer others with similar characteristics, and may not be networked with the most marginalised among target groups.

To triangulate and expand on data received from community members, the study identified a range of potential informants with direct or indirect contact with MARA, such as staff from NGO and state institutions, health and education providers, social services, police, and local community members (taxi drivers, hotel staff, drug dealers, middlemen, clients etc.).

The table presents the sampling framework across sites :

Sampling Framework Strategy	Age	Research Techniques	Recruitment	Field Research Units
<i>Main Target group MARA:</i>				
a) Young Injecting Drug Users				
Skopje	13-18	Interviews; Focus Group Discussions Observations	Direct contact Snowball Venue-based methods	30
Gostivar	13-18			
Kumanovo	13-18			
b) Young Men having Sex with Men				
Skopje	13-18	Interviews; Focus Group Discussions Observations	Direct contact Snowball Venue-based methods	30
Strumica	13-18			
Gostivar/Tetovo	13-18			
c) Young Commercial Sex Workers				
Skopje	13-18	Interviews; Focus Group Discussions Observations	Direct contact Snowball Venue-based methods	35
Strumica	13-18			
<i>Target group Most At Risk Adults:</i>				
d) Young Injecting Drug Users				
Skopje	19-22	Interviews; Focus Group Discussions Observations	Direct contact Snowball Venue-based methods	5
Gostivar	19-22			
Kumanovo	19-22			
e) Young Men having Sex with Men				
Skopje	19-22	Interviews; Focus Group Discussions Observations	Direct contact Snowball Venue-based methods	5
Strumica	19-22			
Gostivar/Tetovo	19-22			
f) Young Commercial Sex Workers				
Skopje	19-22	Interviews; Focus Group Discussions Observations	Direct contact Snowball Venue-based methods	5
Strumica	19-22			
<i>Target group of other Stakeholders</i>				
Professionals Working with MARA		Interviews; Focus Group Discussions Observations	Direct contact Snowball Venue-based methods	18
Key Informants related with specific groups of MARA on different way (taxi drivers, hotel staff, drug dealers)				18

During the course of fieldwork, 89 interviews were conducted with community respondents and key informants, as well as four focus group discussions, four life narratives, nine observations of activity in sites frequented by MARA, and five registry checks, as summarised below:

MSM POPULATION			
Research technique	Research units per cities		Total research units
Interview	Skopje	22	36
	Strumica	9	
	Tetovo with Gostivar	5	
Key informant interview	Skopje	1	1
	Strumica	0	
	Tetovo with Gostivar	0	
Observations and mappings	Skopje	2	5
	Strumica	0	
	Tetovo with Gostivar	0	
	General for MK	3	
Focus group interview	Skopje	0	1
	Strumica	1	
	Tetovo with Gostivar	0	
Total			43

AOSS POPULATION			
Research technique	Research units per cities		Total research units
Interview with AOSS	Skopje	11	17
	Strumica	6	
AOSS Autobiographical life story	Skopje	3	4
	Strumica	1	
Focus group	Skopje	1	3
	Strumica	2	
Key informant interview (3 NGO Field workers, taxi driver, hotel staff, café staff) (Pimp, café staff, taxi driver, Social Worker from CSW, NGO representative)	Skopje	6	11
	Strumica	5	
Observation	Skopje	1	1
	Strumica	0	
Registry check (MOI, CSW, SOS helpline of Megjasi)	Skopje	3	5
	Strumica	2	
Total			41

AID POPULATION			
Technique	Research units per cities		Total research units
Interview	Skopje	17	33
	Kumanovo	7	
	Gostivar	9	
Key informant interview	Skopje	2	2
	Kumanovo	0	
	Gostivar	0	
Observation	Skopje	2	3
	Kumanovo	1	
	Gostivar	0	
Total		38	38
Total for all MARA			122

METHODS AND TECHNIQUES FOR COLLECTING INFORMATION

Four data collection methods were employed throughout the study:

- (1) *Mapping*: In each study site, locations where each risk-taking activities are known to occur were identified, mapped and visited. Sites were characterised according to what kinds of people visited them, what interactions took place, and the demographic composition of community members.
- (2) *Fieldworker note taking*: During data collection, fieldworkers recorded the location in which research took place, the types of participants and their activities, the availability and conditions of facilities, the time of data collection, and the emotional state/ mood of participants.
- (3) *In-depth interviews*: MARA and other key informants were invited to participate in in-depth interviews lasting between 1-2 hours. With participants' permission, interviews were recorded with digital voice recorders, and later transcribed and entered into Atlas.ti for analysis.
- (4) *Group discussions*: Where possible, peer groups of MARA were brought together for informal discussions to give additional contextual information in which to frame individual experiences elicited through interviews.

One of the most important issues during fieldwork preparation was training research staff to perform fairly standardized data collection to maximise comparability of findings between sites. As field staff came from the local community and were familiar with its context, and in some cases were former target group members themselves, it was a challenge for them to suspend their own interpretation of MARAs experience and needs, but to approach the research from a position of open enquiry, and to explore similar topic areas across sites, even when they did not at first seem relevant to the local setting.

Mapping

The field research began with a mapping exercise to establish basic information such as location of MARA communities, their distribution across locations, and comparative numbers at different times and places. Direct observation, knowledge from key informants, and information received in early interviews and focus group discussions provided the data during the mapping phase. Observation was further structured to collect data on the following attributes of each location:

1. *Premises*: physical area or locations
2. *Participants*: people involved
3. *Activities*: set of activities realized by the people
4. *Facilities*: physical existing objects
5. *Act*: individual activities performed by the people
6. *Event*: set of linked activities undertaken by the people
7. *Time*: sequence taking place in definite time
8. *Aim*: the things that people try to achieve
9. *Feelings*: felt and expressed emotions

Given that observation requires the fieldworkers' presence among socially marginalized groups engaged in illicit, and in the case of drug use and sex work, illegal, activity, this component of fieldwork posed certain dangers to the fieldwork team and therefore field observations were limited, although at least two structured observation sessions were conducted for each of the three MARA target groups.

Interviews

All interviews were semi-structured and open-ended, and followed the principles of qualitative methodology, including:

- Using exploratory, flexible, open questions that encouraged respondents to shape their own narrative according to their view of events;
- Avoiding leading questions, boundaries on topics of interest, or passing judgment on the experience and perceptions of the respondents;
- Building rapport with respondents through informal conversation, including sharing experiences and information between researcher and respondent;
- Exploring topics fully before moving to a new subject area;
- Comprehensive note taking to document the content as well as the process/ atmosphere of the interview;
- Where permission was granted, interviews were tape recorded for subsequent transcription.

Group discussions

Focus groups or group interviews are useful additions to other ethnographic data collection methods as they demonstrate the way in which people discuss shared experiences, express behavioural norms, characterise group identity, and interact.

FIELDWORKER NOTE-TAKING

Fieldworkers were trained in taking comprehensive notes, not just in cases where interview respondents did not agree to recording but during all data collection. Field notes consisted of four parts, and a standardised fieldwork note taking form was used for each research activity:

Condensed description of the research (The fieldworker notes a short summary of the research activity immediately at the end of the data collection to ensure as much detail is captured. These proved useful for subsequent expansion of notes.)

Extended description of the research (Using the summary as a guideline, the fieldworker expands the notes to record the details of the activity including the setting in which data collection occurred and the content of findings.)

Autoreflexive reflections (Fieldworkers' own emotional responses are noted regarding the topics covered and the process of conducting the research in order to address personal concerns or bias. These notes are taken to assist the process of fieldwork research and are available only to the assistant researchers and supervisor. The fieldworkers have the opportunity through this method to reflect on their experiences, difficulties in fieldwork, and emotional stress that may be caused by exploring sensitive and potentially upsetting subject matter..)

Analysis and interpretation of the received results (Fieldworkers provide initial interpretation of the data and reflect on what the findings indicate so far, and what additional avenues of exploration may yet be required.)

For internal management, a process monitoring form was also filled in after each data collection activity, to maintain an up-to-date record of the study's progress.

ETHICS

The Institute of Ethnology and Anthropology from the University "Ss Cyril and Methodius" in Skopje is an accredited education and scientific institution and according to the legal framework in Macedonia, ethical approval from additional institutions was not required to conduct the study, particularly as there was no clinical component and no biological specimens taken from study participants. However, the research team established a Supervisory Committee to advise on ethical procedures and provide oversight throughout the study development and implementation.

While Macedonia does not have its own codes for research ethics, the study sought to comply with ethical guidelines available from international organizations such as the American Anthropological Association (Statements on Ethics, Council of American Anthropological Association, <http://www.aaanet.org>), the Association of Social Anthropologists of the United Kingdom and Commonwealth (Ethical Guidelines for Good Research Practice; <http://www.theasa.org/>). Fieldworker training covered basic principles of ethical research and research supervisors ensured they were adhered to during data collection (Kristin G. Esterberg, 2002: 49-50). Some specific issues related to this study are described below:

Protection of the physical, social and mental wellbeing of the respondents and their personal integrity and privacy.

This research specifically focuses on behaviour among adolescents that is either illegal (IDU, SW) or highly stigmatised (MSM) and therefore could potentially place research participants at risk of legal prosecution or other harmful consequences. As a result, ensuring **confidentiality** was of critical importance. This implies complete protection from identification of participants, and therefore any information received had to be presented in a way that could not lead to subsequent harm or abuse; this includes publication of study findings that could potentially lead to repercussions against study communities. Fieldworkers were given special training on privacy and confidentiality, and did not record any identifying information on study participants, even if they were known to fieldworkers through outreach services. All data was therefore **anonymised** at the time of collection.

During study planning, the research team discussed a range of ethical concerns, including how to ensure confidentiality should representatives from the Ministry of Interior (MOI) or other law enforcement institutions request access to the primary data which, according to routine practice, would be kept in the university's data archives. As in many international research studies, the original data transcripts become part of the public domain through the archive system and could potentially be used in ways harmful to respondents or their wider community. Similarly, the research team addressed whether writing up the research findings could itself draw unwanted attention to already marginalised groups or used in law enforcement, for instance through the identification of popular venues for IDU, SW or MSM. This could potentially drive specific communities "underground" where they would be even harder to reach with accessible services.

The decision made was to conduct the research as thoroughly as possible and to submit the full findings, including locations, time, duration and other characteristics of the three target groups and their behaviour, in the report submitted to the UNICEF Office in Skopje, which commissioned the study, as well as to the research Supervisory Committee. Subsequently, any drafts prepared for publication would require disguising the names of specific locations and identifiable details in order to maximise confidentiality and anonymity at community, as well as individual, levels.

Finally, the study adhered to principles of **informed consent** and offered each person approached for recruitment into the study timely and complete information regarding the aims and process of the study and requested confirmation of voluntary participation. Fieldworkers described the objectives of the study, the expected results, and how results could be disseminated to respondents prior to commencing data collection. Fieldwork could not start until rapport and understanding had been established between the researcher and respondent and informed consent obtained, except in the few cases of direct observation where the researcher did not elicit information from specific individuals, but rather recorded characteristics and activities in a given venue.

Remuneration for the respondents (Incentives)

Previous research with MARA, especially AOSS and AID, has demonstrated that members of these communities are particularly aware of any financial rewards available to them, such as through participation in research. Offering an incentive for both agreeing to provide data and recruiting peers into the research would make a significant difference to raising awareness and interest in the study, and would also demonstrate that researchers valued the views, knowledge and time commitment of MARA, who are often seen as worthless by society. This needed to be carefully balanced against inadvertently coercing vulnerable young people into cooperation that was not truly voluntary. Giving gifts rather than cash was considered, but rejected due to difficulties in selecting items that would be appreciated by all respondents and did not further stigmatise them (such as by giving condoms to sex workers who might not identify solely as sex workers, or products that might imply a lack of hygiene among participant groups, etc.). As a result, a symbolic financial contribution was offered in the sum of 150 MKD (approximately US \$ 3 or ū2.4) to motivate, but not unduly influence, potential respondents. This proved successful, although most MSM did not accept the incentive, saying such motivation was not necessary. During group discussions, refreshments were also provided to participants.

Advice and referral

During training, fieldworkers were instructed how to respond if requested to give opinions, advice, or help. Considering the specific target groups, this was anticipated as a likely occurrence. Field researchers were instructed to first complete data collection, in order to avoid introducing bias and then to refer the respondent to an appropriate institution dealing with the issue raised. The problem that emerged most frequently was ignorance about how and where to access good information on health, rights, and services.

Personal safety

The field work among the three MARA target groups in many cases involved data collection “on-site”. As mentioned previously, relevant venues, night-time activity, and the types of people present had the potential to pose risks to research staff as they attempted to observe events or directly contact respondents. Fieldworkers were trained in how to identify risky situations and resolve conflicts among members of target groups, or handle situations that become difficult (due to i.e. police intervention, misunderstanding with clients, interruption by outsiders, etc.). Most field researchers already worked in NGOs with direct experience of these settings, but there were a few cases during study implementation where research staff experienced dangerous circumstances and even physical assault. Research staff were advised to avoid on-site data collection where possible and to arrange interviews in safer location.

ADVANTAGES AND DISADVANTAGES OF THE METHODOLOGY

Strengths

This study design proved practical, feasible and appropriate for exploring the contextualised experiences of *extremely hard-to-reach* target groups such as MARA. It brought together a range of stakeholders for the improvement of HIV prevention and health promotion interventions, including governmental and nongovernmental institutions, and an academic department with extensive experience of social science research. The research questions and methods were thus developed in line with current policy priorities, and to contribute information relevant to design of recommendations and programs.

Another important advantage of the methodology was the involvement of *field researchers*, who were either directly involved with the target groups of MARA through projects and services, or were current or former members. Fieldworkers played an important role in planning the sampling and recruitment strategy. They were well acquainted with local conditions and had open access to MARA and could thus build the requisite trust to encourage participation. It is unlikely that fieldworkers without this “privileged access” would have been able to collect data on such sensitive issues. Using “snowball sampling” on top of this direct recruitment further penetrated social networks of hard-to-reach groups, allowing initial respondents to refer peers who might not have any contact with services or go to the venues commonly associated with drug use, sex work, and MSM.

Interviews proved useful to data collection as both fieldworkers and respondents felt comfortable with the method; as a result, the majority of the study findings emerged from interviews. There was initial scepticism toward focus groups during protocol development, as fieldworkers were concerned that MARA may not wish to discuss issues in front of others, might find public identification with a marginalised population unacceptable, or might not wish to socialise with others who might be in direct competition (particularly in the case of individuals who sell sex). These apprehensions proved unfounded, and fieldworkers found that while it could sometimes be difficult to organise a time and venue for a focus group, with adequate preparation and careful selection of respondents they were a feasible method.

Weaknesses

Venue based research involving the presence of fieldworkers in locations frequented by hard-to-reach groups proved impractical and very risky for the field researchers. In the course of data collection, field researchers encountered dangerous situations on several occasions and in one instance a fieldworker was physically attacked. Luckily this did not result in serious consequences, but it was quickly decided to immediately discontinue of this planned component of the study.

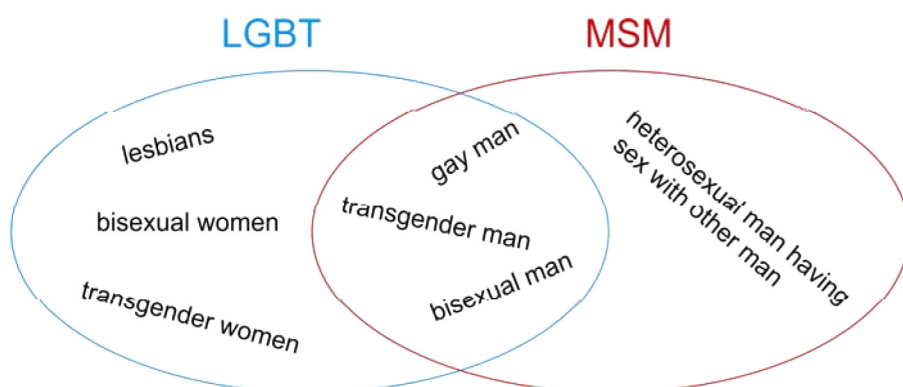
Similarly, using interactive methods drawn from participatory research approaches (PR) such as role plays, mapping activities, visual diagrams etc., did not prove successful, primarily as respondents’ lacked interest in participating.

ADOLESCENT MALES
THAT HAVE SEX
WITH MEN (MSM)

ADOLESCENT MALES THAT HAVE SEX WITH MEN (MSM)

INTRODUCTION

Men that have sex with men (MSM) is a term recently introduced in health promotion literature and does not designate a sexual orientation or identity but simply refers to same sex male activity, regardless of the motivation or interpretation of the actors involved. The term is usually applied to HIV/AIDS and STI prevention contexts in order to target sexual behaviour shown to be epidemiologically associated with epidemic transmission, without using stigmatising language or making assumptions. “MSM” is often conflated with the concept of a male homosexual, or gay, population, which causes confusion. Although some MSM (gay, bisexual and transsexual males) consider themselves as members of the LGBT-community, others who engage in MSM practices do not identify them as members of the LGBT-population, but for a range of social reasons, cultural traditions, curiosity or various other motivations have sex with men (Vrangalova 2006: 128). The diagram below illustrates the way in which the LGBT and MSM concepts overlap yet remain distinct domains. Understanding how specific groups and individuals self-identify within both LGBT and MSM populations is vital to the development of appropriate risk reduction approaches:



Representation of MSM in relation to the LGBT population

The MSM population is associated with unprotected anal sex, which is a particularly risky behaviour for transmission and acquisition of HIV and other STI. While there is a common public perception that MSM have particularly poor knowledge about HIV/AIDS and STIs, and low use of condoms and lubricants, in fact a high level of ignorance exists throughout society in Macedonia, due to weak provision of sexual and reproductive health education.

BASIC DEMOGRAPHIC INFORMATION ON THE RESEARCHED MSM POPULATION

The priority task of the researchers was to get in touch with the MSM population aged 14 to 19 years (born between 1987 and 1992). To increase the chances of eliciting information on this group, sampling was extended to age 22, although at least one respondent was 23.

Age Structure of the Informants

	Skopje	Strumica	Tetovo with Gostivar	Total per age
Age	Number	Number	Number	Number
23	0	1	0	1
22	1	2	0	3
21	1	2	1	4
20	1	0	0	1
19	6	2	2	10
18	11	1	1	13
17	1	1	1	3
16	1	0	0	1
Total per cities	22	9	5	36

Ethnic Structure of the Informants

	Skopje	Strumica	Tetovo with Gostivar	Total per ethnicity
Ethnicity	Number	Number	Number	Number
Macedonians	11	6	5	22
Albanians	1	0	0	1
Roma	7	0	0	7
Serbians/Macedonians	1	1	0	2
Croatians	1	0	0	1
Bulgarians	1	0	0	1
Not determined	0	2	0	2
Total per cities	22	9	5	36

Religious Affiliation of Informants

	Skopje	Strumica	Tetovo with Gostivar	Total per religion
Religion	Number	Number	Number	Number
Christians (orthodox)	9	4	4	17
Muslims	10	0	1	11
Christians (Roman Catholic)	2	1	0	3
Atheists	1	0	0	1
Not determined	0	4	0	4
TOTAL	22	9	5	36

Regarding educational background, most informants (15) completed secondary education, six were still pupils in secondary school, eight were university students, and the rest had only attained primary education level. Most MSM MARA respondents reported they were continuing to live with and depend financially on their parents, and only three lived alone and maintained themselves. Five were employed. The research did not put any emphasis on respondents' self-identified sexual orientation, but the interviews suggested that most identified themselves as bisexual, or felt a dilemma in defining their their sexuality due to having had at least one heterosexual sexual relationship. Others clearly and publicly identified as gay.

DESCRIPTION OF THE SCENE

From the results of this research as well as from previous experience and field work of the nongovernmental organizations involved, MSM meet each other through a range of locations and methods, such as:

- » Internet
- » Gay clubs and gay-friendly clubs;
- » Cruising places;
- » Through friends.

This study also identified private houses and apartments of MSM individuals that served as settings for MSM to meet and have sex. Introductions between MSM in private homes are informally arranged and often are organised by social networks based on city of origin, or residential area.

INTERNET

MSM from Skopje, Strumica, Gostivar and Tetovo usually meet sexual partners through the internet (and mostly through *chat*), stating that outside of Skopje, there are no suitable *cruising* places², so they have to use alternative ways of meeting. MSM also look to meet sexual partners from outside Macedonia, and this is facilitated through the internet. For some, the internet, i.e. “cyberspace” is seen as a disappointment, for others it serves as a place to meet new sexual partners or friends, or a place to start different types of relationships. The websites Gay Macedonia and *Gayromeo* and *Gaydar* are the most popular:

„ The most frequently on Internet ... Well, there is a Mirc programme ... And there is a channel *Gay Macedonia* where the gay population leaves photos and one can simply search for a male. I have found many of my partners here in the past... I made my profile at *Gayromeo* four to five months ago, I think that is a German web site that helps in finding a partner or a partner either for only an adventure or a relationship, depending what you want. You leave your profile as a short biography describing what you want. It is normally discreet and one has a contact with people worldwide, even from Macedonia...” (AU_DD_MSM_003.doc)

GAY CLUBS AND GAY-FRIENDLY CLUBS

In Skopje, gay, or “gay-friendly”, clubs provide a central social focal point and LGBT parties are often arranged weekly. Other popular venues are also referred to by MSM as *gay* or *gay-friendly places*.

CRUISING PLACES

Respondents identified a few “cruising” places in Skopje, mainly located in the central city area (the exact locations are known, however they are not mentioned in the study because of possible misuse):

Prior to commencing fieldwork, members of the research team had heard about the use of public male toilets as cruising sites, but no informants mentioned it as place for meeting sexual partners. It is possible that the public toilets are frequented more by adult MSM.

The Roma population in one of Skopje’s settlements reported a finding sexual partners within their community, often in open spaces, where sex also occurs.

INDIVIDUAL AND COMMUNITY INFLUENCES ON THE HIV/AIDS AND STI RISK AMONG MSM

This section presents findings on individual and social level determinants of risk behaviour among MSM MARA.

Individual characteristics of MSM

Knowledge that influence behaviour

Accurate knowledge on HIV and AIDS among MSM appears poor. Although almost all respondents had heard about the HIV-virus and AIDS and knew it was a fatal disease transmitted through sex, they did not have additional information regarding relative risks or protective measures. Primary sources of information came from some nongovernmental organizations, schools and media:

² The places where the members of the MSM population gather, meet and hang around.

Informant: I have heard of HIV/AIDS, meaning I have heard at school, read in magazines, through media, so I know pretty well about the notion HIV/AIDS. According to me it is a disease of the twenty-first century. This means not only the young but also the older are infected.

Interviewer. What do you know about AIDS in general?

Inf.: On AIDS? What shall I say on AIDS? It is a disease that is the most frequently transmitted through sexual intercourse, either in relation between a male and a male or a male and a female, and I am not sure in relation between women and women. It means that the disease is transmitted through sexual intercourse. I have been informed that it can be transmitted a little bit through swallowing of saline, through blood. It is mostly transmitted through vaginal and anal sex. And I know that it is dangerous and a disease that causes death. There is still no medicine to cure it.

(AU_DD_MSM_003.doc)

MSM from one Roma settlement in Skopje exhibited least HIV-related knowledge, possibly because many have not continued education beyond primary school. According to a key informant from the NGO sector, when the EGAL office was opened in the Roma settlement several months ago, a preliminary assessment determined that the knowledge was low to none:

“On opening the premises of EGAL in the Roma settlement in Skopje, we met a different group of persons and/or the Roma population, where the level of education is very low - the average level of education, ... is lower in relation to the others. Here a significant difference has been noticed in knowledge. Most frequently those people who attend the curriculum after the primary school have a little bit bigger ... not little, but sufficiently bigger information, while those that have not completed their education, even the primary school, or have only completed the primary school, have even less information on HIV/AIDS.”

(AU_KI_MSM_001a.doc)

The situation was the same for knowledge of STI. The key informant suggested that many MSM experienced STI but did not take any treatment measures, but rather waited for the disease to go by itself. He suggested that future programmes should focus on providing comprehensive sexual health education to the MSM community³.

Interviewer: Have you ever heard of any sexually transmitted diseases?

Inf.: Well, yes I have such as hepatitis, gonorrhoea, chlamydia ... Too much this was discussed at school.

Interviewer: Do you know any symptoms of those infections?

Inf.: Symptoms? .. I don't know, some swellings in the sexual organs, redness.(AU_AM_MSM_003.doc)

MSMs' knowledge and use of condoms and lubricants depended on their general education and social and economic background. Macedonian MSM appeared to have better knowledge about condoms and lubricants compared to Roma. According to the information from the key informant in the Skopje Roma settlement some sexually active MSM have never seen or used condoms in their life and let alone lubricants⁴. Respondents said they did not like condoms because they reduce pleasure and so avoid using them; as for lubricant, users reported it facilitated sexual activity: “it hurts” less and “slides” better and “enlarges” the anus.

Interviewer: Have you ever heard of a lubricant and what is its purpose?

Inf.: Yes, I have.

Interviewer: What do you use it for?

Inf.: I use that for an anal sex, it is better for me because it don't have a pain. And it is better because I don't have a sex with a dry anus. (AU_AM_MSM_003.doc)

³ Key informant (AU_KI_MSM_001a.doc)

⁴ Key informant (AU_KI_MSM_001a.doc)

Attitudes related to the risky behaviour of MSM

Descriptions of MSM sex specified several possible roles: *active*⁵, *passive*⁶, or universal (*uni*)⁷. Some MSM, are exclusively or only *active* or only *passive*, and the greatest part are *uni* (versatile).

MSM self-identify and are defined within their communities according to their preferred role in sex. However, MSM who report the *passive* or *uni* roles also identify themselves as part of the LGBT population, whereas many who exclusively practice the *active* role in sex do not perceive themselves as part of this population. These are often married men who have never had a long-term relationship with another men and who identify themselves as heterosexual, but regularly visit the “terminals” or other venues for anonymous MSM sex. Taking the active role in penetrative sex maintains their “masculinity” and they characterise themselves as “big guys that fuck men because women are not enough for them”, rather than as gay or bisexual.

In this study, respondents reported most MSM practice masturbation, anal and oral sex while some practice fingering, and rimming and fisting while the use of sexual toys (dildo and vibrator) were not mentioned at all.

Sexual networking generally crosses ethnic and religious lines, although there appear to be some patterns based on social background. Among MSM, there appears to be less intolerance than found in other social research conducted among the general population in Macedonia. Some distinctions appear apparent, with Christian and Muslim individuals preferring to socialise with others from the same religion. This is not always the case, however, as respondents from the Roma community stated that they avoided contact with Albanians, despite sharing the same religion. On the other hand, some Macedonian (Christian) respondents reported seeing contact with Albanians (Muslim).

Interviewer: Is the ethnic belonging important to you?

Inf.: Yes, it is. Of course (laughing). Meaning ... I don't know. I think I would never have a sex with a Roma.

Interviewer: With a Roma? Why?

Inf.: I don't know, I cannot explain to me.

Interviewer: Do you have any prejudice towards Roma?

Inf.: I neither have prejudice nor stereotypes, but somehow they are rejective to me, I don't know why.

Really, there are some that are clean and care of themselves but ... I can't explain that to me ... Simply I cannot accept that. (AU_ZJ_MSM_003.doc)

Interviewer: Tell me if you make selection of partners according to their ethnic and religion belief?

Inf.: Well, Let me say that I avoid contacts with

Interviewer: Albanians?

Inf.: With Alb ... No, generally with Muslims.

Interviewer: With Muslims.

Inf.: Eh, now ... I do not do that consciously – even when I do that I understand that it is subconsciously because, how I would say, this is how I was thought ... I don't know, I have some prejudice that things go like this and we are on one side and they on the other side – although I don't consider myself to belong to any religion ...” (AU_AM_MSM_003_04.doc)

Interviewer: Good. Do you select partners according to the religion belief?

Inf.: No; I don't. According to me all people are equal regardless of the ethnic, religious belief. This means I have no limitations, I am simply not a racist”. (AU_DD_MSM_003_03.doc)

Similarly, the wealth or status of other MSM did not play a particularly significant role in partner selection, although physical appearance and clothing were decisive factors influencing choice. For the most part, among gay-identified MSM, a “feminized” partner was not as desirable as one who was masculine or *straight looking*. Respondents frequently repeated that if they wanted a woman, they would find a woman, rather than a feminine-looking man. Being gay was associated with attraction to masculine appearance. Some members of the gay population declared their interest in the challenge of finding heterosexuals or *straight men* as sexual partners, although when asked if they would accept a relationship a married man, most stated they did not want to meddle in the families of others. Not all informants shared this view, and one Roma MSM stated that sex is better with married men because of their greater experience in sex.. Among MSM who do not identify as gay, however, there are some who look for partners with a more “feminized” appearance to play the passive role.

Risky behaviour of the MSM population

MSM reported their first sexual experience between the ages of 9 and 18, primarily with a male partner. In some cases, mostly from the Roma community in one Roma settlement in Skopje, the first sexual experience was with a relative or closer friend and was violent; among other cases first sex was voluntary.

⁵ When the wishes and inclinations in the sexual intercourse are insertive or penetrative.

⁶ When the wishes and inclinations in the sexual intercourse are receptive.

⁷ When the wishes and inclinations in the sexual intercourse are both active and passive, of course in agreement with the partner.

I was about eight-nine years of age, I had a sex with someone, he was my cousin and I tried that with him for the first time, but then it was against my wish but I was forced. But that is how I started...” (AU_SJ_MSM_001.doc)

„ My first sexual experience was at thirteen and a half years of age ... Then I started feeling I like men. I acquainted one through an Internet, we made an appointment and I went to his place... He was the first ...” (AU_AM_MSM_002.doc)

A few MSM reported having their first sexual experience with a woman; the majority of respondents had had at least one sexual experience with a woman during their sexual life.

„The first sexual intercourse I had with a girl And later with men ... When I started the first year, prior to starting one week before that year, I entered that gay world, but before that I was purely a straight person and I went out with girls and had sex with them ...” (AU_ZJ_MSM_003.doc)

When asked how often they change their sexual partners, MSM usually answered that they would like to have stable and longer relationships; only six of 36 informants agreed to disclose the number of sexual partners in the past year of throughout their sexual life. All six informants mentioned having more than two partners per year. Other respondents said that they do not frequently change partners, although widespread avoidance of reporting specific figures suggests that the question was considered too personal, or respondents were wary of giving socially undesirable responses that could reinforce negative stereotypes about promiscuity.

MSM reported almost always using condoms during anal sex although use drops off after they have been with a particular partner for longer.

Interviewer: How often did you use a condom with your partners in sex?

Inf.: Always.

Interviewer: Always? It has never happened to you ...

Inf.: Always. It has never happened to me.

Interviewer: Good.

Inf.: Regardless the partner insist it has never happened to me and it will never happen (laughing).

Interviewer: Good. We are talking about the anal sex.

Inf.: Yes. (AU_ZJ_MSM_003.doc)

„Usually I practise to use but sometimes, I have not used few times ... More times I have used. Few times ... Twice – three times no ...” (AU_ZJ_MSM_002_02.doc)

Interviewer: Do you often use a condom during an anal sex?

Inf.: I do not use with my boyfriend.

Interviewer: Why?

Inf.: Because I know him what a man he is. I have already been with him for two years and to be honest it is good that I protect myself with a condom, but I feel better without a condom, but only with him, I use it with others ...” (AU_SJ_MSM_003_06.doc)

In comparison condom use for anal sex, condoms are hardly used for oral sex.

Case study - risky behaviour

Erdzan⁸ is an eighteen years old Roma from Skopje. He finished primary education and lives with his parents in Roma settlement in Skopje. He had his first sexual experience between ages eight and nine with his 20 year old cousin. Despite changing partners often, Erdzan does not use condoms for anal or oral sex because he enjoys sex more without them.

Erdzan is aware of the condom's function and that it protects from STIs and HIV/AIDS. He suggests that this is not as important as enjoying the moments of sex for him. However, if one of his sexual partners were to insist, he would agree to sex with a condom.

⁸ The name is invented in order to hide the true identity of the person.

Interviewer: Do you know why the condom is used?

Inf.: Well yes, to protect you, not to catch anything, but I do not want that.

Interviewer.: So the condom is not important for you?

Inf.: No, it is not important.

Interviewer: Have some of your partners used condoms?

Inf.: Yes, it happened to me once but I did not feel anything, there was no pleasure, the condom bothers me a lot.

Interviewer: And what if the partners want to have sex with you only with a condom?

Inf.: I will accept to put on the condom...

Erdzan has had group sex with three men on once occasion and this was unprotected, i.e. no one from his intimate friends used protection. After the end of the sexual act, Erdzan felt scared and regretted the event.

Interviewer.: Did you experience sex with many partners at the same time?

Inf.: I have

Interviewer.: How many partners?

Inf.: Well I had it with three.

Interviewer: At the same time?

Inf.: Yes, only once. I had three and then I could not anymore, I felt tired.

Interviewer: What did you do with them?

Inf.: Well I blowed all of them, one fucked me behind, I wanked another, I blowed the other one and that is how I came. Each had their turns on me and that is how they came.

Interviewer: Do you practice often this kind of sex?

Inf.: With three men no, it happened only once, in that moment I felt very disgusting I even regretted it.

Interviewer: Why did you regret?

Inf.: I felt very humiliated when I was doing it. I was not aware, I did not want to be like this.

Interviewer: Why did not you feel nice at the moment?

Inf.: Yes, in the moment I felt nice, but later I regretted. Why? Why, because I was with three, I got scared not to catch anything [diseases] because I did it.

Interviewer: Why did you not use condoms? Did you think it is not necessary?

Inf.: Yes

Interviewer: How did you know that it is not necessary?

Inf.: Well I saw that they do not mention it, I didn't either (laughs).

Interviewer: So for you it is not important whether you use condom or not?

Inf.: Yes...

(AU_SJ_MSM_001.doc)

The risky behaviour of some MSM remains similar for new sexual partners. Many respondents reported having sexual intercourse with persons they do not know; one stated that he barely knew one partner, another entered into a sexual encounter on the recommendation of friends. Others were more aware that sex with persons they do not could pose risks and so used a condom whenever possible.

Use of alcohol and recreational drugs could affect condom use, although drug use was rare. If alcohol was consumed in large quantities prior to sex it could negatively influence condom use.

MSM and the wider social community

In Macedonian society, homosexuality is considered socially unacceptable and thus MSM remain a hidden population and avoid publicising their sexual orientation to family members, particularly parents. Some expressed having had a wish to confide to their parents, particularly during adolescence, but did not do so out of fear that they would be misunderstood and receive a negative reaction. A few confided to other family members, most commonly their sisters, who were said to understand and accept them as they are. Others disclosed to relatives who live far away, including abroad, and who guarantee discretion.

Interviewer: Fine. Tell me whether your family knows about you? Have you ever thought of telling about your sexual orientation?

Inf.: My family doesn't know but I would like them to know, but I don't know. I think they will not understand me ...

Interviewer: Why do you think that they do not understand you?

Inf.: Because (laughing) ... how shall say, they are brought up in a patriarchal manner ... this topic is a taboo for them ...

Interviewer: Have you ever tried ...?

Inf.: According to their reaction, when they hear something about such men, their reaction is such that I would neither dare nor tell them”.

„My sister knows about my sexual orientation and has accepted that in a normal way. She is modern, communicative, positive, and pleasant. She always supports me. This doesn't mean I share almost everything with her, but I can trust her on this topic. I had decided to tell her when I had a period of depression, unease about why I am a gay, why I am attracted by men. Simply I was still inexperienced how I could entrust my secret. My sister is very close with me. I gathered courage and decided to tell her and my life since then onwards has become easier in terms of ... I cried and she asked me –, why do you cry” and I told her without telling her directly ... as if ... at the beginning going around, because when talking directly it is not always good, especially to tell her that I am a gay or something like that. I started telling her that there are such and such people, this and that. We discussed the matter of lesbians, gays, straight people, and she asked me why I was talking on that matter. And then I told her – Ey, my older sister – I am a gay - At first somehow she was surprised and said: Well, fine, she told me that I have her entire discretion and in terms of that you are a gay, my support . She accepted it not that easily, however, this was quite enough to me.” (AU_DD_MSM_003_06.doc)

The situation with friends is similar. Members of the gay community in Macedonia very rarely dare admit their sexual orientation to close friends out of fear of losing them as friends, worse, “betrayal” and exposure to the wider community. The situation is the same with colleagues from work. Fear of exposure at work seemed particularly salient and MSM expressed concern that they could lose their job. Some believe there has been some discussion of their behaviour within their work or school, although it has not been confirmed and no one knows about their MSM activity officially.

For MSM from a Roma settlement in Skopje it was especially important that their parents and close family not find out about their activities, and were less concerned about neighbours and colleagues from work recognising their sexual orientation.

MSM seek to avoid stigma and degrading and mocking behaviour through their secrecy, and therefore for the most part reported few episodes of discrimination. Only some Roma described such instances, including in the family, on the street, and within the neighbourhood; they reported having been called called by pejorative names (buljas⁹), and publicly insulted.

No discrimination by staff at medical facilities was reported, although the physicians were not aware of the respondents' sexual orientation. One MSM, from the Roma settlement, had experienced problems with the police, specifically from the “Alfa” unit, who degraded and insulted:

Interviewer: Have you had unpleasant experience with the police because of your gay orientation?

Inf.: I had. Not with the police, but with the “Alfas” and it happened twice. The first time was you know, but the second time... We sat over there, all of the company and all of us gays.

Interviewer: What did you do there?

Inf.: Well sitting and waiting for our customers.

Interviewer: Is that the place where you gather?

Inf.: Yes. We saw from afar a car in which were the Alfas, they lit us with their headlights and came out from the car. They asked for our identity cards, and then I was only 16 years and I told them that I was not of age and they asked me: “What are you, a pansy?” and I answered them “I am gay”, and they answered me back “Aaaa you are gay”.

Interviewer: What happened then?

Inf.: Well nothing, they moved away and left. But the second time they humiliated me and I felt insulted... Well, on the second incident I had, I was the only gay in the company and when we saw off another gay friend, I was left with two hetero friends. We were coming down when one car with the Alfas passed by. They stopped and looked at me. “Who the hell are you, gay” they told me, and I replied “Don't you see who I am?” “You look like a girl” so I said “I am gay”, “Aaa you are gay, you wanna crawl?”. I just looked at them and I asked “Why should I crawl?” and they started to laugh, grin. I just kept my mouth shut and was quiet. They asked for my identity card to which I replied that on the 22nd of October I will be 18 years and I will go and get one issued, but I can honestly tell you that even now I do not have an identity card. They started to laugh at me, I do not know how long and then my friends even started to laugh at me in front of the Alfas and one from the Alfas asked “Why do you laugh at your friend, isn't it a shame?” “Surely some of you go out with him?” And they said that no one goes out with me, I do not know... They said so many stupid things among them and told me that I was free and I left.

⁹Equal to homosexual, but in pejorative connotation; homosexual who practices passive position in sex.

Sexual violence and physical abuse due to sexual orientation were not widely reported. Only two MSM respondents (Roma from the Skopje Roma settlement) had some problems. One was beaten and sexually abused by his twenty year old married cousin, and the other was beaten after breaking up with a boyfriend.

INSTITUTIONS OFFERING SERVICES TO MSM POPULATION

At the moment three nongovernmental institutions work with the MSM population in Skopje. Those are EGAL (Equality of Gay and Lesbian), CCHR (Center for Civil and Human Rights) and MASSO (Macedonian Association for Free Sexual Orientation). These organizations have existed for only several years, beginning in 2002. The oldest one is the Center for Civil and Human Rights, which from its beginning has focused on the visibility of the LGBT population in Macedonia and campaigned for awareness and tolerance within the general population¹⁰. The organization MASSO works on legislation related to the LGBT population, and the newest is EGAL, established in 2004, which works on the sexual health of the LGBT population and cooperates with the Republic Institute for Health Protection in Skopje where free HIV-testing is provided. MASSO receives the most attention within the media and is therefore best known and has become a synonym for LGBT in Macedonia.

As these organisations are centred in Skopje with minimal activities in the interior of Macedonia, the LGBT has not had access to sufficient knowledge throughout Macedonia. Their activities are limited by available funding, yet the fact that they have managed to reach LGBT is apparent from this study. Respondents reported particular familiarity with MASSO, then EGAL, although the CCHR was not mentioned at all. This reflects MASSO's dominance in the media, and EGAL's direct contact with MSM through outreach workers who distribute condoms, lubricants and sexual health materials. EGAL does not seek publicity or media coverage to avoid drawing attention to their target communities and potentially causing harm to users of their services. The CCHR, despite being the oldest organization, started to become better known only in recent through the publication of the magazine "Hello". Although study respondents have heard about these organizations, they do not know much about their work beyond that they work for improvement of LGBT status in Macedonia.

When asked about the available services from these organization, respondents knew most about EGAL, which gives out free condoms and lubricants in cruising sites, and also MASSO although they are not as clear on what it offers.

Informants suggested they trusted nongovernmental institutions more than state institutions. However, most MSM informants had not ever sought services either from nongovernmental organizations nor from state institutions, and they express negative attitude towards them. Some have had a poor experience themselves or have heard about someone else's bad experience, or fear disclosure of their sexual orientation.

Interviewer: Do you consider these organizations to be trustworthy and that they could help you in case you asked for a service?

Inf.: I don't have any experience with them, I have not asked for a service, however, I am not a hundred percent sure that they are a hundred percent discreet. (AU_DD_MSM_001_06.doc)

„Well, I don't know, I am somehow sceptical about that issue so I don't know. I wouldn't dare. Maybe if possibly I ask for a service I wonder if this would be discr... discrete, but I don't know. It takes time...” (AU_DD_MSM_001_07.doc)

LEGISLATION IN MACEDONIA RELATED TO THE MSM RISKY BEHAVIOUR

The research explored whether MSM adolescents were aware of the laws regarding sexual activity between men. The answers varied: some felt MSM was not punishable, others believed it to be a punishable offence, while others were not familiar with the issue. A majority were not completely sure.

MSM were divided in opinions regarding legislation for same sex matrimony. Some thought that such law was necessary and if it was enacted they would be ready to make use of it, and some thought that it should not exist because it is not a normal thing.

¹⁰ Key informant (AU_KI_MSM_001a.doc)

The view was also expressed that even if marriage were to be legalised in Macedonia, no one would use it because they would thus admit that he/she is a homosexual (come out) and this was unlikely due to traditional disapproval, homophobia and stigma and discrimination prevalent in the social environment. Some stated that they would only openly live with an MSM partner if they were staying somewhere where no one knew them.

Interviewer: Do you consider it necessary to have a law on marriage between the same sexes?

Inf.: No, I don't. It is Ok to have. I am not against that but, I think that in Macedonia none would dare ...(AU_ZJ_MSM_001_05.doc)

Interviewer: It means that you feel prepared to use that law if adopted?

Inf.: I have not thought of that, yet, but I assume that as the time passes it would be possible.

Interviewer: Where would you live? Would you stay in Gostivar?

Inf.: No, I would not. No way.

Interviewer: Yes.

Inf.: No.

Interviewer: No. Where would you like to go?

Inf.: I would live in another town either in Skopje or in another place except in the town I originate and where I live ...(AU_DD_MSM_001_08.doc)

ADOLESCENTS
WHO OFFER SEXUAL
SERVICES (AOSS)

ADOLESCENTS WHO OFFER SEXUAL SERVICES (AOSS)

INTRODUCTION

Discussing adolescents' or young people's exchange of sexual services for money or material goods is internationally classified as abuse or commercial sexual exploitation of the children. For example, WHO defines Commercial Sexual Exploitation of Children (CSEC) as "using a child for sexual purposes in exchange for money or other gain between the user, middleman or agent and another person profit in from the child trafficking for these purposes". WHO follows the United Nations in the identification of 3 forms of CSEC: child prostitution, child trafficking and child pornography. They define child prostitution as "an act of engaging or offering services from a child to provide sexual acts for money or other goods with that or any other person" (WHO, 1996).

Nevertheless, many authors and researchers believe that analytical frameworks that emphasise exploitation (i.e.: child prostitution and paedophilia) limit understanding and possibilities for care for the young people involved, and that "using the terms like 'child prostitution' is prone to very limited use regarding providing services because there is evidence showing that in all except one instance 'the prostitution' did not describe the reality of the person in question" (Amanda Davis, 2001).

"Many children do not consider themselves as exploited. For some, this experience is part of the cruel reality of life on the street. Some seek attention and feeling of personal value which often is unavailable from other places. Others appreciate the fact that there is a degree of anonymity, regardless from the real limitation of their life choices" (Grabosky, P., & et al., 1998).

The CSEC also presents the difficulty in differentiating between a child and a young person. Many youth agencies define young people as aged from 12 to 25. The Convention on the Right of the Child, however, defines a child a person below 18 years, regardless of country-specific definitions.

Some authors suggest that it is important to recognize physical and sexual abuse of young people/children that take place within a commercial context, and that this should be defined more precisely as "commercialized child sexual abuse". This definition allows for reviewing the issues related to the 'commercial' sexual exploitation of the children, in situations when it takes place, but also allows for reviewing a wider context in which sexual exchange is a common behaviour of young people and needs to be understood within local parameters.

Sexual exchange is itself further classified into several typologies: survival sex, opportunistic sex, sex for favour or gain, formal sexual work where persons see themselves as professional sex workers and the previously elaborated sexual exploitation.

In the literature, survival sex and opportunistic prostitution refer to satisfying immediate 'needs,' and are generally considered to comprise a 'survival strategy'. **Survival sex** is often described as selling sex to meet general, basic needs for food, shelter, money or drugs. **Opportunistic sex work** is associated with satisfying a "concrete" need that may not be immediate: "an act involving giving sexual services in return of goods and services such as drugs, food or accommodation and/or act involving non differentiated sexual promiscuity often motivated by the desires for confirmation, attention and love". Together, the concepts of survival sex and opportunistic prostitution are differentiated from more formalised sex work (organized and seen as work/profession/career) (Amanda Davies, 2001).

Other authors have highlighted that many young persons engage in sexual exchange for more than survival in some situations engaging, and can be motivated from 'gain' related to pleasure, enjoyment or emotional safety and sometimes is used from the young people as a way of sexuality research (Saunders, P., 1998).

ECPAT (**End Child Prostitution, Child Pornography and Trafficking of Children for Sexual Purposes**) acknowledges that there are differences between sex work (prostitution), survival sex, sex for services and opportunistic sex work, but group them together under the umbrella term **commercial sex activities** (CSA) which is less condemning of young people. (Amanda Davies, 2001).

No relevant or systematic research on the prevalence and context of sex work in Macedonia have been conducted. In terms of interventions, only one organization provides services specifically designed for the support of sex workers: HOPS – Options for Healthy Life from Skopje. The services given by HOPS are oriented towards risk reduction in sex work, with a focus on HIV/AIDS/STIs, violence, use of drugs and alcohol, stigma, discrimination, and have been directed towards adults. For persons under 18 years there are no specific programs or support systems. HOPS started activities among the sex workers in 2000, and the program has involved around 200 women, men and transsexual persons that do sex work mainly on the street or in the Roma settlements in Skopje (Manderson, L., Bennett, L. R., & Sheldrake, M., 1999).

According to information from HOPS, most sex work in Macedonia takes place in night clubs, bars/restaurants and private residential facilities. However, these sites are accessible only to a limited number of visitors and it is extremely difficult to establish contact and develop health and social services. The open (street) scenes are the most obvious form of sex work and provide the opportunity for direct access to sex workers. Furthermore, the open scenes are where sex workers with the greatest number of health, social and legal problems (low level of education and knowledge on SRH, STIs and protection, high level of risky behaviour related to use of drugs and alcohol, high level of violence, stigmatization, problems with personal documentation and lack of recognizability in the frames of the institutions etc.) are concentrated (V.Dekov, L.Ignjatova, H.Jankuloski, D.Kostovski, M.Toseva, 2006).

Regarding sexual exchange among adolescents, there is no confirmed information. Some evidence from the field provided by HOPS and anecdotal information suggest that young people participate in all the abovementioned forms of sexual exchange, but this study is the first serious research of this situation.

The aim of the study was to explore the different forms of sexual exchange among adolescents in Macedonia, to examine the forms and situations of risky behaviour for HIV/AIDS and STIs, to look at the context in which they appear, to discover the social contexts which shape risky behaviour of AOSS and to make recommendations for the development of an appropriate support system for these young people according to their needs and life situations.

Sex workers or persons who exchange sexual services represent an extremely hidden and hard-to-reach group for access, communication and research, particularly those who are under age. Thus, access for this study was extremely limited and could not hope to reach young people engaged in all forms of sexual exchange. This assumption was proven in the course of the research. Adolescents who offer/exchange sexual services do not identify their behaviour as sexual exchange/work and often do not consider themselves to belong to a group of sex workers, making it difficult to establish contact with them. Fears of stigma and discrimination, the police, violence, and exposure all also mitigated against the researchers' ability to recruit study participants. Furthermore, sexual exchange (both formal and informal) usually involves large numbers of participants such as: procurers, protectors, middlemen, etc. many of whom also fear prosecution (particularly if it is discovered that minors are involved) and therefore seek to prevent or hinder contact with AOSS.

Respondents were recruited from Roma communities in Skopje and Strumica (where several forms of sex work have been identified, including formally organized sex work, survival sex, opportunistic sex) and young people (secondary school students) from Strumica (engaging in opportunistic sex and sex for favours). Some key informants provided information on sex for favours among university students and secondary school students in Skopje, but it was not possible to collect information directly from this target group.

GENERAL DEMOGRAPHIC INFORMATION ON THE RESEARCHED AOSS POPULATION

The research covered adolescents who offer/exchange sexual services from ages 13 to 20. Two female sex workers aged 26 and 28 offered particularly rich information on particular aspects of young people's involvement in sex work and were included in the study through the life-narrative method, in which respondents are encouraged to give an account of their life histories, using their own perspective to guide the storyline and highlight specific events and the links or causal relationships between them.

Age structure of the interviewed AOSS

	Skopje	Strumica	Total
Age	Number	Number	Number
13 years	1	0	1
16 years	4	0	4
17 years	3	3	6
18 years	2	3	5
20 years	3	0	3
26 years	0	1	1
28 years	1	0	1
Total per cities	14	7	21

Respondents started to exchange sexual services for some remuneration at the age of 11, 13, 14 or 15 years, together with peers/ friends of the same age.

„I started going out with a girl to one old man... He called us once and we were always going there, when he received his pension and he gave us money ... And you know how it is when you have eighteen years of age. One is not clever at that age.“ (AU_KP_ANSU_03)

Also, different types of key informants confirmed the existence of adolescents offering sexual services:

“There are 16 year old girls. (Are there younger than 16?) Well I do not believe. I haven't asked if they are younger or not...Well sometimes they come, so I drive them to the hotels. And the same in private houses. And in homes...the ones I drive are 12, 13 years... Well most of them are from two settlements in Skopje some...All of the Roma...” (AU_KP_ANSU_11 taxi driver)

Five male and 16 female AOSS were included in the study. The male respondents offer sexual services only to men, although some knew males who offer sexual services to women. During the research we did not succeed in reaching this group.

Gender structure of the interviewed AOSS

	Skopje	Strumica	Total per gender
Gender	Number	Number	Number
Male	3	2	5
Female	11	5	16
Total per cities	14	7	21

Respondents were in agreement that the majority of young people who exchange sex are females, with a minority represented by MSM sexual exchange. There was evidence that among Roma settlements, there are boys and young men who declare themselves as heterosexuals, have emotional and physical relationships with females, but have sexual intercourse with men who self identify as homosexual for money. Two of the male respondents fit this characterisation and stated that they do not feel they are homosexuals and have no attraction to men, but offer sexual services to the homosexual community for payment.

Ethnicity of the interviewed AOSS

	Skopje	Strumica	Total per ethnicity
Ethnicity	Number	Number	Number
Macedonians	0	5	5
Albanians	1	0	1
Roma	13	0	13
Turks	0	2	2
Total per cities	14	7	21

Among respondents from Skopje, 93% were Roma, primarily because the research focused on the previously neglected Roma community. Data collection was guided by the assumption that because the Roma population in Skopje is characterised by extreme poverty, low educational attainment, poor livelihood opportunities, and some types of coercion, sexual exchange might be more common among young Roma. The fieldwork team already had built up relations with key Roma community members through HIV/AIDS prevention activities and this contact and established trust facilitated the study's access to Roma for data collection. Indeed, it proved easier to conduct the study with Roma than among other ethnic groups. The greatest advantage was using outreach workers as field researchers in the study.

Although there is some information about secondary school students offering sex for money of other benefits in Macedonia, the study did not manage to establish a contact with these adolescents, despite specific efforts to do so. The information gleaned on the existence of sexual exchange among secondary school and university students came from one key informant of Macedonian ethnicity who works in an elite café in the center of Skopje.

In Strumica, the structure of respondents differed slightly. This was partly due to good access to the Roma population and the inclusion of Turkish respondents, but also again due to the nature of the contact between local field researchers and specific key informants who are involved in sexual exchange. Thus researchers managed to reach ethnically Macedonian respondents, who behave with some slight differences compared to other ethnic groups.

First, there are differences in education between Turkish, Roma and Macedonian adolescents. Turkish and Roma respondents reported very low educational attainment: four had finished primary education, six completed 4th or 5th grade and six had no education at all. By comparison, Macedonian respondents were all secondary school students actively involved in their schooling (3rd and 4th year in secondary education).

Reasons for lack of school attendance by Roma adolescents vary:

In some cases the parents themselves do not enrol the children in school:

„Why I do not go to school?! They did not enrol me ...” (AU_KP_ANSU_03)

Other parents do not pay much attention to whether the children go to school regularly and do not help to motivate them to stay in the education system, so some invariably drop out and face no resistance. In yet other cases, parents withdraw the children from school and this occurs for a range of reasons (poverty, the need for the child to make money and contribute to the family budget, etc.). Most respondents came from poor and large families (from 4 to 8 members, and two respondents had small children living with them) where no one or only one family member works or receives a pension. Often the jobs in which family members were employed were unskilled labour (cleaning lady, butcher) with low salaries that did not cover the survival needs of the entire family.

Six respondents mentioned that they also receive financial assistance from the social welfare system, from 1600 to 3000 MKD which also is not sufficient to meet the needs of a family. For some respondents, therefore, the discontinuation of schooling was directly linked to initiation of offering sexual services.

DESCRIPTION OF THE SCENE

LOCATIONS

Location where they meet with the clients

AOSS meet clients in previously agreed places. In Skopje these are either very busy streets, crossings, kiosks or bus stops, the Old Railway Station, in/under some bridges near the Vardar, in some cafes or in deserted, empty and dark places, such as parks, parking lots, schools etc. with the aim to limit visibility and remain unnoticed within the environment except by potential clients.

In Strumica, in Turkish and Roma neighbourhoods, AOSS meet on the street, while respondents from Macedonian ethnicity state that they meet in private apartments (mostly rented by the AOSS themselves), in cafés/bars/restaurants and in hotels outside the city – in the vicinity of Strumica, but also in Bansko, Gevgelija, Valandovo.

Location where services are provided

Sex is offered in hotels, private apartments or outdoors in parks, deserted and empty yards and parking lots, in a car/truck, and in one Roma settlement in Skopje the information was given that they also use car-washes.

„ In car washing services where cars are washed... In a Roma settlement. We have car washing services in a Roma settlement near the fabricated houses. There are such services down the street there, where my aunt lives. When it gets dark they place rugs. Also at that shop there where the car machines are placed. They place rugs there and have sex. ..“ (AU_MC_ANSU_10).

„ It depends on the client, for instance. Someone may fuck in the car ... to do that and may also go to a hotel to have a sex and etc.“ (AU_FN_ANSU_02p)

Open scene

All AOSS respondents and key informants from Skopje knew the open scene, or “near the television”, “on the cube”, “near the Macedonian (television)” or “at the whores’”. The open scene comprises locations where sex workers stand and promote themselves to clients in the open and where they negotiate directly with clients and provide services in the nearby vicinity, again in the open, in a car or a hotel. Five of a total 14 interviewed AOSS from Skopje have currently or previously worked in the open scene. Young people from Roma settlements in Skopje, however, did not often go out on the open scene but developed new models to find clients.

Location out from the place of residence/ mobility

AOSS from Roma settlements in Skopje regularly went to work in Gostivar, Tetovo, Kicevo and Ohrid, for more money, more “customers” and higher discretion, or because they did not want anyone from Skopje to discover the way they earn money. When they go to other cities, AOSS work in restaurants or bars as waitresses, dancers and at the same time offer sexual services. They stay there from several days to six months and subsequently return Skopje, and then migrate out again in a cyclical pattern. At home they say that they work as wait staff in restaurants. All the respondents reported that in these places they have met AOSS coming from diverse locations including Prilep, Bitola, and cities from Eastern Macedonia. At the same time they also know young people, male and female, who have come to Skopje to work, mainly from the nearest cities Kumanovo, Tetovo and Gostivar, but also from Bitola, Prilep, Stip and Strumica.

„ Some go to Gostivar because people have more money there. There are less clients here in a Roma settlement and when we the female go there we agree among us how much money we shall request from the clients, we arrange on the phone. The client might say that we meet in town, for exp., and we take a taxi. The client pays the taxi and we all go to hotels“ (AU_KP_ANSU_09_IV).

No information in Skopje was given on migrants from other countries coming to work in the sex industry in Macedonia. Only one respondent had considered going abroad, to Belgrade, and had unsuccessfully tried to enter Italy illegally; the others had no plans to leave Macedonia for work. In comparison with Skopje, in Strumica all respondents confirmed knowing persons from other countries who had come to Macedonia to earn money, as well as Macedonians who had emigrated to make money, most frequently to neighbouring Greece, Bulgaria and Serbia. AOSS cross the border with Bulgaria in both the directions (both Macedonians and Bulgarians) by taxi to work for the night, and then return the same evening to their home country.

Apart from going to and from neighbouring countries, AOSS move inside Macedonia as well. Most AOSS travel between neighbouring villages (Vasilevo, Gradosorci, Bosilovo, Dabilje, Dobrejci) and nearby cities (Radovis, Stip, Gevgelija, Dojran), although some travel from Ohrid, Skopje, Tetovo, Struga.

In comparison with Skopje, respondents from Strumica often change their locations for meeting clients and exchanging sexual services to avoid becoming noticed, remembered and labelled as sex workers, particularly if working in small towns.

„Yes, I can... if for example I go in that motel the waiter will make a deal twice to three times, the same waiter will see me. Strumica is a small town, bla, bla, bla. Someone may hear and for this we change places. There are many places in Strumica, small motels on the outskirts of Strumica and around. There are enough places, I think.” (AU_FN_ANSU_09c)

Working hours

The working hours of AOSS mostly depend on the clients. Regardless of location and organization of the work, most work at night, staying later in the summer period and leaving slightly earlier in the winter – i.e. immediately after the dark. Those who live with their parents come home earlier while those working in restaurants outside the city work later. All confirm that there are clients who call during the day, and if they are free, AOSS go out to work. It is common for them not to differentiate between days in the week, and often work every day. In Strumica, the respondents who go to school state that because of the school obligations they usually work during the weekend.

„Well, I can say – this weekend: on Friday, Saturday, Sunday. Those are the three days, aren't they. I attend a school. ... I provide sexual services on Monday, Tuesday, and Wednesday. It might happen after school, but most frequently during the weekend... the others, too. I can also tell about the others, not only for me.” (AU_FN_ANSU_09c).

MODELS OF THE SEXUAL EXCHANGE ORGANIZATION

Individual work

Some AOSS choose to work alone to hide their behaviour and do not want to be recognized as persons who exchange sexual services; others work alone to avoid competition and maximise their profit. AOSS who work alone in Skopje are usually connected to another person who has the role of a partner or boyfriend with whom they are emotionally connected. This person can sometimes act as a middleman who finds and arranges clients, and a protector who monitors the clients' behaviour and waits in the vicinity while AOSS is with the client to protect her from violence. The sex worker will give him part of the earned money for these services, or “they spend it together” because they function as a couple.

In Strumica, respondents separated their relationship with an emotional partner/boyfriend from a contact who took the role of middleman. The emotional partner is usually not familiar with the way the sex worker earns money and is not involved in the business, while the middleman is the one who finds and arranges clients, for which he receives compensation, but does not have the role of protector.

Work in peer groups

Some AOSS work in groups for protection and to have someone with whom to hang around and share common interests, but also to avoid looking suspicious and to provide alibis for one another, particularly to parents – when they go out, stay out late, change their clothes and makeup. Mostly such groups form spontaneously, these are groups of girlfriends who decide together to exchange sex for compensation, or one persuades the other, but there are also groups who are organized/established by third parties who profit from them, or receive some percentage for brokering and protection. The groups can be between two and even ten girls or boys. The number in groups change as members enter or leave the group, but in Skopje respondents could not (or would not) explain how and why this happens, and in Strumica they explained it as spontaneous grouping/division according to interest.

“Well that depends from the chicks, they do not want to work and the groups change..”
(AU_KP_ANSU_03)

In groups organised by a third party the middleman/protector is often directly involved in the organisation and monitoring of the group:

Inf.: The groups form like this...Through friends. Through girlfriends. That means if I want to persuade some person who I feel that she is a little, you know, unsteady, slightly unsteady, she is easily...much easier to be persuaded, let's say to persuade that chick. She comes on...in the group there is always some chick who is like the boss, something like that. She is the one that leads them. She leads them. And through this chick, when she buys for herself a golden ring, ... from one thousand denars or let's say she buys a good perfume, good clothes. In that way we say you win this person. You win a person. But that comes back later. But when she swims in these waters, so to say...it is very difficult to get out.

When she gets back on track, it is hard to get off... And the person herself if she wants to enter in that group, ...to work with you there are some conditions for that. Those are conditions, starting from the finances, who gets what money, where and how she would sleep, how she would behave towards the... client and many other things. As first, it must not happen that she is cold towards the client. She will be immediately refused. Normally...

Interviewer: How many persons there are usually in such groups?

Inf.: Depends... how powerful is the person. They can be ten, even fifteen. And they can be two...

Interviewer: And when and how the members of the group change?

Inf.: When she is near the end, so to say, everybody knows about her. That means that this girl should be renewed (replaced) with another. I send this girl to my friend, my friend sends me back his girl. We swap. Because he is fed up let's say with this person and so. Compensation.... Lets say I have in Gostivar, in Skopje or anywhere else and we hear each other ...” (AU_FN_ANSU_05).

Usually members of the same group feel close and exchange experiences, information on “good” and “bad” clients, clients' preferences and wishes; they jointly negotiate prices, help with money, exchange clothes and makeup to look more attractive. Often one member who is more experienced, older or simply has more leadership skills will teach and advise the others. This advice relates to the work itself: behaviour with clients, establishing a good price, wearing clothes, makeup, managing violence and similar.

COMMUNICATION MEDIA IN THE SEXUAL EXCHANGE (CLIENTS, MIDDLEMEN, PROTECTORS, NEGOTIATORS)

Each sexual exchange, regardless of being formally or informally organized, involves many actors. In addition to the persons offering sexual services, there are clients, managers of bars/clubs where services are offered, those who organize the working hours and working conditions of sex workers and promote them to clients, negotiate, agree the price, take care of the payment, etc., those who transport sex workers to clients or vice versa, and those who protect the interests of the sex workers in front of the clients, protect them from violence, abuse or robbery, and receive a certain percentage or fixed amount from the sex worker or sometimes from the clients as well. Middlemen can perform one, two or a combination of these roles, and are referred to as managers, pimps, middlemen, negotiators, protectors, etc.

Clients

The structure of AOSS clients is diverse. They can be local, from nearby villages and cities, or foreigners, including tourists, drivers, and soldiers. Clients range in age, nationality and religion, and come from different socio-economic backgrounds (workers, students, businessman, single and married men etc.) For AOSS, these characteristics are unimportant as long as the clients pay the requested price for the service.

Some respondents from Strumica, however, stated that they “go” with businessmen and foreigners, where possible, as these client groups pay a lot. With the exception of four respondents from Skopje who offer sexual services on the street and directly find and negotiate with clients, other respondents arrange and negotiate with clients over mobile telephones, or arrange transactions through middlemen such as the pimps, other clients, other AOSS, taxi drivers and acquaintances.

Protectors, middlemen, negotiators

Sometimes the middlemen/pimps enter can be exploitative, violent controllers who beat, rape or take all the sex workers' money, however these are rare occurrences and the use of such stereotypes would not help the development of effective programs. The range of relations and relationships between sex workers and their managers or protectors is very wide, and varies from region to region, even from a community to a community. This study confirmed this diversity in the roles of middlemen/ pimps/ protectors.

In Strumca, sexual exchange is more informally organized. AOSS often decide to start sexual exchange with their peers and do so together, sometimes advised by more experienced girlfriends, and connect with middlemen who they call pimps only to find clients more easily. The pimp has the telephone number of the AOSS and when he is contacted by an interested client he calls the AOSS, forwards the number of the client or appoints the place and the time of the meeting. The clients usually pay the AOSS directly, who pay the pimp later, usually a fee between 20 to 30 EUR although AOSS were not sure if middlemen also receive a percentage from the clients. Because the pimps are not present at meetings between the AOSS and client, they do not serve as protectors. However before the meeting, the pimps advise AOSS on how to dress and behave depending on the client's preferences. If the client is not satisfied, or if AOSS does not fulfill the agreement with the pimp (does not appear at the meeting, does not pay the agreed percentage) usually she/he is punished, and the punishments range from being ignored (not having new clients referred), through verbal attacks or arguments, to physical attacks or beating, tearing hair and slapping.

Inf.: Well, a macro in the slang language means for instance, a guy His role is simply to tell you what the client wants, to pay attention to something more. I think that he doesn't offer any big protection, I think so. He is not that influential to offer big protection

Int.: How shall I get in contact with such a person, as you said „the macro”?

Inf.: Most often we exchange phone numbers, we make calls and meet to a place and tell him that we would like to do that, and he would tell you the time he shall find you a client, for instance, and he will call you back. Later I make my arrangements alone.

Int.: Does he charge you for the service he does? He takes a charge from every girl, even the charge is higher than what the girls charge. Probably two to three hundred Euros to one trial.

Int.: Does he punish for the service not provided?

Inf.: Yes he does. One period, for instance, she shall get less and less money and later she shall not be called on the phone.

Int.: Did it happen to tell you how to behave, to order you what to do, and how to dress?

Inf.: Yes, yes it did. He tells us mostly what the client likes us to dress. He tells us whether to have a strong make up, what the client wants us to do, because most probably they talk that between them before finding us, the girls.

Int.: Do you have to fulfil what he would tell you?

Inf.: Mostly yes, I have to. Later he tells us that otherwise he would have a problem with the client. .
(AU_FN_ANSU_02p).

Respondents reported that pimps themselves might use sexual services from AOSS, but see these as short adventures, not intimate partnerships.

In the Turkish and Roma community in Strumica, the term for the pimp/middleman is “pezevenk” who has the same role and influence as previously mentioned. However, because the respondents from this community are paid less for sex, they consequently pay the “pezevenk” less. Here the payment is around 20% from the total amount. In addition to using a pimp or pezevenk, negotiation can be conducted by clients themselves, who if they are happy with the given service will recommend the AOSS and connect them with other interested clients.

The AOSS exchange or refer clients among each other. Taxi drivers also negotiate as do staff in café bars, clubs, restaurants, hotels, or persons who by their everyday work are in contact with a lot of people who express interest in procuring commercial sexual services. These middlemen sometimes are paid in money with prior agreement for the amount, and sometimes they are just treated with a drink or food or other favour by AOSS or the clients.

In comparison with Strumica, in Skopje the study found more complex and diverse structure of roles for middlemen, pimps, protectors, intimate partners which could not always be clearly distinguished. Intimate partners often played the role of protector or middleman and might escort the AOSS while with the client to protect her from robbery or violence, or remain available by phone and come if called in a difficult situation:

Inf.: I experience him as a boyfriend (And?). Nothing. He waits for me when I get out. He is concerned for me that something wrong does not happen to me, for someone not to lie to me. He writes down his number of the register plate being afraid that the man may take me somewhere to another place. And that's it. He drives after us following us where we go, or calls me on the phone.

Interviewer: And how much do you pay him?

Inf.: I don't pay him anything because he is with me.

Interviewer: Do you give him a portion of the money that you earn?

Inf.: Sometimes I do, sometimes I don't.

Interviewer: Do you spare the money together?

Inf.: Yes, we do.

Interviewer: Who makes arrangements with the people he or you?

Inf.: He does, and later I go to the man. He, sometimes, calls me or we are together when he makes an arrangement with someone. (AU_KP_ANSU_03).

Some pimps/partners hire third persons as protectors who are hired to remain near AOSS and respond in case of difficulties in return for a per diem. Unlike in Strumica, the payment of the middlemen/pimps/protectors is not a set percentage or agreed amount, but often the whole amount or majority of the earnings. This is particularly the case with intimate partners, who receives the money from AOSS, manages them, and covers basic expenses such as basic needs or new clothes. The AOSS see this most often as "common spending", which is normal and acceptable in a personal relationship. Often an arrangement starts as a free decision by the AOSS, but then becomes exploitative through attachment to only one middleman or protector, who confiscates all the earnings. Some middlemen/pimps/protectors use mental and physical violence against AOSS (threats, intimidation, beating) to secure such control. In some cases, intimate partners start to "sell" AOSS, to make money for drugs or for some other need.

Inf.: Then I started dating with the taxi driver. He started selling me and so...

I didn't want at first but later I liked that (laughing)

Interviewer: Is a portion of the money you earn given to your family?

Inf.: No... I don't. I earned the money for him. He spent money on me only when I wanted to buy some clothes or food, that's what he bought to me. (AU_KP_ANSU_03).

Taxi drivers are very important in negotiating sexual exchange in Skopje. Most of the respondents who decided to exchange sexual services turned to taxi drivers to help them find clients. Most of them still cooperate with taxi drivers who send them clients or transport them to the clients for compensation. In addition to persons who negotiate and provide protection during the sexual exchange, there are individuals involved who offer premises for the sexual transaction, also for a payment. Some may provide protection as well. Information from respondents who work in the restaurants outside Skopje (mostly Gostivar) suggests that the owners/proprietors of those restaurants do not get involved in negotiations and arrangements with clients and do not receive compensation but will cooperate with waitresses who find clients while working by agreeing to "let them off." The client then pays their daily salary.

Payment, methods, rates

Price for sex vary according to the age, perceived beauty, and social and educational status of AOSS, the type of the clients, the type of service and the place where the service is given. The research showed that there is a difference in rates and method of payment between respondents in Skopje (mainly from the Roma ethnicity) and respondents from Strumica (mainly from the Macedonian ethnicity and of higher education status). Among the respondents from Skopje, the price of services ranges from 200 to 3000 denars, and averages from 500 to 1500 denars. The cheapest service is the one given outdoors or in a car where the entire exchange lasts for less time, while more expensive services occur in a hotel or apartment where AOSS stay for one or two hours. It is rare for clients to book a sex worker for the entire night, although in these cases the price is significantly higher. When the service is provided in a hotel, the client also pays for the room.

According to AOSS, foreigner clients pay more than "ours". The rate depends on the type of the service as well, namely oral sex is cheapest at 200 to 500 denars, while the average price of vaginal and anal sex is 1000 denars, and for a combination of services the cost is from 1500 to 2000 denars. The same services in a hotel cost 2000 or 3000 denars. All the respondents exchange sex solely for money, and receiving clothes or gifts is rare.

Interestingly, some respondents charge more for vaginal sex more than for anal, although other research from many countries suggests it is common for anal sex to be more expensive.

In Strumica, all female respondents of Macedonian ethnicity stated that they exchange sexual services only with businessmen (mostly from Greece, but also local businessmen) who have much higher social status and therefore pay much more than clients in Skopje. The rate in Strumica ranges from 30 to 250 EUR. The rate also depends on the type of the service: oral from 30 to 60 EUR, vaginal and anal sex more expensive, and combination of services double. Among these respondents it is common to receive gifts from the clients in addition to payment for sex, including clothes, cosmetics, jewellery or opportunity to shop in the nearby duty free shops. Receiving the gifts is not seen as compensation for the sexual service but as an act of attention and pleasure. Most respondents have permanent clients and say that if they find them cute they lower the price. Some reported that some clients have requested group sex or have wanted to include more AOSS in one sexual act. In such situations, they pay more and separately to each AOSS.

INDIVIDUAL CHARACTERISTICS AND INFLUENCE OF THE COMMUNITY ON THE RISK OF HIV/AIDS AND STI AMONG AOSS

Risky behaviour (reasons/manners of involvement in sexual exchange, using protection, availability of condoms, drugs, mobility, violence and exploitation)

Reasons/manners of involvement in sexual exchange

The main motivating factor for entering sex work appears to be poverty and parents' inability to satisfy all the needs of respondents :

„ We were ten girls ... We were only girls among us and none knew, we had no conditions from our parents, because our parents told us they had no money, we went to school and wanted to dress well, and have money, go to discotheques, have money for books and food. Our parents are poor. Today if I bring money at home they will have food otherwise they have no food to eat; there is no job we get only social assistance ...” (AU_KP_ANSU_09)

From 21 respondents, one respondent was forced to give sexual services, three respondents started to exchange sex to get money for drugs for themselves and their partner, and others to contribute to the basic income of the family, or to satisfy personal aspirations such as money for “hanging out,” clothes, cosmetics, etc.

Some evidence suggested that parents in the Roma community send their children to beg or steal to help support the family, and if they do not earn a certain amount of money they are physically abused or sent back out until they earn it. In that situation, some young people find it easier to start selling sex to earn the money more quickly and “easily” for themselves and their family.

An exception came from two male respondents who offer sexual services to homosexuals, and reported that they did not come from poor families and do not send the money home, but spend them on themselves, most often for going out.

Use of protection

AOSS tend to use condoms with clients but not with a boyfriend/intimate partner. They have received information on disease and pregnancy prevention from nongovernmental organizations, television campaigns, or school, and try to regularly use condoms when exchanging sex. Respondents claimed they enjoy sex more without a condom which is why they avoid them with a personal partner, or the partners themselves do not want to use condoms. They also associated condoms with their work and having sex with strangers rather than with relationships where there is mutual confidence and familiarity. Three respondents from Skopje stated that they do not use condoms with clients either.

„ Why if, for instance, I give him a condom he would ask me where I have it from, why condom for me, he would suspect something...” (AU_KP_ANSU_09).

Interviewer: Is there anybody that you don't use a condom with?

Inf.: I don't use it only with my boyfriend (laughing)

Int.: And why don't you use it?

Inf.: He doesn't like that. (AU_KP_ANSU_03).

„ He is my boyfriend whom I have been in a relationship with for a long time, I know that he is clean and I don't use a condom with him .“ (AU_FN_ANSU_03p)

Int.: Tell me whether you use a condom?

Inf.: Condom?. I don't use it.

Int.: Aren't you afraid of diseases and getting pregnant?

Inf.: I don't know.

Int.: Don't the clients ask that from you?

Inf.: No, they don't. One Albanian asked me for a condom. I asked him what a condom was?! He told me about AIDS. I told him that I can't accept the condom. I am now afraid about what you are telling me about AIDS. (AU_MC_ANSU_10)

Int.: Tell me whether you use condoms?

Inf.: No, I don't.

Int.: Haven't you ever used a condom with anyone?

Inf.: No, I haven't. I have used it with nobody. I do that usually without it. (AU_KP_ANSU_07).

While the majority of respondents claimed regular use of condoms with clients, their level of knowledge on protection is very low. All except two female respondents from Strumica had no knowledge about quality or type of condoms, no information on what they should consider when while buying condoms and select them according to criteria such as whether they are strong or break, smell nice, are expensive or cheap. Most choose what kind of condom to use depending on how much money they have.

All respondents encounter clients who do not want to use condoms and who offer extra money for sexual intercourse without a condom. Some respondents (especially in Strumica) were adamant that they do not accept unprotected sex regardless of the offered price, because "health is priceless", although others admitted they might accept if in crisis or if the pimp/middleman guarantees the client by saying he "knows him and he is clean". Thus, use of condoms can be influenced by the pimp/middleman, especially in situations when his influence over the AOSS is greater in general.

With the exception to three respondents who did not have information on condoms and do not use them, all the others stated that they know how to procure condoms and availability is not a problem. Most get free condoms from nongovernmental organizations with which they cooperate or buy them in kiosks and pharmacies.

Use of drugs and alcohol

Two respondents from Skopje and two from Strumica use heroin, mainly intravenously, but also "on foil" and "through the nose". One of them was on long-term methadone treatment, two have sought health assistance for treating the problem but later started again, and one respondent had not sought treatment at all. Before seeking professional help, most tried to solve their addiction themselves and subsequently advise others who have the same problem.: Those who did eventually turn to assistance programmes did so after receiving information and motivation from local nongovernmental organizations with which they contact, and previously could not access the appropriate information.

Int.: Why didn't you apply for the methadone therapy?

Inf.: Because I didn't know. I didn't know about that, ... I even didn't have a sick card. I am telling you that with the assistance of C, I was is sued a sick card and everything I needed. I was even given a therapy without a sick card and in the end I was told that if I didn't bring the sick card I would pay for all the therapy in private. Then we started with C to search for money every day ... (AU_KP_ANSU_08_I)

Related to drug use, two AOSS imitated sex work to earn money for drugs, and two started to use drugs while engaged in exchanging sexual services, indicating complex cause and effect links between these two types of behaviour. Among the remaining respondents only one occasionally uses marihuana or exctasy, and all the others use only alcohol. Some report using alcohol occasionally for special events such as weddings, birthdays

and celebrations, and others drink with clients and during work in order to be “more relaxed” or to have “more fun” for themselves and the clients. All claimed that even when under the influence of alcohol or drugs during work, they are able to insist on condom use.

Mobility/migration

Migration (outside or within the country) can influence risky behaviour in several ways: the migrant can face language and cultural barriers that make communication and negotiation with clients difficult; they can find themselves in situations where they do not know where and how to ask for services, advice or help; they may have problems with legal documents (especially important for minors) leading them to hide and become hard-to-reach for the police, but consequently also for social and health interventions; and they can face poor working conditions that are difficult for them to influence.

From the statements of AOSS who regularly go to Gostivar, Tetovo or Kicevo to work in restaurants, living and work conditions appear to be quite poor. If the restaurant is in a village, or outside a city, the girls live in the restaurant, sometimes sleeping on the chairs, and do not have access to hygienic facilities. If the restaurant is in the city and the proprietor/owner has enough money, he rents an apartment for everybody who works for him, sometimes 15 or 20 persons.

„ For instance there is a village in Gostivar, there is a Coffe bar there. We live in a flat hired in Gostivar. One flat has five rooms for exp... Fifteen persons dwell in those five rooms, three persons in each room times five rooms it makes fifteen person...” (AU_KP_ANSU_09).

Violence

Violence is a direct factor in the creation of an unsafe environment in which sex workers find it difficult to negotiate and practice safe sex; it leads to low self confidence and self respect, feelings of inferiority, depression and humiliation, all of which contribute to vulnerability to manipulation and abuse by third persons. Violent clients rarely use condoms, especially during rapes, and the violent sex leaves injuries and lesions which are an entry to infections.

AOSS from Skopje have had very bad experiences with violent clients, including rape, beatings and robbery. AOSS working on the street are especially vulnerable to violence. The Romas in Skopje are particularly afraid of “Albanians” who they believe to be more frequently and fiercely violent:

Inf.: He will take me by force, pay me, get into the car and do that thing by force and bite me and steal my money. Many times I was bit, and my money stolen. Many times. I don't want to talk about that any longer.

Int.: Where did they take you in the most cases?

Inf.: I don't know in some woods, in some hidden places, the most hidden ones, and far way. They will call some friends and they sleep with me and then take me home. One is lucky if allowed to go home, if not, then nothing. (AU_MC_ANSU_05)

In Strumica, respondents mainly work with local or foreign businessmen, and claim that they have never experienced violence from clients. They know clients who enjoy sado-masochistic sex, but distinguish it from violence.

Study interviewees did not want to talk about violence from partners and pimps, and denied its occurrence, although local NGO field workers report coming across extremely violent situations in their work with sex workers and have witnessed the with visible consequences on AOSS including bruises, swellings and even fractures.

Sexual exploitation/Human trafficking

The research received one narrative on forced prostitution and human trafficking occurring in restaurants in the Gostivar region, which demonstrated a completely different characterisation from most of the sex work reported throughout the study.

Case study:

Forced prostitution/human trafficking:

Inf.: They sold me once. In Gostivar... I do not know him, once or twice I have seen him, not more. I know him that much. And that is how I was tricked. ‘Let's go for coffee’... to buy me coffee and talk to me.

'Come on, come on'. ...He got me in his car and straight to a restaurant. He left me and walked out. And he does not say anything, 'Sit here, I will come, I am going to the toilet'. He walked out and left me. And so. The owner, I cried to him and I told him how things are, why he brought me here? 'Why he brought you, you are sold here. Because I spoke to him prior to this, he got money for you...I paid him for you. I paid him a lot of money for you, he told me you were a young girl, pretty and that is that. You are paid for' – he says – 'you will work here, you must'– he says. I started to cry.

Int.: And what were you supposed to work?...

Inf.: What. You know everything, prostitution, something else, all by force. You serve, alone, work alone, they have put me even to dance striptease. Which I never in my life have done, there they put me. And I was doing that for money every night, non-stop. There was something like a hotel, his rooms, downstairs a restaurant. And there were other girls, and every night upstairs with customers.

Int.: And how many girls were you?

Inf.: We were ten, fifteen....The girls taught me [how to provide services] several days, then later they put me to play....And they were older [the other girls]. They were twenty, twenty five, twenty three, twenty two. I was eighteen... All were locked inside there. You have food, drink everything inside... From the open window if you want you can watch, if not, sit inside. Darkness, bars all was closed...bars especially for the girls. I found out after a while, they told us - 'these are put... for you especially, for the girls'... And you do not have any chance to escape from there. All life...I was there one year and a half... I managed somehow to escape with one "kurban". We agreed to meet in a hotel, to give me fifty Euros, to take me to another hotel, not inside the hotel where I work. In another, and to take me for a walk and to bring me back again ... Yes. He agreed with the owner. And in the end I lied to the owner and all, I did not go back there again. After he took me, he put me on the bus, gave me money, everything, he did not even sleep with me and left me in Skopje. I came here and he never went back to the owner after he saved me somehow.

Int.: And how did they treat you there?

Inf.: Very bad. Beating, one or the other, everything... And for the beating I can not tell you. Beating to blood, on the legs... With a baseball bat

Int.: And the bruises? The customers did not see them, or ask where from did you get these?

Inf.: They did not let us wear short pants so as not to be seen. Pants, long skirts, so as not to be seen. But before that all the girls wore mini skirts. After we are beaten or whatever, we wore pants. Not to be seen, or asked. And no one can feel that you know. And in order not to feel the pain you sit, and slowly, not to let be noticed. The owner sees everything from there... He watches everything, what is going on... If I tell the "kurban" he goes and tell this to the owner, he knows him and tells him everything.

Int.: And what is kurban, what does kurban mean?

Inf.: A customer...

Int.: And did the Police come?

Inf.: They did, they did. Yes, to drink, eat, there were, yes. There were some. Very close [to the owner], as soon as they come, they eat, drink and sit to the owner, have a chat...

Int.: And sometimes at night all of a sudden, did it happen that the police came to save you?

Inf.: That is called a raid. But there wasn't any. We waited from all sides but there was no police. We waited for the police to come... Only they could, no one else. Only the cops. But no way (to come)... We must not have even telephone, nothing, nothing...

Int.: And did you have separate rooms, or...?

Inf.: All in one. All... We hang around all of us together, yes. When you are in trouble, you hang around. We planned all the time, thinking how we will, how we will run, what to do. You can't. We cried all of us... We thought of [an escape plan] but we did not succeed... There were alarms there on the door. One night we tried, when I see the alarm... The owner came down, and beat us to death. We lied. 'Where are you going?' 'In the toilet.' 'No, you are not going to toilet, you, so many girls all of you go to toilet?' And we all wanted to go out and escape. We made an alarm, what ever happens happens, you know. Let him kill us but we must succeed tonight. And we did not succeed in any way. He caught us, he broke us beating and that was that. It was left to that and we got scared.

Int.: And how much money did they pay for you?

Inf.: Fifty euros each. Three thousands denars, two thousands, four. Depends. To one, thousand and five hundred denars they were paying... The landowner took them downstairs on the door. I was waiting upstairs, [for the customer] to come... After I dance [striptease], they would pick me immediately, I go upstairs. After I dance again to one song, you know, again...Every song they pick me...

Int.: And upstairs how did the customers treat you?

Inf.: Bad. They want from us, bad and everything. You will do this, do that, because I know the owner, if you do not do that I will tell him to beat you. And from fear I had to do something nicer, to make for them...

There were good as well, yes. There were so me good, felt sorry for you, they will not sleep with you, although they paid. They will pay and not sleep with you. They will go upstairs on purpose. They will sit, talk to you, treat you, do everything but do not touch you at all. They feel sorry. They know what they do to us, how, but can not help us. What can they do...?"

Peer groups not members of AOSS

During the research there were 3 focus groups and 1 group discussion conducted with the general population of young people aged 14 to 18 years, aiming to explore their knowledge, perception and attitudes towards their peers who exchange sexual services. One focus group and 1 group discussion took place among young Romas in a Roma settlement in Skopje, one focus group in the Turkish community in Strumica and one focus group with female secondary school students in Strumica. All the participants in focus groups knew of AOSS, some personally, were familiar with locations they frequent, methods of communication with clients and middlemen, and claim that they can be recognized by the clothes, makeup, hairstyle and their manner of behaviour when they want to attract customers. Respondents were also aware that AOSS hide their behaviour because of shame and fear of stigma and discrimination.

„Very rarely, they have a mask put on the face ... I don't know who hides behind it, because they are ashamed or afraid of discrimination.“ (AU_FN_ANSU_06)

However, young people's personal attitudes towards AOSS were generally not discriminatory nor stigmatizing. Almost all appreciated that AOSS did not have a basic income, little support from parents, and could not see other possibilities in life, so they exchange sex to survive or gain things that are unaccessible. The Romas in Skopje mainly acknowledged survival side of the sexual exchange and blamed the parents who, directly or indirectly, force children to engage in sex work, while secondary school students in Strumica commented more on the aspect of stigma, discrimination and inappropriate responses from relevant institutions (centres for social work, education, physicians, media, police) who further make difficult the situation of the AOSS. The Turkish participants in Strumica even justified the existence of persons who sell sex out the need to ensure the virginity of girls in their own community could be protected.

INSTITUTIONS OFFERING SERVICES TO AOSS

Health institutions

Eight female respondents required health services for pregnancy (4 for abortion of pregnancy and 4 for delivery). Six from the total eight respondents received assistance from the nongovernmental organization HOPS in Skopje. Taking into consideration that among 21 respondents, 7 are male, of the 14 female respondents, 8 or 57% had already experienced a pregnancy. This suggests a generally low use of contraception or condoms.

Three respondents sought treatment of drug use (two with assistance of HOPS) and three sought help for treatment of mental disorders (anorexia/bulimia and depression, anxiety and neurosis, psychosis). Of the remaining respondents, some attended ordinary health services for colds, injuries and other primary health care needs, while some have never gone to a doctor at all. All respondents, however, did not feel they had a close relationship to health workers, and were not entirely clear on what services were available, which is why they also said they did not experience any particular stigma from the health sector. Nonetheless, they differentiate between private and state owned health institutions, claiming that they have more confidence in private services and trust that there they can get better quality treatment.

AOSS' opinions on the need for specialised health services only for persons exchanging sexual services were divided. Some thought separate services were a good idea because they could access them without feeling shame or awkward, and could obtain information directly relevant to their work. Others felt sex worker specific services would be discriminatory and as they did not identify themselves as separate from the general population, did not want to be set apart.

„No problem. Why other institutions are necessary? Simply this is a job as many others. Are other institutions needed for the tobacco producers, I don't know, for the farmers or accountants? Aren't these the same as the other jobs?“ (AU_FN_ANSU_01c)

Social care institutions

Findings show that AOSS do not understand the role played by the centres for social work (CSW) and associated them only with giving social financial assistance. Six respondents stated that their families are beneficiaries of social financial assistance, some had been visited by a social worker at home, but have never discussed topics other than the family's economic situation. Only three respondents from Skopje were in direct contact with the CSW because of concrete needs, but were not satisfied with the communication received and results from the contact.

One female respondent described having a conversation with a social worker who was called by the police when she had reported a person who sold her. The social worker questioned her on the details, after which she was told that if it happens again she is free to ask for help. Another female respondent asked for assistance from the CSW after the birth of a paralysed child, being interested in the possibility of permanent financial assistance on the basis of being a single parent. However, because she did not have documents for personal identification, she was refused by the CSW until she could come back with the appropriate paperwork. A male respondent reported physical violence and sexual abuse by his stepfather, and explained that he exchanged sexual services in order to survive and asked for protection and shelter by the CSW. Because the case was not appropriately treated by the CSW, the NGO HOPS referred the case to all relevant institutions (Ministry for Labour and Social Policy, Ombudsman, the Helsinki Committee for Human Rights), however the institutions were unable to address the case, and at the same time contributed to a series of stressful and unprofessional situations. The individual in question was placed in a series of institutions, some of which expelled him or treated him as a psychiatric patient, and now lives alone with friends and avoids institutions, in which he has lost trust.

Because the social work centre is the only body with an official mandate for work with children and young people with impaired behaviour, troubled family relations, etc., the study also examined how the CSW obtains information on children who offer sexual services, how it processes this information and responds through protection and support mechanisms. Several visits were paid to the CSW in Skopje and Strumica to discuss work with AOSS, and research staff submitted written requests for official data on the number of registered AOSS in these centres.

The police, prosecutors, parent or the school can contact CSW. Often adolescents are first put in touch with social services for other reasons before social workers learn that they are exchanging sex. The primary entry point is through the police who encounter young people who have been involved in a crime or anti-social behaviour, and they are obliged by law to call the CSW to be present at the initial police interview. However, in practice this referral rarely takes place, or the police question the adolescent in the absence of CSW and call the CSW only after the fact, to comply with legal requirements.

Measures taken through the CSW can include initiating action against parents for neglect, referral for family therapy, and sending the AOSS for a medical check-up at the Clinic for Infectious Diseases and Febrile Conditions. Usually monitoring of the parents is recommended. If the parents again are found to have neglected their children, the adolescent may be placed in an institution. CSW does not have the authority to remove children from their families, but offer their opinion to the Court in the decision making. The police is then charged with ensuring Court orders are implemented.

From the CSW Strumica, information suggested that while there was no special register on AOSS, staff come across such cases during their work, particularly when a young person runs away from home and parents request an investigation and in that way cooperation starts between the police and CSW. When the young person is located, the finding police will work with an official from the CSW to return him/her home. The social worker then becomes involved with the family, conducting an assessment interview and seeking solutions within the family for improvements to the situation. AOSS are usually registered for reasons other than their involvement in sexual exchange.

Based on the submitted requests for number of registered AOSS in the centres in Skopje and Strumica, there were registered 8 AOSS in Skopje (the time period was not stated), and no reply was received from Strumica. In any case, CSW do not implement any specific programs for AOSS and commercial sex workers, although they have some direct contact with these target groups through provision of other activities (education, distributing promotional material, distributing protection, mediating in legal and other procedures).

Nongovernmental organizations

Most of the respondents are known to nongovernmental organizations that work with persons at-risk of HIV/AIDS, such as NGO HOPS from Skopje and NGO Izvor from Strumica. Respondents confirmed that they were familiar with the services offered by these organizations (information, condoms, print materials, advice and testing, assistance in receiving personal papers and health insurance, gynaecological check up, referrals etc.), and expressed satisfaction with them. For most of them, these organizations are the only places where they can speak openly and honestly about issues that are important to them, receive help and support without being judged. They hear about the NGO activities from field workers, friends and acquaintances.

Regarding other nongovernmental organizations active in their local communities, these were less known. One respondent from Skopje stated that he asked for help from the Roma nongovernmental organization related to issuing personal documents, but he was not satisfied with the received service.

Inf.: Once I went to her place to tell her about my problem. It helped me nothing.

Int.: What kind of a problem?

Inf.: I need to change my address. I have one passport issued abroad and one here. I would like to get issued a new one because its validity date has expired. I can't change the address, for instance. I was told that they assist in money to get a new passport issued. I went there and they promised that they would come to my street. I gave them the number of the street, you know ... And nothing happened.

(AU_MC_ANSU_14n)

NGO that deal with youth issues, children's rights and social support were contacted to assess their level of contact with AOSS. For example, it was assumed that AOSS might use the SOS helpline provided by First Children Embassy in the World Megjasi although no calls were reported to have been received that were clearly identifiable as from AOSS and the only 3 were referred to the services by an outsider.

Police

All respondents having had contact with the police usually not specifically related to sex work but to routine requests regarding identification, detentions for presence at fights and during thefts, etc. For six respondents, the contacts with the police were directly related to sexual exchange and one respondent was detained for enabling use of drugs.

From the six mentioned respondents, two were reported by the parents as missing (at a time when they were forced into sexual exchange by third persons), and three reported sexual abuse and exploitation by the family or others. Three respondents who worked on the street were caught "in the act", or detained for "prostitution" (Art.27 from the Law on Misdemeanours against the Public Order and Peace of RM). Although these cases involved minors, a social worker was not called, nor any additional procedure initiated. Although the young people were mainly not satisfied with police the attitudes towards them, and explain that they are cold, incorrect or "provoking" in trying to elicit information from them, no respondent reported physical abuse by police officers. The respondent who was reported because of enabling use of drugs explains the attitude of the police towards the family of the detained person.

„ Immediately after the search in my apartment when they turned all the things upside down, first they informed my father who was still employed, a former military person. My father came right away. I can not forget that event ... so he was kept for two hours in the police station and I about five to six hours. He was deprived of his official pistol though he had a document to keep that. The excuse was that I might do something thoughtless and for me that he was disappointed. Few days later they returned his pistol in a very evil manner through the official at his work and not personally.“ (AU_FN_ANSU_02p)

LEGISLATION IN MACEDONIA RELATED TO AOSS RISKY BEHAVIOUR

In the legislation of the Macedonia "prostitution" is a misdemeanour against the public order and peace (Art. 27 from the Law on Misdemeanours against the Public Order and Peace, last amended in 1984), and some other actions related to prostitution (procuring, inducing, initiating, making profit by enabling provision of sexual service) are treated and punished as criminal acts (Art. 191 from the Criminal Code of RM, 1996). The respondents from Skopje were unfamiliar with these legal regulations related to the "prostitution", and did not know their rights and obligations under the law, had not thought about it much. They reported that it was forbidden activity and that they could go to prison or a correctional home.

Respondents from Strumica involved in the educational system had greater knowledge and awareness of their rights regarding discrimination, and some discussed the need for legalisation of sex work.

ADOLESCENTS
INJECTING
DRUG USERS (AID)

ADOLESCENTS INJECTING DRUG USERS (AID)

INTRODUCTION

Injecting drug users is a term related to people which administer drugs by injecting, although injecting is not the only way IDUs might use drugs. IDUs is a specific subgroup from the general group of persons who use drugs (PUD); they might further differ and form identifiable sub-groups based on sex, age, ethnicity, social status, educational status and other criteria. Adolescents injecting drugs represent a specific group of IDUs. AID are characterized by high risk habits in the use for drugs, high risk sexual behaviour and relative invisibility within the wider social community. This makes them hard-to-reach for existing institutions offering services which increases their vulnerability to HIV/AIDS and other transmitted infections by blood and sexual intercourse. A special factor influencing the vulnerability of IDUs is existing legislation that limits possibilities for implementing programmes for under-age IDU.

GENERAL DEMOGRAPHIC INFORMATION ON THE RESEARCHED AID POPULATION

In the research, the target group were AID from 13 to 18 years of age, from Skopje, Kumanovo and Gostivar. Due to the difficulty in accessing the youngest AID, an additional group of AID aged 19-22 years were recruited to offer retrospective information on their own experiences when younger, and also to serve as key informants regarding the behaviour of the social network peers who do fall into the age group of interest.

Age structure of the interviewed AID.

	Skopje	Kumanovo	Gostivar	Total per age
Age	Number	Number	Number	Number
22	4	0	1	5
21	2	0	0	2
20	4	1	3	8
20	4	2	3	9
19	3	2	2	7
18	0	2	0	2
Total per cities	17	7	9	33

All the respondents reported that they inject drugs with friends and/or know other AID similar to their age and younger, which confirms the study's assumptions regarding the existence of a larger number of AID, including those that are under 18 years.

The research covered 9 (27.27%) female IDU from total 33 respondents, and according to the respondents' statements it can be noticed that there are many female AID, however still in smaller number than males.

Gender structure of the interviewed AID

	Skopje	Kumanovo	Gostivar	Total per gender
Gender	Number	Number	Number	Number
Male	15	3	6	24
Female	2	4	3	9
Total per cities	17	7	9	33

The study recruited AID from Macedonian, Albanian and Roma ethnicity and evidence suggests that IDU behaviour can be found among all ethnic and social groups in Macedonia.

Ethnic distribution of the interviewed AID

	Skopje	Kumanovo	Gostivar	Total per ethnicity
Ethnicity	Number	Number	Number	Number
Macedonians	10	7	7	24
Albanians	4	0	2	6
Roma	3	0	0	3
Total per cities	17	7	9	33

The largest number of the respondents (no=23, 69,70%) are Christians, of which 22 (66.67%) are Orthodox and 1 (3.03%) is protestant, while 9 respondents (27.27%) are Muslims. Only 1 (3.03%) respondent did not give a religious affiliation.

Religious structure of the interviewed AID

	Skopje	Kumanovo	Gostivar	Total per religion
Religion	Number	Number	Number	Number
Christians (orthodox)	9	6	7	22
Christians (protestants)	1	0	0	1
Muslims	7	0	2	9
DK	0	1	0	1
Total per cities	17	7	9	33

Thirty people interviewed had completed primary education (90.91%), and among these, three (9.09%) are University students, 17 (51.51%) have completed secondary school, six (19.35%) are secondary school students, and four (12.12%) discontinued their education during secondary school, which in one case related directly to use of drugs and the attitude of teaching staff. The remaining three (9.09%) respondents had not completed primary education.

Most AID live with their parents, or, rarely, with one parent or guardian and with brothers and/or sisters. Only one (3.03%) respondent lives alone, and one (3.03%) was previously homeless person in Gostivar but under the care of in the Psychiatric Hospital Skopje, which during the winter period accepts some homeless people for substitution therapy¹¹. Only two (6.06%) respondents are married, and one (3.03%) divorced.

Social status and class affiliation did not appear related to initiation of drug use or the way drugs are used. The respondents covered by the research came from various families, ranging from parents who exploited their children for material gain, to families where the parents manage companies and earn more than the average salary and basic living wage as defined by the State Statistical Office.

¹¹ The care of the homeless persons who undergo substitution therapy with methadone is not officially the responsibility of Psychiatric hospital. However due to lack of appropriate programmes, a compromise has been made to take patients during the winter period.

Health insurance was used by 23 (69.70%) respondents, eight (24.24%) did not have health insurance and two (6.06%) did not answer the questions. Some receive insurance through their parents because they are still students or are registered as unemployed, or work but are not registered and do not receive paid contributions.

Experimenting with drugs seemed to start before age 18 (no=31, 93.94%), usually with lighter drugs such as marihuana or benzodiazepines, and subsequently stronger drugs such as opiates and opioids (Onceva 2003; UNICEF 2002: 82-84, 100-101; WHO/UNDCP/UNAIDS 2006: 5), but some started to inject heroin immediately. Most of the respondents (no =24, 72.73%) initiated injecting drugs below 18 years. The age for initiating use of drugs and initial age for injecting drugs is shown in the Tables 5 and 6.

Structure of interviewed AID according to the age when they used drugs for the first time

	Skopje	Kumanovo	Gostivar	Total per members
Age	Number	Number	Number	Number
10 years	1	0	0	1
11 years	0	0	0	0
12 years	0	0	1	1
13 years	3	1	2	6
14 years	1	2	1	4
15 years	5	2	2	9
16 years	4	1	2	7
17 years	2	1	0	3
18 years	1	0	1	2
19 years	0	0	0	0
20 years	0	0	0	0
21 years	0	0	0	0
Total per cities	17	7	9	33

Structure of interviewed AID according to the age when they injected drugs for the first time

	Skopje	Kumanovo	Gostivar	Total per members
Age		Number	Number	Number
10 years	0	0	0	0
11 years	0	0	0	0
12 years	0	0	0	0
13 years	1	0	0	1
14 years	0	0	0	0
15 years	2	2	2	6
16 years	5	1	2	8
17 years	3	3	3	9
18 years	4	1	1	6
19 years	0	0	0	0
20 years	1	0	0	1
21 years	1	0	1	2
Total per cities	17	7	9	33

DESCRIPTION OF THE SCENE

Drugs are available and can be bought from many locations in the cities, and when there are shortages people travel to the villages surrounding of Skopje or other neighbouring cities. The locations where the injecting drugs are sold are described as discrete, hidden from the police and other citizens, but known and accessible to adolescents using drugs, and sales are facilitated through communication by mobile telephones.

Locations where drugs are injected are also hidden from the police and other citizens. If parents are out from home, young people might inject drugs in their own home or at friends', otherwise many discrete venues are selected such as deserted facilities, basements, cars, parks, and dealers' homes. There did not seem to be an easily identifiable "open scene."

„ ..maybe at somebody's place, where there is nobody at home or ... we go to some deserted place, some houses which are not built up and such things” „ We meet downtown and we go anywhere and try to find ... Downtown, anywhere in the street.” (AU_RJ_AID_001.doc).

Due to constant fear of the police or the possibility of being recognized, AID regularly change the places where they inject drugs, which makes them more hard-to-reach for the harm reduction programmes. Most respondents expressed a wish for the existence of permanent and legal locations where they could freely and safely inject drugs without receiving police abuse, where they could get sterile injection equipment, advice and necessary medical care and social services.

„Yes, it would be nice to have, for instance, one place such as a free shop. One place to have where the fans of marihuana can consume. I also think that it is better for safety reasons to have a specific place in which one can come and inject a drug because they do that in the entrances of buildings. The syringe is injected in the building entrance, the needle thrown away and then small children will come out, that is dangerous because they may step on it and wound them. So it is better to open for safety reasons a centre that shall be legalized. In order not to have so many tensions and if one consumes the drug to know the place where and how to get it.” (AU_KP_AID_003)

„I think that there is a need for that, because there are anywhere, I don't like that as there are many diseases. Hmmm, one can find a syringe anywhere you like in Skopje. Also, a needle and you can simply stab you. I think that it is needed, or at least give them a place, and let them drug themselves. If they want them and have chosen such kind of life, let them. The only thing is not to make problems to other. Well... if they destroy themselves may not destroy other's life.” (AU_KP_AID_006)

„There would be at least any kind of a control. There shall not be thrown anything around in the town. Let not God be for somebody to prick and catch hepatitis. He/she may catch a HIV infection. For this it is better that the place is marked rather than the anonymous place be everywhere in the town and become such a mass.” (AU_SD_AID_002)

„Well, yes. I would like, I would like. That would be better for everybody. This would mean, we who consume drugs, we would know that in that place we could do these things. We don't like to go to a place full of people... people that may see us, a place... Still the scenery is bad. And where such places shall exist, we would know that... that place is for me, I think for those like us, and I think that would be much better.” (AU_PP_AID_004.doc)

INDIVIDUAL CHARACTERISTICS AND INFLUENCE OF THE COMMUNITY ON THE RISK OF HIV/AIDS AND STI AMONG AID

Short description of the daily routine

AID wake up according to their own scheduled tasks, but also depending on their need for drugs and whether the previous dose has lasted. Many have no obligations, except for the students and those who go to work, but even these appear to sleep longer hours if they are not experiencing withdrawal. Many AID meet up with friends daily; their socializing centres around the company with whom they use drugs, although they might also spend time with peers who do not use drugs or at least do not inject. AID being injecting before going to school/work and/or during classes/working hours in order to avoid potential withdrawal and maintain their concentration on their studies/ work. The use of drugs does not necessarily present an obstacle to schooling, and, as mentioned previously, most respondents completed secondary education in spite of using drugs during that time.

AID often report being involved in criminal activities although this is not always related to drugs, but sometimes occurs under the influence. It sometimes reflects AID's acceptance of the behaviour of peers and desire to "fit in" with others in their immediate social networks. Other changes in usual daily behaviour occur within the family and can raise the doubts of parents and lead to family arguments and conflict..

Habits associated with injecting drugs

The most commonly used drugs were marijuana and heroin but also methadone, ecstasy and trodon/tramadol, and more rarely, cocaine and LSD. Benzodiazepines are also used, but only mentioned when prompted during an interview, suggesting most respondents did not consider them as drugs, especially because they inject them in combination with heroin or methadone. Most often heroin is injected (no=33, 100%) and rarely methadone is mentioned, and the frequency of injecting depends on availability of money, individual needs and the duration of the injecting experience. AID inject from several times a week to five-six times per day, or "...depends how you manage with the money, that is how you consume it" (AU_PP_AID_002.doc), and two or more types of drugs can be used on a given day, at the same time or consecutively.

The lack of finances sometimes motivate AID to perpetrate thefts, frauds, exchange of sexual services, re-dealing drugs, assistance in providing drugs. Some AID have no direct contact with a dealer and obtain the drugs through middlemen, intimate partners or a friend; and there are cases when methadone is obtained from a pharmacy with forged or illegally issued prescriptions.

„ From persons that sell ... that use. Here... We collect money, or simply this money that I have provided as ..., I give the money to a person using drugs from my company and... and it gets drugs for me" (AU_PP_AID_003).

„Well, yes If I have managed, or ... or if I buy methadone ..., or ..., buy on a receipt. What I know, or take with him (unclear), he to take from the pharmacy or on my name if I take a receipt from a doctor, and buy methadone from the pharmacy." (AU_RJ_AID_001)

„ Well, I don't know... One can find anywhere, from some people. We know those that take heroin, we take from them. And, they have no idea, from some pharmacies ...,and one girl's mother works in a pharmacy. And she also takes from the pharmacy, her mother brings it to her at home" (AU_SA_AID_005)

„Well I would like to say ether you have no enough money or you have given money to the dealer and left without money and one comes here for sterilized things. This is for the reason not to get into a situation so that you can be forced to inject you with another needle, a needle from somebody else, with another syringe and things of that sort" (AU_KP_AID_003).

„Yes, it happen once to me (to take someone else's accessory, and since then I have caught a hepatitis C ... from the same needle" (AU_SD_AID_002).

„Not that I found that, but it has happened to me few times, a certain time before coming to you're your organization ... after we have heard that such preparations are given, since then I have never used. But it happened twice, three times and four times from drugs ... one injection and ... and we used that together." (AU_PP_AID_001)

Injection equipment is obtained from pharmacies, through needle-exchange programmes, and re-use of injection kit is not uncommon. While AID had information on the dangers of sharing equipment, the immediate need to inject drugs outweighs fear of potential consequences.

The practice of injecting drugs socially links AID and encourages companionship both during injection sessions and on other occasions. Drug preparation is usually in a joint container, called a "cooker"¹², which is a potential risk for transmitting HIV, Hepatitis B and C and other blood-borne infections, especially if the cooker was previously used by other IDUs and/or because of the manner of sharing the prepared dosage.

¹² The Cooker is a container where heroin is prepared by heating it, diluted with water or limonthus or vitamin C; the components are diluted and mixed. A spoon can be used as a cooker or be improvised from a metal lid, bottom from a can and similar, and some equipment exchange programs distribute cookers specially made for such purpose.

The prepared drugs are shared in many ways, depending on interpersonal relations, but most characteristically and potentially risky are:

- ~ Extraction of the prepared drugs directly from the cooker, each with own syringe, where the risk for transmitting HIV, Hepatitis and other infections is present in the contact of the needle or the syringe with the cooker, but also in possible touching of various non sterile needles or syringes.
- ~ “Front loading” is a way of sharing when with one syringe, with or without a needle, is extracted from the cooker, the quantity is measured and then reciprocally decanted, inserting the needle from the full syringe in the outgoing hole of the syringe in which it is decanted. In this case it is enough that only a part of the kit is contaminated in order to elevate transmission risk.
- ~ “Back loading” is when the drugs is filled in one syringe from which then it is decanted in the other syringes through the opening for the syringe clip in which it is decanted. This way of dividing is more characteristic for dividing methadone, because of its density, but there is high risk because of the possibility that the full syringe is contaminated.
- ~ The most risky way to divide the drug is when the full syringe is used in turns from one user to another when each person injects one agreed part of the joint drug. This results in blood mixing between shared injectors.

„Well, it depends. Mostly ..., why should we torch ourselves, once, twice, three times and you fill it once and we inject us.“ (AU_PP_AID_004.doc)

„No. We aspirate one syringe and then ... we measure it and divide among each of us.“ (AU_PP_AID_004.doc)

„Well, no. Sometimes it happened to us with those we were, that we used the same syringe. For instance, sometimes.“ (AU_SA_AID_001.doc)

„When finally he read that there were 3,4 ml inside of the liquid, he took the third syringe and started filling it through its opening of the needle. He divided the liquid into equal portions in two syringes. He gave one syringe to the guy in front of him. Finally the time came for injection.“ (AU_PP_AID_004.doc)

Equipment for preparing and injecting drugs is subsequently disposed off, often without care for proper and safe disposal, in this way creating additional risk of transmitting of HIV, Hepatitis B and C and others The only stated reason for this behaviour is the fear not to be discovered by parents.

Behaviour in crisis

AID who have already developed addiction will suffer withdrawal symptoms if the discontinue regular use, including “rhinorrhoea” (nose bleeding), lacrimation (excessive shedding of tears), pain in the muscles, chill, skin shivering and after 24-48 hours there are cramps in the muscles and the stomach”, but the need for drugs remain. (World Health Organization, 1994: withdrawal syndrome). The occurrence of these symptoms depends on individual tolerance to drugs but often with time, the cravings for drugs grow more pronounced and individuals experience the need to inject higher quantities in shorter time intervals. (Schaffer Library of Drug Policy, 1988; World Health Organization, 1994: tolerance). All study respondents reported having felt the abovementioned symptoms. In such cases, their priority becomes taking another dose as soon as possible, or at least temporarily calming the crisis using sedatives, analgetics and similar medications which ease the cravings until heroin or methadone can be obtained.

Injecting drugs is linked to another phenomenon called “needlemania,” the addiction to needle or injecting. When AID are in situations when they do not have drugs they inject water or some other liquid to experience the feeling of injecting.

Sexual behaviour

Despite reports of regular condom use by AID, it does not appear to be regular practice, especially during sex with an intimate partner. Being under the influence of drugs will also affect sexual behaviour.

Sex with many partners at the same time is a rare occurrence but was experienced by a few respondents under the influence of drugs.

Case study
(AU_SA_AID_001)

Eva¹³ is seventeen years old, living with her parents and the elder brother who, at the time of the interview was imprisoned for trafficking drugs. She lost the right to schooling because she repeated the first year of secondary school twice. Her father was laid off from work due to excessive use of alcohol, and she does not know where her mother works. She does not have health insurance, and the social assistance they used to receive in money is discontinued, but she suspects that her mother takes the money and does not share it with the family. Eva is unhappy with family relations and reported that they do not have the basic domestic appliances that every average modern household has.

Her first sexual experience occurred when Eva was 14, when she was forced by her mother to give sexual services to her boss.

“...I was forced to that and I had to accept it... From my mother. Well..., she use to work there in one factory and... in order to get higher salary from the boss, I had to go with him and so I did... I had no choice. How could I react. I did not want, I resisted, but I couldn't. ...If you want this, if you want that, but you must do it, you must...”

Sexual intercourse with her mother's boss continues, and the use of condom depends on his mood. Eva knows that sex without a condom is a risk for transmitting HIV and other STIs, but she has no force to resist. Now Eva has a boyfriend, but continues to exchange sexual services to get drugs. She started to use drugs with her brother, but because now he is in prison she does that with her boyfriend. When injecting drugs with the boyfriend she does not take care to use sterile injecting kit.

“Most often... Depends. Sometimes ..., we smoke it, sometimes..., depends, how we can and if we are in crisis. For example, we try to finish it as soon as possible, not to see how we did it, made it, it is most important to satisfy ourselves.”

For several months, Eva was placed in a home for minors because of the drugs, but the relations in the institution were disappointingly bad, and after coming out she suffered humiliation and abuse from the police because she uses drugs. She is very disappointed in the world in which she lives and from the behaviour of responsible institutions. She is aware that she has rights, but when she tried to report to the police that she is abused by her mother she did not get a response and suspects that her mother has connections in the police.

Eva is not different from other peers, but has found herself in circumstances that do not support her and other vulnerable young people.

The example of Eva is an introduction to topic of the wider social community and legislation on adolescent drug use.

The impact of the community

Family

Knowledge that a child is using drugs causes shock and confusion among parents and one of the usual reactions is to compensate for prior lack of attention by sending the child for immediate treatment. However, such reactions often cause the opposite effect because AID perceive these efforts as undue pressure and misunderstanding by parents. AID hide from the parents, ignore discussions and advice, and lie about giving up drugs. Even AID who believe that they could get support from their parents reported being afraid to ask.

„ My parents. I... I am sorry for them. I feel terrible about them. My mother is about to die. They are depressive, sorrowful ... trying to help me in any way, but it's useless. There are no results from me. Not that I do not want but, I feel powerless in that regard. They feel ... I do not know perhaps too much pain. Apart from what I have done, all these lies ... all these thefts from home, they are still good to me and forgave everything. Let me tell you honestly ... Sometimes I act very furiously. After some time later I have to confess myself that ... that I am a drug addict, and I am dependent on that. They want to help me but, only they do... At moments it doesn't interest me at all. Not, at all. Simply, I do not listen to them ...I am so uninterested. It is all the same to me (laughing)” (AU_PP_AID_009)

¹³ The name is invented and has no links whatsoever with the real person.

Contrary to AID who at least receive some support from their parents, in the previously described case of Eva, it was an inappropriate family situation that contributed to use of drugs and deepens marginalization and involvement in risky behaviour. There are individual cases when AID start to inject following the example of elder relatives and/or friends or AID who persuade younger relatives and/or friends to using drugs for financial profit.

Friends

The stigmatization from the wider social community pressures AID to hang out in increasingly isolated circles with others who use/inject drugs; this makes AID communities very difficult to reach with existing health and social services. Social networks further reinforce risk-taking as normative group behaviour.

Intimate partner

Among those with a regular intimate partner, AID often inject drugs together using joint equipment and practice sex without condoma. They justify the risky injection and risky sex with mutual trust, but may also have occasional, sometimes unprotected, sexual intercourse with other partners, as well as sharing injection equipment with others. Female respondents also reported exchanging sexual services for money and/or drugs without regular condom use. Those who have intimate partner who are not drug users themselves often hide their behaviour from the partner.

School

AID will use drugs before and/or after classes in order to avoid withdrawal symptoms. The teaching staff is aware that there are students using drugs in the school and there are initiatives to help these students to stop, but there is an impression that their efforts are futile. Their efforts rely on students' self-initiated consultations, and attempt to promote complete abstinence. There are also cases where a student is discovered injecting drugs and is expelled from the school.

INSTITUTIONS OFFERING SERVICES TO AID

Health institutions

According to the Constitution of the Macedonia, each citizen is "guaranteed the right to health care and at the same time it is the obligation of each citizen to care and promote hir/her own health and the health of others (Art. 39 from the Rulebook).

AID rarely expressed the need for health treatments not related to the use of drugs or damage caused from injecting drugs. In the rare cases occurrence of abscesses, trombophlemitis and similar health disorders caused from long-term and incorrect injecting, AID turn to harm reduction programs. While such programs exist in the cities covered by the research, they are not present in all cities. For the usual health disorders such as colds and flu, AID receive help from family doctors, but if medical personnel knows about their injecting drug use and try to reproach or advise them, this is extremely unpopular among AID. No respondent covered reported having been refused medical attention, but gave examples for other IDUs who had been turned away from services.

Not all AID have a need for addiction treatment, but some have had treatment o the insistence of parents but without substitutional therapy, commonly known as "dry detoxication". Not many AID receive substitution therapy, commonly known as "methadone therapy", mostly because of no need to treat addiction, but also for the "high threshold" for AID to receive such treatments. (Gajdadzis-Knezevik et al, 2005: 48) Additional difficulties for treatment with methadone is the lack of programs in many cities. In Kumanovo, one program was established in 2005, in Gostivar there are none, and the oldest such program in Macedonia is in Skopje, but has been closed for several years. All of these initiatives face resistance from including from health workers, local government bodies, and the general population, due to sever stigma against all IDU, including AID.

Social care institutions

AID do not try to contact the Social Care Centres nor are aware of their function and the services they provide, they only link them with the financial assistance, commonly known as "social assistance", which their parents might during economic hardship. Among the few AID with contact with Social Care Centres have been taken there because of juvenile delinquency, family violence or similar social problems, and it is consequently discovered that they use/inject drugs. The services given by the Social Care Centres, are supposed to include care for IDU according to amendments to the Law on Social Care, 2004: "for the persons who use, or abuse drugs and other psychotropic substances and the members of their families by giving counselling services, information,

consultation and education, employment assistance, cultural, fun and recreational activities” (Trajanoski, 2005: 48). However, this study found very few AID involved in this program, and these were forced to cooperate during legal settlements, and had to attend in the presence of a parent. As the previously cited example of Eva demonstrates, Social Care Centres have very little interest in AID and their needs.

Nongovernmental organizations

Many AID do not have any information about the civil associations that give services and support to PUD, nor have considered the possibility of receiving help from these organizations. Those AID who know about NGO working in the area of drug use have heard only about harm reduction programs and counselling centres and do not have any information about other organizations offering help and services for AID. The utilization of the existing services for PUD is small, most often due to the legal limitations for work with AID, but also because many AID do not recognise that they are at risk from poor outcomes of problematic drug use¹⁴. Inappropriate laws remain that create legal obstacles to the distribution of sterile injection equipment for persons under 18.

„ Adolescents below eighteen years of age were not contacted by us directly through the programme for injection equipment exchange because we are not allowed under the legal obligations ... and in that case we need to inform their parents. Only a medical worker may inform for a certain consulting from time to time, the social worker and so on. So we do not have a strict programme i.e. our programmes are not strictly designed for persons under eighteen years of age. The reason is not because we do not want but, because we are forbidden by the law.“ (AU_KP_AID_007)

Nonetheless, all respondents expressed satisfaction with harm reduction programs and emphasised the need for expanding activities to meet the needs of AID.

LEGISLATION IN MACEDONIA RELATED TO THE AID RISKY BEHAVIOUR

Relations with the police

All AID who had contacts with the police for drugs or suspicion of drug possession stated that they were mentally and/or physically abused, and that the police confiscate all drugs or injecting equipment when found. When police encounter AID they search them in public places trying to find the drugs. The repressive measures used cause AID to fear police interference and therefore drives them more “underground” which again makes it difficult for them to be reached by services and shapes their vulnerability to HIV/AIDS and other infections.

Legislation and behaviour of AID

According to the National Program for Elimination of Drug Abuse and Trafficking in Drugs, the drafting of a special law on drugs has been planned since 1996 but does not yet exist, despite increased efforts in previous years (Trajanoski, 2005, 1; 28). The existing laws punish possession regardless of the type and quantity of the drug and the use of drugs¹⁵, which are punished through fines and imprisonment. Stigma associated with criminal conviction compounds the stigma of drug use and further marginalises AID and makes hinders efforts to re-integrate them into families, school, and other social contexts.

A great number of AID in Macedonia do not know the legislation on drugs, and those who say they know it are not well informed, often not understanding how it is possible that all drugs are treated equally by law. AID believe that the access of the persons addicted to drugs to the harm reduction programs and to other health, social and educational offices and services should be regulated by law.

¹⁴ According to the European Monitoring Center for Drugs and Drug Addictions, under problematic drug use is “injecting or longterm/permanent use of opiates, cocaine and/or amphetamines”. (EMCDDA, 2006)

¹⁵ Pursuant to the Article 43 from the Law on Production and Release of Narcotics from 1991 and according to the Law on Misdemeanors against the public order and peace, the possession and use of the drugs in Republic of Macedonia is punishable with a fine or imprisonment sentence (Trajanoski, 2005: 35-38)

REFERENCES

Metodija Angeleski

- 1994 Prostitucijata i nejzinata povrzanost so drugite socijalno-patoloki pojavi, Makedonska revija za kazne-no pravo i kriminologija, God. 1, br. 2 (1994), str. 388-397
(Prostitution and its relation with other social -pathological phenomena. Macedonian review for criminal law and criminology, No.1/2, 1994, pp. 388-397)

Arnaudovski i dr.,

- 1996 Arnaudovski Ljupco, Coneva, Ljubica, Angeleski, Metodija, Prostitucijata vo Makedonija, Skopje: Republicki zavod za unapreduvanje na socijalnite dejnosti
(Prostitution in Macedonia, Skopje, Republic Institute for Social Activiites)

Veljanov - Kunovska

- 1996 Veljanov, Slncomil i Kunovska, Silvija, Znacenjeto i ulogata na kriminalistickata tehnika vo resavanjeto na problemot zloupotreba na droga : (prednosti i nedostatoci na neкои ponovi instrumentalni metodi za detekcija i identifikacija na opojni drogi) Vo: Bezbednost, God. 36, br. 1-2 (juni 1996), str. 98-107
(The importance and role of the forensic techniques in solving problem of drug abuse: advantages and shortages of some new instrumental methods for detection and identification of narcotic drugs), In. Bezbednost, No.36/1-2, June 1996, pp. 98-107)

Sne ana Vrangalova

- 2006 Misterijata na seksualnata orientacija, sovremeni koncepti i makedonski perspektivi, EGAL, Skopje, 228
(The mystery of sexual orientation, contem porary concepts and Macedonian perspectives, EGAL, Skopje, pp.228)

Gajdadzis-Knezevic i drugi

- 2003 Gajdadzis-Knezevic, Slavica, Pacoska, Natka, Savevska, Mirjana, Spasovska-Trajanovska, Aneta, Aleksovska, Nada, Velkovska, Suzana, Ilievska, Dragica Semejstvoto mladite i drogata : priracnik za mladi i roditeli : [sam/a ne mozes - zaedno mozeme poveke] : Skopje : Vinsent grafika
(Family, youth and drugs: handbook for young people and parents : [you can not do it alone – together we can do more], Skopje, Vinsent grafika)

Slavica Gajdadzis-Knezevic, Liljana Ignjatova, Stavre Gramov

- 2005 Upatstvo so protokol za primena na metadonot pri tretmanot na opijatna zavisnost, Skopje: Centar za prevencija i tretman na zloupotreba i zavisnost od drogi i drugi psihoaktivni supstancii vo Kisela Voda, JZO Psihijatriska bolnica „Skopje“, 2005
(Guide and protocol for metadon use during the treatment of drug addiction, Skopje, Centre for prevention and treatment of drug addiction and drug abuse and other psychoactive substances in Kisela Voda, JZO, Psychiatric Hospital “Skopje”, 2005)

Amanda Davies

- 2001 Sex Exchange Behaviour. On behalf of the Department of Families. Queensland

Dekov V., Ignjatova L., Jankuloski H., Kostovski D., Toseva M.

- 2006 Namaluvanje na teti i HIV: Priracnik, HOPS, Skopje.
(Harm Reduction and HIV: guidebook, HOPS, Skopje)

Grabosky, P., & et al.

- 1998 The Commercial Sexual Exploitation of Children: A stocktake and analysis for Australia's National Action Plan. Canberra: Australian Institute of Criminology

Jordan Jovev

2002 Bolesti na zavisnost: zavisnost od alkohol, droga i tutun , Skopje: Centar za prevencija na zavisnosti (Diseases of addiction: addictions to alcohol, drugs and tobacco, Skopje, Center for prevention of addiction)

Kristin G. Esterberg

2002 Qualitative Methods in Social Research, Mc Graw Hill

Manderson, L., Bennett, L. R., & Sheldrake, M.

1999 Sex, Social institutions, and social structure: Anthropological contributions to the study of sexuality. (Annual Review of Sex Research, 10, 184-199.)

Ministerstvo za zdravstvo

2003-2006 Nacionalna strategija za SIDA
(National Strategy on AIDS)

Ministry of Health

2005 Protocol and Procedural Guidelines for Conducting the 2nd Generation Surveillance System for HIV/AIDS

Ministry of Health

2006 Universal Access Report

Lawrence Neuman W.

2003 Social Research Methods: Qualitative and Quantitative Approaches, 5th edition

Silvana Onceva

2003 Stavovi i odnesovanje na mladite vo vraska so drogite i nasoki za primarna prevencija na zloupotrebata na drogi vo Republika Makedonija. Magisterski trud. Skopje: Univerzitet Sv. Kiril i Metodij, Medicinski Fakultet Skopje, 2003
(Young people's attitudes and behaviour towards drugs and guidelines for primary prevention of drugs abuse in Republic of Macedonia, MA theme, Skopje, University St. Cyril and Methodius, Faculty of Medicine, Skopje 2003)

Marsha Rosenbaum

2007 Safety First, (Drug Policy Alliance, 2007),
<<http://www.safety1st.org/pdf/safetyfirst.pdf>>

Saunders, P.

1998 Sexual Trafficking and Forced Prostitution of Children. (Paper presented at the Journalists' Seminar, New York)

SCHAFFER LIBRARY OF DRUG POLICY

1988 How bad is Heroin Withdrawal?, (Schaffer Library of Drug Policy, Jara A. Krivanek, Heroin, Myths and Reality, Allen & Unwin, 1988),
<<http://www.druglibrary.org/schaffer/heroin/herowith.htm>>

SZO/ONKDK/ONSIDA

2006 Supstituciona terapija za odrzuvanje vo vodenje pacienti so opioidna zavisnost i prevencija na HIV/SIDA, Izlozuvanje na stavovite na SZO/ONKDK/ONSIDA, (Skopje: Makedonska mreza za namaluvanje na steti, 2006).
<http://www.mhrn.org.mk/biblioteka/supstituciona_terapija_za_odrzuvanje.pdf>
(Replacement therapy for maintaining and guiding patients with opioid addiction and HIV/AIDS prevention, A presentation of attitudes of WHO/UNODC/UNAIDS, Skopje, Macedonian Network for Harm Reduction, 2006)

Todorovska- Gurcevska

1996 Todorovska-Gurcevska, Slobodanka Individualno-psiholoskite i socijalnite aspekti na zavisnicite od droga vo Republika Makedonija, Makedonska revija za kazнено pravo i kriminologija God. 3, br. 1-2, septemvri 1996, str. 318-327
(Personal psychological and social aspects of drug addicts in Republic of Macedonia, Macedonian review for criminal law and criminology, No. 3/1-2, September 1996, pp. 318-327)

Bosko Tomovski

1994 Droga : bolest na denesninata, Skopje : [Avtor]
(Drugs – Disease of modernity, Skopje)

Toseva - Dokuzovski

2005 Toseva, Marija - Dokuzovski, Branko, Otvorena skopska scena : izvestaj od istrazovanje, Skopje:
HOPS - Opcii za zdrav zivot
(Skopje Open Scene : Research Report, Skopje, HOPS-Healthy Options Project Skopje)

Zarko Trajanovski

2005 Politikata na Republika Makedonija za borba protiv drogite, analiza na zakonskata regulativa za
drogi vo Republika Makedonija, vo rakopis, 2006
(Republic of Macedonia policy to support the fight against drugs : an analyses of legislation on drugs in
the Republic of Macedonia, manuscript, 2006)

Vladimir Trajkovski

2003 Genetski aspekti na seksualnata orientacija i homoseksualnosta: Godisen zbornik. Kn. 56, 2003,
str. [447]-459.
(Genetics aspects of sexual orientation and homo sexuality : Year book, Book 56, 2003, pp. [447]-
459).

Ivan Tulevski

1997 Namaluvanje na stetata od upotreba na droga: zbornik na statii, ...,Skopje, Institut Otvoreno
Opstestvo Makedonija
(Harm reduction and drug use : a collection of papers, Skopje, IOM)

Tulevski - Sekutkovska

2004 Tulevski, Ivan G.: Sekutkoska, Slavica, Droga, opasen predizvik vo mladosta : Skopje : Zdruzenie na
socijalni rabotnici na grad Skopje
(Drugs – dangerous challenge during youth, Skopje, Association of social workers, Skopje)

UNICEF

2002 Rapid Assessment and Response to Risk-Prone Sexual Behaviour and Use of Psychoactive
Substances in Highly Vulnerable Groups of Young People Aged 10 To 24 in the Republic of
Macedonia, UNICEF 2002
<http://www.cpha.ca/English/intprog/hiv_prev/rarmaced.pdf#search='RAR%20%20Macedonia'>

UNICEF

2006 Procenka na sluzbi dostapni do mladite
(Assessment of Youth Friendly Services)

Ljubica Coneva

1994 Nekoi fenomenoloski karakteristiki na prostitucijata vo Makedonija, Vo. Bezbednost, God. 34, br. 2,
juli 1994, str. 312-321
(Some phenomenological characteristics of prostitution in Macedonia. In. Security, No. 34/2, July
1994, pp. 312-321)

Ljubica Coneva

1994 Javnoto misljenje za i protiv legalizacija na prostitucijata vo Makedonija Vo. Bezbednost, God. 34, br. 3,
oktomvri 1994, str. 479-490
(Public opinion for and against the legalization of prostitution in Macedonia, In. Security No. 34/3,
October 1994, pp. 479-490)

WHO (World Health Organisation)

1996 Commercial Sexual Exploitation of Children: The Health And Psychosocial Dimensions. (Paper
presented at the World Congress against Sexual Exploitation of Children, Stockholm, Sweden)

WHO (World Health Organisation)

1994 Lexicon of Alcohol and Drug Terms. Geneva: World Health Organization, (World Health
Organization, 1994)
<http://www.who.int/substance_abuse/terminology/who_lexicon/en/index.html>

ACRONYMS

AID	Adolescents injecting drug users
AOSS	Adolescents who offer sexual services
CCHR	Centre for Civil and Human Rights
CSA	Commercial sex activities
CSEC	Commercial sexual exploitation of children
CSW	Centre for Social Work
ECPAT	End Child Prostitution, Child pornography and trafficking of Children for Sexual Purposes
EGAL	Equality for gays and lesbians
FR	Field researchers
HERA	Association for health education and research
HOPS	Healthy Options Project Skopje
IDU	Injecting drug users
IEA	Institute of ethnology and anthropology
KI	Key informant
LGBT	Lesbian, gay, bisexual and transsexual
MARA	Most at risk adolescents
MASSO	Macedonian Associated for Free Sexual Orientation
MHRN	Macedonian Harm Reduction Network
MIA	Macedonian Interethnic Association
MOH	Ministry of Health
MOI	Ministry of Interior
MKD	Macedonian denars
MSM	Males that have sex with men
NGO	Non-governmental organization
PR	Participatory research
PUD	Persons who use drugs
RIHP	Republic Institute for Health Protection
SRH	Sexual and Reproductive Health
SRQ	Specific research questions
STI	Sexually transmitted infections
SW	Sex work
VCT	Voluntary counselling and testing
WHO	World Health Organisation

HISTORY OF THE PROJECT

At the beginning of 2006, initiated by the Macedonian Harm Reduction Network, represented by the NGO HOPS from Skopje, discussions began with the Institute of Ethnology and Anthropology of the University “Ss. Cyril and Methodius” from Skopje on developing a network of non-governmental, academic, scientific and educational institutions to improve the approach towards socially marginalized groups in Macedonia, with a focus on adolescents at risk of HIV/AIDS and STIs. The network’s aim was to conduct policy relevant research through multidisciplinary partnerships that might strengthen uptake of results at local and national levels.

As a result of these discussions, an Agreement for Cooperation and Mutual Cooperation between MHRN and IEA (Annex. Agreement for Cooperation MHRN and IEA) created the Center for Research and Work with Socially Marginalized Groups that would combine theory and practice, research and implementation, use of different research methodologies and analyses, and provide a sound evidence base for the development of policy and project approaches targeting socially marginalized groups.

One of the first initiatives identified was conducting formative research on Most At-Risk Adolescents for HIV/AIDS and STIs in Macedonia. At the beginning of 2006 (January – March) discussions started with representatives from the UNICEF Office in Skopje as a possible source of funding for the project, as well as active partner during study design and implementation.

Training Seminar for Qualitative Study of MARA (Bitola, May 2006)

In May 2006, in Bitola, a Training Seminar for Design of a Qualitative Study of MARA was organized with present members of initiating institutions (IEA and MHRN in which the NGOs listed below are members) and other relevant institutions attending, including the Ministry of Health (MH), Republic Institute for Health Protection (RIHP), Institute for Sociology, and the Institute for Social Work and Social Policy. As representatives of MHRN nongovernmental organizations were present, especially those who work with specific target groups: HOPS (which works with person injecting drugs, harm reduction programs and commercial sex workers), the Centre for Social Work (SOS helpline for information on drug abuse and advice for harm reduction), HERA (HIV/STIs peer education among school youth and socially marginalized groups), EGAL (which works on promotion of sexual health and rights of the MSM population) and MIA (HIV/STIs peer education among school youth and socially marginalized groups).

The following objectives guided the seminar:

- (1) Training for the core research group, composed of individuals with different professional and scientific skills, to determine and realize specific research study for MARA with special emphasis on the realization of *qualitative research*;
- (2) Selection and development of research protocol (research questions, methods and techniques for collecting information, analyses, correlation of the objectives and the results, proposals for practical application of the results and creating intervening strategy)
- (3) Exchange of experiences on advantages and disadvantages in the use of the quantitative and qualitative analysis in the study of MARA and discussion on the “best practices” in work with MARA (Annex. Project proposal to IEA).

The seminar was lead by Ms. Joanna Busza from the Center for Population Studies from the London School for Hygiene and Tropical Medicine.

At the seminar, exchange of skills and experience was organized among participants for assist with planning qualitative data collection and analyses, while reviewing the advantages and disadvantages of this methodological approach, as well as experiences from “frontline” work with MARA in other countries throughout the world. At the seminar, the facilitator presented several “best practices” for qualitative research based on her personal field and scientific research. Also, several experiences from Macedonia were presented, especially from the previous experiences of IEA in the field research work with MARA.

The most worthwhile work realized at the seminar was the practical preparation and drafting of study details. This was particularly valuable as it brought together all research stakeholders for the first time and made it possible for them to participate directly in all stages of study design. After the finalization of the draft protocol and project proposal of IEA, at the end of the month of May, the project was submitted to the UNICEF Office in Skopje. By signing the agreement for partner cooperation between UNICEF and IEA, from 1st July 2006 the mapping and the community based study on MARA to HIV/AIDS/STIs in RM was formalised.

Training Seminar for the Field Researchers (FR) (June 2006)

As all target groups within the overall MARA category represent *extremely hard-to-reach target groups* for research, and because the study aimed to maintain a bottom-up approach drawing on the skills, experience, and strengths of NGO with direct access to the target population, the field research conducted in local communities was determined to be most suitable for data collection by local community members themselves. Research staff were thus selected from persons who either work with the target group in the field (representatives of NGO outreach staff) or are current or former members of one of the target groups. This dovetailed with the second objective of building the capacity and skills of NGO staff to strengthen future research activities relevant to their work.

In June, participants from the training were selected. Three separate training seminars were held for field researchers (FR) according to whether they would recruit MSM, AOSS or AID. The reason behind this division was that the trainings were designed to address the *specific research questions (SRQ)* that differed by target group. During training, the target groups and how they could be identified was discussed with special emphasis put on the difference between identification of MARA groups by the *wider social community* (outward identification) and *self identification* (inward identification). Researchers received background training on theoretical principles related to qualitative research and the differences between insider and outsider knowledge to ensure fieldwork took account of both approaches. This component of training was especially important because some of the field researchers are current or were former members of the target groups and brought their own biases as well as expertise to the study.

An additional component of the training courses was addressing issues that lead MARA to be *extremely hard-to-reach*, which meant that it would be difficult to identify and recognize them. At the training courses the following social factors were covered:

- MARA may try to hide their behaviour due to the fact that in some communities it is considered socially unacceptable or illegal
- They have experienced bad experiences with the authorities or with services
- Lack of feeling of belonging to a defined community
- MARA may not recognise do any needs
- Some MARA may not be known about at all and therefore difficult to recognise and identify for the study

Participants were trained in possible ways and practical techniques for identifying and recruiting study respondents, while at the same time staying within the methods specified in the protocol and not jeopardising the privacy or anonymity of respondents.

The training also covered practical field research work and keeping *field notes*, reviewing the basic types of field notes and good practice for writing them up as comprehensively as possible. Special emphasis was put on this part of the training, having in mind that the most field researchers did not have any prior theoretical nor practical research background. In the third part of the training, participants worked with the assistant researchers and mentors on developing *specific research questions (SRQ)*, to be used in the topic guides for interviews, focus group discussions, etc. The topic guides were designed as an aide memoire for stimulating natural flowing conversations with informants for each separate subgroup: MSM, AOSS, AID. Field researchers also practice recording data collection using digital dictaphones.

Training on using the software for qualitative analysis: Atlas.ti

For ease of processing, classification and coding transcribed data, special software for qualitative analysis was used, Atlas.ti. Assistant research staff underwent training in the software package prior to entering data.