BORDER|NET work

2010-2012 CROSSING BORDERS, BUILDING BRIDGES

A Fact Finding Mission on patterns of risk related to social determinants, barriers and access to services of sex workers, including Roma and young people in Republic of Serbia and border regions to EU

BORDERNETwork Package 4

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JAZAS

BORDERNET*work* 2010-2012

Highly active prevention: scale up HIV/AIDS/STI prevention, diagnostic and therapy across sectors and borders in CEE and SEE

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About this Report

Report on Fact Finding Mission in Republic of Serbia and border regions to EU in the frame of the EU-funded (Public Health Programme) project BORDERNETwork n° 20091202, Area of Cooperation Interdisciplinary cross-border networking (Work Package 4) and Community-based HIV/STI prevention among ethnic minority/migrant groups (Work package 8)

General Objective of the Fact Finding Mission

To sort out gaps in and between the core strands HIV/AIDS/STI prevention, diagnostic and therapy in border areas between EU and ENP country, Serbia.

For the purpose of the assessment along the external EU border the BORDERNETwork project coordinated by SPI Forschung envisaged subcontracting the Association Against AIDS-JAZAS, based in Belgrade to conduct a Fact Finding Mission.

Specific objective: Interdisciplinary networking

To scale up the implementation of highly active prevention through boosting network cooperation on national, model regional and cross-border level in CEE and SEE in a three-year period.

Introduction

Involving civil society, public health and health care services in interdisciplinary networks the aim of BORDERNETwork is to advance combination prevention, to coordinate bilateral health targets and assure their political and practical implementation in 5 EU model regions and in border areas to ENP countries.

Main focus of the fact finding mission, conducted by JAZAS in Serbia is on information on particularities of local epidemiological situation (e.g. HIV/AIDS/STI, HIV Co-infections, Tuberculosis) and patterns of risk related to social determinants of various vulnerable groups, e.g. young people at risk, mobile groups, representatives of most at risk groups (IDUs, Sex workers, ethnic minority/migrant groups), PLHIV. At same time the scope and barriers of the available prevention measures were assessed.

The findings aim to bring understanding about various shortcomings of the measures undertaken so far and make a clear outline of the unmet needs of target groups and communities, related to prevention, medical and social offers, universal access to treatment, care and support.

The various **target groups addressed** in the frame of the Fact Finding Mission were**:**

- Mobile Young People (migrants or frequent travellers to EU) and representatives of ethnic minority communities in vulnerable situation (e.g. ROMA);
- Special focus will be put also on young women, working abroad, assessing the risk of trafficking in women;
- Additional focus will be on young PLHIV and their access to prevention, treatment and social assistance.

Thematic priorities:

- Composition of the ethnic minorities in the country, most important ethnic minority group in terms of HIV/STI;
- Vulnerability of the group towards HIV, HIV/STI prevalence, affected regions;
- Access of the ethnic minority groups to information about HIV/STI prevention, diagnostic, counselling and treatment;
- Patterns of mobility, additional risks related to mobility;
- Access to services for HIV/STI prevention/HIV treatment, counselling and testing, sexual and reproductive health;
- Behaviour related to prevention of risks and risk-exposure;
- Needs related to information and skills for protection

Geographical scope: 2 Serbian cities: Zajechar, bordering Romania, and Subotica bordering Hungary

The two cities were chosen based on their proximity to border lines and the contacts in NGO sector already available at the onset of the research project.

Target group: sex workers (including Roma SW and young people)

The target group was chosen based on experience by the research organization (JAZAS), as well as the need to explore this issue in border areas, based on their level of marginalization, vulnerability, discrimination and stigma in order to ascertain whether there are any other specificities and characteristics related to this group in border areas related to HIV.

Timeline

Preparation of Rapid Assessment and Response (RAR) in two cities: February – March 2011

- identification of stakeholders and relevant NGO's
- identification of focus group participants
- Scheduling of focus groups and interviews
- Preparing questions and topics.

RAR in field: April 2011

Desk Review: April 2011

Report and Analysis: May-June 2011

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Data and methodology

The following data were used for conducting this 'mini- analysis":

Secondary data, which include a literature analysis (published papers and research results), official statistical data from official institutions and NGOs.

Primary data, which were purposively gathered for this analysis.

Data were gathered in border territories: in Zajechar and Subotica in April 2011.

Primary data were gathered through semi-structured and unstructured interviews:

- In Zajecar - interviews were conducted with two NGO representatives, an HIV specialist, a representative of city government a social worker and two sex workers.
- In Subotica – interviews were conducted with a medical doctor working in HIV prevention, 2 NGO representatives, a city government representative, a social worker and four sex workers.

In total, 16 people were interviewed.

There were numerous difficulties in conducting this Rapid Assessment and Response, ranging from logistical (scheduling and willingness to participate) to obvious discomfort among some participants to speak on the topic of sex work and HIV, which is in and of itself a significant fact for the research.

The methodology in the RAR had to be changed in part, due to difficulties in arranging focus groups. There were not enough participants that were willing to meet in one spot at a specific time in order to be able to conduct a focus group in Zajechar. In Subotica, outreach workers did not have enough rapport with sex workers to be able to invite them to a focus group, which rendered it impossible to speak to them but on the hotspot.

Desk Review: Topic 1 & 2

Topic 1: Profile of NON-EU country's background situation

The Republic of Serbia is located at the crossroads between Central and Southern Europe.

As of January 2010, Serbia (without Kosovo) had an estimated population of 7,306,677 (not including over 200,000 internally displaced persons from Kosovo, who will be counted as a permanent population in the next census, taking place in 2011) (1)

The largest ethnic group in Serbia are Serbs (83%), Hungarians are the second largest (3.9%), making up 14.3% of the population in Vojvodina. Other minority groups include Bosniaks, Roma, Albanians, Croats, Bulgarians, Montenegrins, Macedonians, Slovaks, Vlachs, Romanians,[2] According to UN estimates, around 500,000 Roma live in Serbia (3). Serbia has the largest refugee population in Europe (4). Refugees and internally displaced persons (IDPs) in Serbia form between 7% and 7.5% of its population.

Regardless of the poverty measure one decides to utilize, the higher poverty risk among refugees and IDPs, and especially among Roma, is clearly evident in comparison with the domicile non-Roma (5).

Roma women, in general, face higher poverty levels vis-à-vis Roma men and the broader mainstream society. The same UNDP report shows that 41% of Roma women surveyed earned 30 EUR per month or less, whilst only 20% of Roma men fell into the same income category. Many Roma communities lack adequate living conditions, often lacking even basic infrastructure and amenities such as: heating, insulation, sewage systems and running water. This situation is exacerbated by the fact that these communities are often far removed from public services and employment and educational opportunities. Frequently, housing conditions are so substandard as to cause a public health risk. Roma women, who spend more time in the home than Roma men, are most susceptible to health risks arising from substandard living conditions.

A lack of personal documents and residence registration is a problem in Serbia, particularly amongst ethnic minorities. Lack of identity documents is high among Roma, particularly among refugees, IDP's and returnees and among Roma living in illegal settlements (6). The Roma community is one of the groups most affected by a lack residence registration.

High levels of racism and discrimination against Roma in Serbia has a great effect on the manner in which state institutions and governmental officials of all levels approach Roma issues. Due to this discrimination and the marginalization in society, Roma are unable to access service equally or to exercise their basic human rights. This is especially true for Roma women.

The health care system Serbia, like other parts of former Yugoslavia, has inherited a health system financed by compulsory health insurance contributions, based on 12,3% payroll taxes. The system was used to provide easy access to comprehensive health services for the entire population.

Unfortunately, political problems that shaped the economic performance, has resulted in a substantial health system resources reduction. The viability of the system was challenged by the reduced financial basis of health insurance contributions where two million employed financed seven million insured. A cumulative effect of all these events

caused significant deterioration of the health status of population widening the gap between Serbia's and EU populations (7).

Health care in Serbia is provided through a wide network of public health institutions owned and controlled by the Ministry of Health. The law provides for private practice which, however, may be pursued exclusively by way of private funds.

The whole of the private health care sector is not included in the public funding scheme and as such, it represents no supplementary component of the public system nor does it offer to insurers the possibility to exercise rights arising from compulsory insurance.

Health Care System in Serbia

Health services (public sector) are organized on three levels:

- primary health care: with health care centres in all municipalities
- secondary care: comprised of general hospitals
- tertiary care: highly specialized institutions (top level medicine), medical university clinics and institutions

Aside from these, there is a network of institutions which deal with preventive and public health activities, such as the Institute of Public Health and numerous departments.

Barriers are:

According to legal regulations, accessibility and availability of health services are equal for all citizens, however in practice there are a plethora of barriers for vulnerable groups. According to JAZAS research (8), one of the most significant barriers is the „incompatibility between vulnerable groups needs and what they find is available to satisfy those needs in health care sectors"

Inadequate communication with health workers like judging, underestimating, condemning, patronising, discriminating against patients, lack of gender sensitivity of health workers and so on.

The high degree of stigmatisation and discrimination, which alienates sex workers from health care system for fear of being judged, humiliated or something like that, is complicated by criminalisation of this phenomenon.

Barriers to accessibility, besides discrimination and stigmatisation, include: poverty, lack of proper documents, low level of health literacy, alcohol and drug use, violence, dependence on pimps and managers, lack of information about services and above all and foremost fear from potential punitive measures should they reveal their work.

20% of female sex workers do not have health insurance or documents necessary to use health services.

HIV and the Health System

There are no specialized health services for HIV. Management of HIV is divided into primary health care (education, working with vulnerable groups, patient illness histories including risky behaviour), public health institutes (VCCT, education, registering and

monitoring), specialized institutions (departments for venereal diseases, centres for drug addiction treatment) and infectious diseases clinics and departments (for opportunistic, AIDS-related infections).

Solutions to the challenges of the HIV epidemic to date

There is no specific law which regulates HIV/AIDS in Serbia, but there are several other laws, regulations and protocols which pertain to it.

The only law which specifically mentions HIV/AIDS is a criminal law which imposes punishments on those who know their HIV + status but do not reveal it to their partners, thereby endangering them with being infected with HIV. This in effect represents criminalization of HIV to a certain extent.

The Law on Anti-Discrimination prohibits discrimination against people on any basis, including their health status.

Overview of legal provisions of the Republic of Serbia which may apply to the field of HIV/AIDS:

- Constitution of the Republic of Serbia, 2005
- Criminal Code, Republic of Serbia, 2009
- Family Law, Republic of Serbia, 2005
- Law on health protection, 2005
- Law on health insurance, 2005
- Labour Law
- Law for protection of citizens from infectious diseases, 2004
- Law on prohibition of discrimination, 2009
- Law on the protection of personal information, 2008
- Law on Public Health, 2009
- Law on transfusion, 2009
- National Strategy for the Fight Against HIV/AIDS, 2005

The National Strategy to Fight AIDS defines national priorities for prevention, especially among groups at a higher risk for HIV, treatment and PLHIV rights and the fight against stigma and discrimination.

The Strategy has enabled the implementation of numerous prevention programs among vulnerable groups; it has created a framework for their development and implementation and defined priorities and responsible organizations and institutions.

While the Law on Anti-Discrimination had a significant effect on stigma and discrimination against PLHIV or people who are at a risk for HIV, other laws are merely a framework for the implementation of activities or in certain cases such as the Law on Public Peace and Order which impedes activities, such as implementation of programs among sex workers.

There are no legal documents or protocols pertaining to HIV and border areas in particular.

The non-governmental sector: Aside from significant activities in educating the general population, NGO's are particularly significant in the work they do with vulnerable 'hard to reach' populations, especially in terms of advocacy and lobbying for the rights of vulnerable groups as well as in raising awareness and lobbying for sensitive and politically conflicting issues for vulnerable groups.

HIV prevention among especially vulnerable groups

The National Strategy from 2010 (9) identifies the following as vulnerable groups: injecting drug users, men who have sex with men, sex workers, prison inmates. Aside from these, youth and indigent and marginalized communities, which Roma are part of, are recognized as needing specific and more intensified activities in terms or prevention efforts.

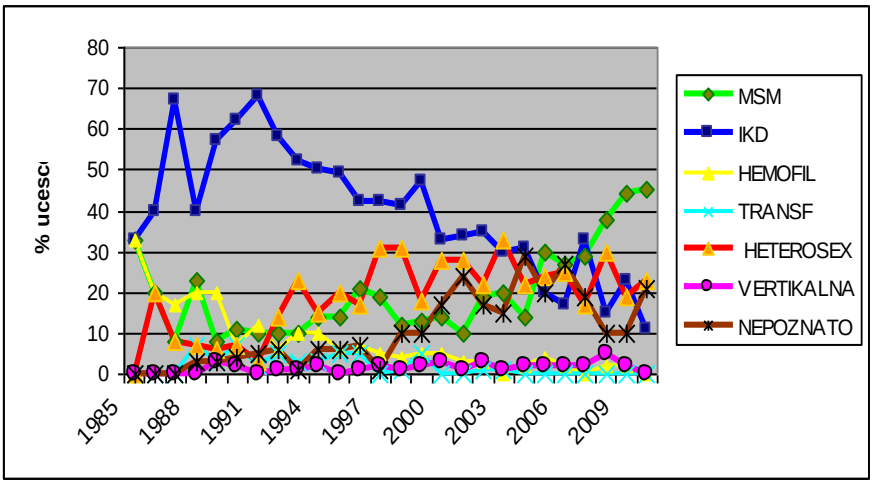
During the implementation of the National Strategy to Fight HIV/AIDS, for the period 2005-2010 significant successes were identified, however, weaknesses which need to be addressed were also recognized.

Some of the weaknesses are: high stigma and discrimination related to all vulnerable groups, insufficient cooperation between the civil and government sectors, insufficient cooperation on local levels, insufficient capacity of the non-governmental sector, lack of predefined standards of work, monitoring and quality control, insufficient degree of use of participatory approach, lack of gender-sensitive programs where needed, lack of programs tailored to different socio-cultural milieus and lack of tailored programs for different age groups. There are significant efforts, incomplete to date, to estimate the size of HIV vulnerable populations according to the above mentioned segments.

Characteristics of the HIV epidemic in Serbia

The characteristics of the HIV epidemic in Serbia can be seen from two sources:

1. The Institute of Public Health Serbia: official data on reported number of HIV infections. According to this data, Serbia is a low prevalence country with an estimated HIV prevalence of < 0.1%. The main mode of transmission is sexual (hetero and homosexual) (76%).



HIV infection according to modes of transmission in Serbia

2. Research and VCCT among especially vulnerable groups, conducted every year, which enable better understanding of risk factors and HIV prevalence among vulnerable groups. The limitation of these research studies is that they are based on non-probability samples and the results cannot be extrapolated for the entire population (see topic 2).

Topic 2: Assessment of risk exposure and social determinants of risks of studied target groups

Sexual mode of transmission is the main mode of HIV transmission in Serbia in the last several years. In 2004, sexual mode of transmission was registered as the mode of transmission in 54% newly detected HIV positive people. In 2008, the sexual mode of transmission was registered in 80% of cases. This data indicate an increase in risk of HIV transmission through sexual contacts, especially among persons who frequently change sexual partners and have unprotected sexual intercourse, such as commercial sex workers and people who have unprotected anal intercourse.

Sex workers are most often blamed for the HIV epidemic, because they have numerous risk behaviour and high vulnerability.

During the last two years, HIV and STI prevention programs as well as the voluntary, confidential, counselling and HIV testing program among sex workers were conducted in the field in Belgrade and a few other cities in Serbia.

This repeated study on HIV prevalence, knowledge, attitudes and behaviour of SW, and the introduction of HCV and syphilis prevalence research will enable us to obtain a more real picture of HIV, HCV.

In 2010, a research study conducted by the Institute of Public Health and implemented trough JAZAS shows that there has been an increase in the number of sex workers that have been included in some prevention programs in the past two years.

This has resulted in a significant increase in levels of knowledge among SW about preventing sexual transmission of HIV and dismissal of misconceptions related to HIV.

A high percentage of condom use with commercial sexual partners has been steady, and there is an increase in the number of sex workers who got tested for HIV and know their result. The biological research component indicated the existence of a dual risk among sex workers, which is also indicated by the high percentage of SW infected with HCV. Over 70% of those infected with HCV are intravenous drug users. Of the 250 study participants, 4% are infected with syphilis, while the HIV prevalence has decreased from 2.2% to 0.8% since the previous research study (10).

Socio-economic determinants of health and other aspects of HIV/AIDS epidemic

Socio-economic determinants of health have changed to some degree in Serbia after 2000 (11). Between 2000 and 2009 Serbia has seen a decrease in employment and an increasing trend in unemployment. In 2009, the employment rate was 40.8%, whereas the unemployment rate was 18.1%. The rising rate of unemployment of people between the ages 26-30, as well as people over the age of 50, poses a significant problem. The employment rate during that period was the lowest in comparison with the rate of

employment in 27 EU countries (64.5%). Regionally, only Macedonia and Bosnia and Herzegovina had higher rates of unemployment.

Factors contributing to the spread of HIV infection

Some of the most significant factors contributing to the spread of the HIV/AIDS epidemic in Serbia are:

- ow socio-economic status of a part of the population
- lack of realistic population size estimates of vulnerable groups (injecting drug users, sex workers, men who have sex with men)
- lack of efficacious HIV infection monitoring systems
- inadequate mechanisms for monitoring and assessing the success of the entire response of society to the HIV epidemic
- insufficient level of information of the general population about HIV transmission risks
- high level of discrimination towards vulnerable groups and people living HIV

Small scale survey - qualitative data - Topic 2

Key informant interviews and interviews with sex workers in Zajecar and Subotica were conducted in April 2011. In Zajecar, interviews were held with an NGO representative who works with sex workers, an NGO representative who works with youth, a sociologist at the Center for Social Welfare, an HIV specialist from the Infectious Diseases Clinic and the chief of staff of city government. Two sex workers agreed to be interviewed in this city.

In Subotica, interviews were held with a representative of a PLHIV union, three representatives from a Roma NGO that works mainly with Roma youth, a medical doctor from the Student Health Clinic, a social worker from the Center for Social Welfare, and a representative of city government. Four sex workers agreed to have informal conversations about the subject on a hotspot.

The key informant interviews in Zajecar (bordering Romania and Bulgaria) and Subotica (bordering Hungary) reveal major differences in the understanding of and approaches to HIV/STI risks among vulnerable groups. Key differences between the respective representatives of local city governments are knowledge and information about the work of social services, understanding issues around HIV, knowledge about programs working with target groups (harm reduction) and financing and support of services/programs for target groups. The sociologist working at the Centre for Social Welfare in Zajecar has knowledge and information about working with vulnerable groups, yet is unable to address issues of vulnerable groups, since there is not enough capacity and support at the centre. In Subotica however, the social worker went through specific trainings for working with vulnerable groups, has experience in outreach work with sex workers and has more opportunity for referrals and cooperation with non-governmental organizations and other institutions. The difference between the two medical doctors are that in Zajecar the specialist claims that all health services are tailored and accessible, whereas the doctor in Subotica points to the difficulty of providing VCCT and youth counselling services by specially trained doctors due to other responsibilities. She suggests that

some of the burdens on doctors need to be alleviated in order for proper HIV services to be able to be delivered. From the interviews conducted with NGO representatives, it seems that in Zajecar there is a lack of expert staff, whereas in Subotica (except for the Roma NGO), outreach services for sex workers, as well as the PLHIV union seem to have good relations with doctors and social workers who are sensitized and trained to work with vulnerable groups. However, in terms of outreach services, there is a certain degree of trust among sex workers in Zajecar, whereas the approach in Subotica is much more formal and no closer relationships with sex workers are established.

Although few sex workers were willing to be interviewed, it can be noted that sex workers in Zajecar have a higher level of knowledge about HIV than those in Subotica. There is no street sex work in Zajecar, only indoor, whereas in Subotica, there is a street sex work scene, and those that were willing to have a conversation with the interviewer about HIV displayed low levels of knowledge and information. Indoor sex work, that is brothels, do exist in Subotica, but are unreachable to services. The differences between these two cities may lie in the provision of outreach services: in Zajecar, outreach services are implemented through an NGO, whereas in Subotica, they are provided through the Institute of Public Health. As mentioned above, there was a noticeable difference in approach, and a noticeable level of comfort and trust among sex workers towards outreach workers and the interviewer in Zajecar.

Problems in field work: representatives of certain sectors do not have the knowledge or interest in the target groups. Sex work is not considered or analyzed in terms of risk and needs for HIV prevention efforts due to the fact that this is still a taboo theme in this region. Even attitudes towards sex work among those few individuals and organizations that deal with the issues, are influenced by the general attitudes and atmosphere in those cities. In both cities, those who provide services to sex workers were contacted and interviewed. However, due to the fact that sex work is not recognized as an issue relevant to the different key informants and their respective institutions, the scope of the interviews was widened to include other vulnerable groups. The decision to include other vulnerable groups into this RAR, was made because a greater understanding of the complexity of vulnerabilities as they are related to border areas was more important than pointing out that sex work cannot be talked about.

Conditions for and hindrances to accessing specific services

Under Serbian law, everyone can access health services if they have the required documents: health insurance and personal identification documents (or patients can pay for services). In order to obtain an ID, a permanent address/residence is required. This used to be a major obstacle in acquiring documents for Roma, as they often lack legal addresses. Under a new law, Roma can acquire health insurance without personal documents, based on only a statement and filing of a request, Roma can obtain health insurance for up to 6 months. In practice, however, they are sometimes not granted this right and are turned down.

In the two cities selected for RAR, the most frequently mentioned obstacles for accessing specific services are stigma and discrimination, lack of confidentiality and a low level of consciousness about health. There is a high degree of distrust in health and social welfare institutions among sex workers, as they claim that they do not believe that services are confidential, and more significantly they say that they are certain that small ‘town mentality always prevails and that all staff members gossip’. Another major barrier

to accessing services is centralization. Almost all specialized services are centralized in a few cities, and some particular services are only available in Belgrade.

ART is available and accessible, however, the bureaucracy and administrative procedures attached to it are complicated and do not guarantee confidentiality, so that in effect acquiring therapy is a social risk. PLHIV, upon completing all necessary documentation in Subotica, have to travel to Novi Sad for therapy. Some chose not to risk confidentiality, and even though therapy is covered by medical insurance, they chose to travel to Hungary and pay for their medications. Others, however, upon receiving HIV positive results, chose to forego therapy altogether, for fear of being entered into the system and their status being revealed. Stigma and discrimination of PLHIV in medical facilities, is another hindrance mentioned by the PLHIV union in Subotica. The representative from city government in Subotica points out that, aside centralization which unnecessarily complicates an already complicated procedure around receiving therapy, another issue is the cost of all supplements which are not covered by health insurance. In Zajecar, the HIV specialist is not sensitized to issues of vulnerable groups and stated openly that the 'mental structure' of IDU's (and other vulnerable groups) is such that they have anti-social personalities. He believes they have 'problems with themselves', and he doubts their ability to adhere to HCV, HIV or any other therapy.

All key informants state that the responsibility for obtaining health insurance and accessing services lies with the client. When barriers and hindrances were mentioned, these were talked about in terms of barriers that the client him/herself ought to overcome. Health care professionals in both cities believe that health services are available to all equally.

Cultural barriers in accessing specific services were mentioned in both cities in terms of Muslim Roma: in Zajecar, the sociologist mentioned that Muslim Roma IDP's from Kosovo, were not accessing health care and were giving birth at home, because 'their husbands wouldn't let them'. In Subotica, the Roma NGO talked about the difficulty in addressing issues of sexuality in a community in which this was taboo.

In both cities, service provision, access to services and access to therapy (ART, methadone) are further hindered by the lack of shelters and lack of systemic solutions for persons who have several vulnerabilities, including homelessness.

Sex workers in Zajecar reported not going to the doctor very often, because they 'are healthy'. However, if they needed to go for VCCT or STI screenings, they would not do it in their home town, they would go to Nis, which being a bigger city offers more anonymity. Social services, like health services are not confidential and not considered 'friendly' as stated by sex workers, so they avoid using them. Sex workers from smaller towns and villages in the region have to travel to Zajecar or Nis for VCCT and other specialized health services, because these do not exist in their local health centres (if there is a health centre).

In both cities, key informants stated that health and social services are accessible to sex workers, as much as they are accessible to other citizens, because sex workers do not have to identify as such. However, as the representative of city government in Subotica points out, accessibility isn't the issue as much as the level of information about accessibility and services among sex workers is. Services are available, however, whether or not sex workers are informed about this is an entirely different matter. Also, government institutions cannot provide tailored services, or any means of assistance to sex workers, if the government position on sex work is not clear. So in effect, she concludes that there is no real equal access to health care for sex workers. This

viewpoint was reiterated by the social worker in Subotica, who emphasized that accessibility and information about accessibility are two different issues. Also, she says that sex workers will not identify as such in institutions, because they represent the government and they have a negative attitude towards it.

Shortages and gaps in the information, education and prevention measures

In both cities, according to key informants, media play a major role in the dissemination of information about HIV. However, in Zajecar, media are focused on December 1st campaigns only, whereas in Subotica there are more frequent programs dealing with this issue, but as pointed out by the PLHIV union representative, media are not accessible to all vulnerable populations. Also, in Subotica, HIV education in schools is provided, however the PLHIV union representative states that education ought to be introduced at a much younger age. On the other hand, the representative of city government in Subotica points out that education in schools does not cover those who are not in the educational system, thereby leaving out members of certain vulnerable groups.

In Subotica, the medical doctor states that there is a low level of knowledge among the general public as well as among students. There are misconceptions about both ways of transmission and about therapy. She also states that the media are a major channel for disseminating information, and that the internet in particular plays a significant role in this; however she notes that in Serbia, the internet is still not accessible to everyone.

In Zajecar also, the HIV specialist believes that the level of information among the general population is very low and he points out there are still a lot of uninformed and prejudiced medical personnel, for example, there have been repeated cases of doctors refusing to administer IV's to HIV positive patients, instead calling nurses from the Infectious Disease department to do this. In both cities, as noted by the HIV specialist, and by the PLHIV union, people still believe that HIV can be transmitted through social contact, even medical staff and people who have already been educated about transmission. This indicates that disseminating HIV information alone is not enough; education needs to be more comprehensive and include sensitization.

It is obvious that the only source of information about HIV provided to sex workers in Zajecar is through outreach services of NGO's. However, as with accessibility to services, the responsibility of obtaining information is shifted to the sex worker. The sex worker is expected to be conscious about health and is expected to be able to ask for services and information, rather than be reached.

Due to the fact that there are numerous sex workers who have up to two abortions per year, it can be concluded that they either do not have knowledge of contraceptive methodologies, or that they do not use condoms with their partners/husbands. It is also suggested that the subculture they are members of does not allow for condom use with regular partners. This however, does not exclude condom use with clients.

Also, the NGO's in Zajecar state that, due to the economic status of sex workers, they do not have the habit of buying condoms instead they rely on clients and outreach services to provide them.

In Subotica, the social worker says that the level of information about HIV among sex workers is low, however, so is the level of HIV information among professionals.

Education should begin at the institutional level, she states. She considers outreach to be an important method of disseminating information to sex workers.

Vulnerability

All key informants from Zajecar state that the most vulnerable factors of target populations are socio-economic factors. For sex workers it was added that due to the fact that they mainly work indoors and that reaching this populations is difficult, their invisibility is a major factor in their vulnerability to HIV risk.

The chief of staff of city government stated that the main vulnerable factor for Roma and other minorities is poverty, however she added that the state itself is poor and that there in an increase of poverty among all citizen especially the young.

In Subotica, the PLHIV union representative stated that the most vulnerable factor for MSM is age. He correlates young age with promiscuity, and promiscuity with the specific social milieu in Serbia, and especially in Subotica, where relationships cannot withstand the pressure of hiding, and therefore MSM more frequently have one-night stands or brief relationships. Also, the knowledge that therapy is available lessens the risk perception of HIV among young MSM.

The Roma NGO representatives stated the most vulnerable factor of young Roma is the lack of knowledge and information and their living conditions; however they added that HIV is not a main health concern for them. Roma and women are recognized by the representative of city government in Subotica, as the most vulnerable groups, and she states that even if information was available to them, and more importantly could reach them, that their living conditions do not allow for them to raise their quality of life. Another factor that their vulnerability (Roma) is their low level of health consciousness, as stated by the social worker but she adds that the main vulnerability factor added to this is their socio-economic status.

The medical doctor points out that the entire population is lacking in health consciousness. She criticizes the health system as being unorganized in terms of health priorities and budgeting.

Mobility

According to NGO representatives in Zajecar, sex workers in that area are mobile; however they stay within the borders of Serbia. Migrations are mainly seasonal and are between villages, small towns and cities. Those who do report crossing borders in order to do sex work, also do seasonal work, but in Montenegro.

The HIV specialist states that Zajecar used to be a transitory area through which women were trafficked mainly from Ukraine and Russia to other European countries, but since the expansion of the European Union the transit routes have changed, and there aren't that many cases of trafficking through the region anymore. Nonetheless, he thinks that migrants are a population at risk for HIV, because 'new surroundings provide opportunity for new contacts between people, which consequently lead to risky sexual relations".

In Subotica, there is a big problem with illegal border crossings, according to the representative of city government. The main problem regarding this issue is that the people who attempt to cross the border illegally are not visible due to the landscape (forests). One third of all police interventions in that area have to do with illegal

crossings. Among those who attempt to cross over are a lot of minors and children travelling with their families. The question is what to do with them after they are brought in by the police, since there are no shelters. Subotica is a transit area, and migrations/border crossings go both ways. There are people from Armenia, Azerbaijan and Albania who cross into Serbia as a route towards other European countries. On the other hand, those who have been deported from the EU, mainly Roma, stay in Subotica because of the existence of a mosque and a large flea market.

The social worker points out that illegal crossing are one thing, and trafficking is another issue entirely. The Centre has a 24 hour service for minors caught crossing the border. There is frequently suspicion of trafficking when minors are concerned, however this is difficult to prove, since the procedures for proving trafficking are complicated and the main law enforcement office for trafficking is located in Belgrade. In terms of sex work, the social worker does not have any data about their mobility, although there have been reports and suspicions about groups of sex workers being organized to go and work in Germany, Italy and Belgium. This however, is not sex work, but trafficking, she adds. Crossing the border, according to this social worker, presents an increased risk for HIV, because they have less control of movement and behaviour when speaking about trafficked persons.

Respondents' Recommendations for Zajecar and Subotica

The main recommendation for the improvement of health services for vulnerable groups, i.e. sex workers of the non-governmental sector in Zajecar is better collaboration between the civil society and government sector, as well as better collaboration with the media.

In Subotica, the PLHIV union representative appeals for the government to recognize the role of civil society in HIV prevention efforts, as well as to recognize the role and ability of NGO's to reach vulnerable groups. More importantly, government institutions need to recognize the significance of including PLHIV in prevention efforts, as well as VCCT counselling.

The city government representative in Subotica points out that the visiting public health nurses have a significant opportunity to disseminate HIV prevention information, especially during pre-natal and antenatal home visits.

The social worker also emphasizes the importance of collaboration between government and civil society, but she also states that institutions should have specially trained staff that is sensitized to issues of sex work. Media should have a greater role as well, however they also need to be educated and sensitized to the issues related to providing information that are tailored to target groups.

Sex worker interviews

Zajecar: The two sex workers willing to be interviewed in Zajecar, display a high level of knowledge about HIV prevention. They understand that all sexual relations are risky, they know the level of risk associated with oral, vaginal and anal sex, they know that condoms have to be used correctly and regularly. They do not distinguish between high risk groups and low risk groups, whether by age, ethnicity or gender: rather they believe that everyone is equally at risk and that everyone should protect themselves. They do not consider themselves to be informed enough; however they say that they know enough to understand that condoms are a must. As already stated above, the 'small town mentality'

limits their access to health and social systems; they do not feel like they can anonymously/confidentially use these services. When asked directly how they would feel/behave if a colleague or friend would tell them of their HIV positive status, both without hesitation answered that they would provide support, because this is a highly discriminatory environment.

In Subotica, interviews with sex workers were not possible, since their relationship with outreach workers, as already mentioned are not as close, as those of sex workers and outreach workers in Zajecar. However, the interviewer was able to talk to 4 sex workers on the street. Not all questions could be asked, as there wasn't sufficient time and the conditions for such a conversation were not right. Also, sex workers in Subotica adamantly opposed being recorded, one even opposed to the interviewer taking notes. Regardless of the difficulties in field work, the general impression is that they are much less informed about HIV prevention and transmission than their colleagues in Zajecar. They know that condoms should be used; however they do not really distinguish certain STIs and HIV. They openly say that they wish they knew more, but they cannot identify where to obtain the necessary information. Also, they do not have information about where they can access VCCT services. When talking about health and social services, the answers obtained are the same as in Zajecar: these are not considered friendly or confidential services, and they are avoided.

Conclusions

Institutions do not have developed mechanisms or protocols for sex work in particular, however it seems that mechanisms for vulnerable groups are lacking in general.

In the case of Subotica, key informants who are part of the system, that is they work for institutions; it was much easier to open the subject of sex work, than in Zajecar. It is important to note here, that as pointed out by the city government representative in Subotica, services cannot be specifically tailored, if the government position is not clear. To the same effect, statements given on certain topics are going to reflect the current politics and trends around those issues.

The specific attitudes, whether they be institutional or non-governmental, influence the level of knowledge and information of sex workers pertaining to HIV, their access to health services, and thereby their health.

RAR in the two research locations clearly indicate a high level of deprivation of HIV vulnerable groups, especially sex workers, in terms of:

- social determinants of health
- accessibility and availability of health services and prevention

As a result of social stigma, these groups are not talked about and there are no systematic data and no estimations of the size of the phenomenon, and less so attempts of systematic preventive activities.

Recommendations for local level

a) Assessment of size of HIV vulnerable groups and their basic needs, problems and characteristics, through partnerships between non-governmental sector and the official sector (regional health institutions, health centres, centres for social welfare, police), especially the characteristics and locations of sex work and related issues.

b) Public debate, organized by both sectors together, about possible problems and their solutions on level of local community.

The RAR research shows that the response of health system to specific needs of HIV vulnerable groups, especially sex workers are not relevant and inadequate. Irrelevancy is especially pronounced in border areas, where almost no attention is paid to the specific risks which exist in those territories.

Recommendations for national level

In order to make the health services more accessible and relevant for vulnerable groups, the following is necessary on a national level:

- initiate the introduction of territorially specific approaches in the National Strategy for HIV prevention, which would allow for recognition of specific needs of border areas.
- intensify the implementation and monitoring of the prohibition of discrimination in the health sector
- organize open discussion on discrimination in the health sector

- continuation of seminars for educating medical staff for working with HIV vulnerable groups in the primary health care sector (JAZAS has accredited program)
- development of accredited program for public health nurses for outreach work with HIV vulnerable groups.
- lobbying for continuous support and assistance to NGO sector which offers services and develops specific services for vulnerable groups, especially sex workers in one or more territories (outreach work, drop-in centres)

Recommendations on local level:

- In the framework of the National response to HIV, it is necessary to define specific, local responses, which take into consideration local needs and how these needs can be met.
- In each health centre, a trained counselling unit should be developed to work with HIV vulnerable groups and offer assistance to other staff. The unit should include doctors, nurses and public health nurses.
- Intensify and if necessary formalize local cooperation between NGO's which provide services to HIV vulnerable groups and the health sector.
- Intensify cooperation between the health sector and social welfare sector/ as well as other sectors in the community
- Bridge implementation of local response to HIV with implementations of other local strategies, such as Strategy for Youth, Strategy for Health of Youth, Strategy for Prevention of Drug Use and others.
- Support and assist self-organization of HIV vulnerable groups and support their inclusion in programs and activities implemented in local territories.
- Develop local information pamphlet about local resources in terms of health and social welfare, especially HIV prevention and make it available to HIV vulnerable groups through distribution in the field.

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Annex: List of experts interviewed in the frame of the BORDERNETwork's FFM in Serbia

Institution/ NGO	City	Capacity	Area of operation
Local government	Zajecar	Chief of staff	Development and implementation of local policies
Center for Social welfare	Zajecar	Social worker-sociologist	Triage, referral, social welfare
Youth of JAZAS	Zajecar	NGO	Health and social prevention programs for youth
Timocki Youth Centre	Zajecar	NGO	HIV prevention, sex workers, youth
Clinical Centre – Infectious diseases department	Zajecar	Infectious diseases specialist	Center for infectious diseases for territory
Local government	Subotica	Representative of city government	Development and implementation of local policies
Stav +	Subotica	NGO	PLHIV organization
Roma education centre	Subotica	NGO	Roma organization, Roma inclusion programs, youth center
Students policlinic	Subotica	Epidemoligist, VCT centre manager	Primary health centre, HIV prevention
Social welfare	Subotica	Social worker	Triage, referral, social welfare

BORDER|NET work

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