



**Romania (2008): Baseline Survey  
Findings among Men who have Sex with  
Men in 10 Cities, Romania**

**First round of BSS Tracking Survey**

**The P S I D a s h b o a r d**

**Bucharest, Romania  
May, 2008**

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## Summary

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**Background & Research Objectives** The Tracking Results Continuously (TRaC) survey intends to provide evidence for monitoring and implementation of the PSI/ROMANIA's Global Fund HIV Prevention Program, planned to address men who have sex with men, aged 18-34, from 10 cities in Romania.

The current study represents the first part of the research included in this program and serves as a tool to inform programming. Its main objective is to provide baseline data on selected behaviours related to HIV prevention among MSM and their related determinants. The key behaviours are 1) condom use at last anal sex; consistent condom use (with different types of partners); 2) ever getting tested for HIV and informed of the result; and 3) factors related to MSM opportunity, ability, and motivation (OAM) to adopt safer behaviour.

The survey will also use segmentation analysis in order to divide the project's target at-risk population. This exercise determines significant differences between those who adopt a specific behaviour and those who don't, e.g. people who reported condoms use at last anal sex versus the ones who did not, people who were ever tested for HIV versus the ones who were not. The rationale is that interventions aimed at addressing these differences will have a greater likelihood of changing risk behaviour.

**Description of Intervention** PSI ROMANIA will implement a three year GFATM funded program, targeting men who have sex with men (MSM) in 10 cities in Romania (Bucharest, Brasov, Cluj – Napoca, Constanta, Craiova, Galati, Iasi, Buzau, Targu Mures, Timisoara). The purpose of the program is to increase safer sexual behaviors among MSM through: behavior change communications – training, empowerment and community building; and using a high coverage social marketing (SM) strategy to increase access to and availability of condoms and appropriate testing services.

**Methodology** The study employed a two phases approach, due to practical reasons related to fieldwork: snowball sampling (RDS was planned, but not possible, because of the impossibility to recruit seeds according to RDS principles – seeds to be representatives of various sub-groups of MSM, highly involved in the community, highly sociable etc) and telephone interviewing over a period of 8 weeks; convenience sampling and online interviewing over a period of 5 weeks. The questionnaire for both data collection methods included approximately 60 items, covering the following topics: socio-demographic characteristics, including screening questions; level of exposure to the gay scene; condom use behaviours; HIV testing behaviours; OAM factors related to condom use and HIV testing, DALY measurement questions.

### **Main Findings**

The findings show medium values on the key behaviours measured: 55.9% of respondents reported using a condom at all anal sex acts in the last month (the value comes mainly from sex with regular partner, that represents the majority in the sample – 66% of the target); 55.2% on ever use of health service for HIV testing. If consistent condom use with commercial or with casual partners were reported quite high (over 75%), the lowest protected is the sex with regular partners (53.1% declared consistent condom use in this situation). This sustains the hypothesis of high trust between regular partners, which should be taken into account by the intervention.

Moreover, social norms were identified as more favourable to the desired behaviour in case of casual sex, than in case of sex with a long term partner. Another social norm with low values within the target – that differentiates between consistent condom users and non-users – is the belief that most of the men who have sex with other men use condom when they have anal intercourse.

Compared to values on the overall population, MSM reported higher knowledge levels on both general and specific knowledge: over 80% are aware of ways to reduce the risk of getting HIV; 34.4% recognised all (and only) the correct ways in which HIV could be transmitted. A relevant indicator (as highlighted in the segmentation analysis of *ever tested for HIV*) is personally knowing an infected person: 26.3% of the target reporting themselves in such a situation.

Social norms, measured as general beliefs about condom use, are more favourable in case of casual sex, than in case of sex with a long-term partner.

Segmentation tables identified subjective norms as a common significant predictor of condom use in all the analysis performed: condom use at last anal sex, consistent condom use with regular

partner, consistent condom use with casual partner. Intention to use condoms is highlighted as an important step in the behavioural change.

In case of HIV testing, knowledge related factors and social support are main drivers of the desired outcome: knowing someone infected, knowing correct ways in which HIV can be transmitted are significant determinants of this key behaviour; as well as social support for health service use.

Looking at determinants, HIV testing seems to be a more neutral behaviour than condom use: it involves knowledge and social support, whereas condom use is influenced by subjective norms (inner acceptance, at personal level) and attitudes toward condom use – self-efficacy and motivation.

### **Programmatic Recommendations**

The results of the baseline study sustain the following potential directions of the program:

- Address and promote consistent condom use, by challenging subjective norms involved. Even if harder to be addressed – requiring action at personal level (attitudes and beliefs grounded at personal level), long time commitment to behaviour change and involvement of both partners – values reported for this behaviour highlight it as a focus area.
- Focus on condom use with regular partners, considering it is the lowest protected. MSM in this situation – with a high trust in their long time partners and perceiving themselves in a monogamist relationship – might be highly exposed.
- Influence what MSM believe about their partners, friends in relation to condom use; challenge self-efficacy and motivation. Subjective norms seem to be stronger than social norms in influencing the desired behaviour. From this perspective, the empowerment approach and community building strategies creating/ growth of community support might constitute a successful direction of the intervention.
- Intention to use condoms is also a strong driver of the actual condom use. Thus, further inquiry into what drives the intention is worthy.

**Baseline results regarding condom use for anal sex, with various partners, health service utilization, and related determinants, among men who have sex with men, Romania, 2008**

**Risk Group: Men who have sex with men, aged 18-34, from 10 cities in Romania** (Bucharest, Brasov, Cluj – Napoca, Constanta, Craiova, Galati, Iasi, Buzau, Targu Mures, Timisoara)

**Behaviours: Condom use in anal sexual acts in past 30 days; ever tested for HIV, and getting a HIV test in the past 12 months**

| MONITORING TABLE  | Baseline<br>(n=337) |
|---|---------------------|
| RISK and SEXUAL BEHAVIORS   | % or mean           |
| Proportion respondents who had multiple partners in the last 6 months (vs. one or no partners)  | 58.8                |
| Mean number of anal sexual acts in the last 30 days; range 0-40   | 7.4 (m)             |
| <u>Among those with multiple partners:</u> Of the number of anal sexual acts in the last 30 days, the estimated mean number that were protected (with a condom); range 0-38 | 5.7 (m)<br>(n=198)  |
| Proportion of protected anal sex, of all anal sex acts  | 66.7                |
| <u>Among those with multiple partners:</u> Proportion of protected anal sex, of all anal sex acts   | 71.1<br>(n=198)     |
| Proportion respondents who reported using a condom at <b>all anal sex acts</b> in the last 30 days (consistent condom use)  | 55.9                |
| Proportion respondents who reported using a condom at <b>last anal sex with a man</b>   | 63.5                |
| Proportion respondents who reported <b>consistently using a condom</b> during anal sex with a <b>commercial partner</b>   | 85.0<br>(n=20)      |
| Proportion respondents who reported <b>consistently using a condom</b> during anal sex with a <b>casual partner</b>   | 78.8<br>(n=170)     |
| Proportion respondents who reported <b>consistently using a condom</b> during anal sex with a <b>regular partner</b>  | 53.1<br>(n=224)     |
| Proportion respondents who reported using a condom at all anal sex acts in the last 6 months ∞  | 35.0                |
| BEHAVIOR: USE OF HEALTH SERVICES  |                     |
| Has ever gone to a health service to get a HIV test   | 55.2                |
| Has had HIV test in the last 12 months (of those who have ever had a HIV test)  | 67.0<br>(n=185)     |
| If ever had HIV test, has received the results  | 98.4<br>(n=185)     |
| If ever had HIV test, has received either pre testing or post testing counselling   | 49.4<br>(n=185)     |
| If ever had HIV test, has received both pre testing and post testing counselling  | 33.0<br>(n=185)     |
| OPPORTUNITY   |                     |
| <i>Quality of Care (s)</i>  | 3.2 (m)<br>(n=185)  |
| <i>Social Norms</i>   |                     |
| I think that most of the men who have sex with other men use condoms when they have anal intercourse.   | 2.7 (m)             |
| It's strange to use condom when you have casual sex nowadays. (r)   | 3.4 (m)             |
| It's strange to use condom with a long term partner nowadays.(r)  | 2.7 (m)             |
| Using condom with casual partners it's normal nowadays.   | 3.7 (m)             |
| Using condom with long term partners it's normal nowadays.  | 2.9 (m)             |
| ABILITY   |                     |
| <i>Knowledge</i>  |                     |
| Knows that you can reduce the risk of getting HIV/AIDS by having sex with only one uninfected partner who has no other partners (meaning a monogamist partner)              | 84.4                |
| Knows they can reduce the risk of getting HIV/AIDS by using a condom everytime you have sex   | 92.5                |
| Knows that a healthy-looking person can have HIV  | 99.1                |
| Knows correct ways in which the HIV virus can be transmitted §  | 34.4                |

| <b>MONITORING TABLE</b>   | <b>Baseline<br/>(n=337)</b> |
|---|-----------------------------|
| Has close relative or close friend who is infected with HIV or has died of AIDS     | 6.4                         |
| Personally knows someone gay or bi who is infected with HIV or has died of AIDS     | 26.3                        |
| <i>Social Support</i>   |                             |
| Social Support for condom use (s)   | 2.8 (m)                     |
| Social support VCT – for health services use (s)                                    | 2.4 (m)                     |
| <b>MOTIVATION</b>   |                             |
| Attitudes toward condom use – self-efficacy and motivation (s) £                    | 1.8 (m)                     |
| Beliefs related to condom use and HIV (s)   | 3.4 (m)                     |
| Intention to use condom (s)   | 3.5 (m)                     |
| Locus of Control – condom use and health status (s)                                 | 3.2 (m)                     |
| Subjective norms related to condom use (s)  | 3.2 (m)                     |
| HIV/ AIDS it's a problem between men who have sex with men in Romania               | 3.6 (m)                     |
| Perceived threat/risk – condom use (s)  | 3.7 (m)                     |
| <b>POPULATION CHARACTERISTICS</b>   |                             |
| Mean age (range 18 – 34)  | 24.7 (m)                    |
| Average monthly after-tax income is more than 1500 RON                              | 31.7                        |
| Completed university or more  | 41.5                        |
| Meet at least once a week with friends  | 74.8                        |
| Mean number of known MSM  | 39.3 (m)                    |
| Feeling comfortable with own sexual orientation (scale from 1=minimum to 5=maximum) | 4.1 (m)                     |
| Recruited and interviewed on the internet   | 62.0                        |

(m) = mean; (s) = scale score; (r) = reversed score. Scale scores and mean scores (agreement with particular statements) range from 1=minimum (“bad” direction) to 4=maximum (“right direction”-desired outcome), where not stated else.

§ Proportion of respondents that selected all and only the correct options: unprotected anal sex, oral sex when one man ejaculates in the other's mouth, sharing injecting equipment with an infected person

∞ Computed from questions Q8 and Q9: condom use every time with any partner during the last 6 months and there was no time in the past 6 months when condom was not used

£ Reversed interpretation of the scale score: the higher the score is, the riskier the attitude is (closer to the negative extreme)

### Monitoring Analysis

The preceding monitoring table was prepared in accordance with PSI's behaviour change framework, PERForM<sup>1</sup>, and presents baseline indicators, including: risk variables and key behaviours; opportunity, ability, and motivation factors related to safe sexual practices; population characteristics. Indicators will be monitored over time to detect potential changes in behaviour and related determinants; population characteristics will be used to compare baseline and follow-up samples and to control in analysis meant to emphasise the potential effects of the intervention.

When compared to the overall Romanian population, the socio-demographic characteristics indicate a higher educated target – 41.5% graduated at least university, and earning a relative high income – almost a third of the sample declaring they earn more than 1500 RON monthly (after tax). The sociability indicators emphasise other interesting aspects in the target description: 74.8% of the target meet at least once a week with friends; the average number of MSM they know is 39.3. MSM usually feel comfortable with own sexual orientation: the overall score was 4.1 on a scale, where 1=minimum and 5=maximum. The mean age was 24.7 years, the range being 18 – 34 years old, as defined in the study design.

Regarding key behaviours, two main areas were measured: sexual behaviours and use of health services – as two programmatic focus areas for PSI Romania's intervention. The sexual risk profile show average values: 58.8% of the interviewed MSM had multiple partners in the last 6 months (*versus* one or no partners), the mean number of anal sexual acts in the last month being 7.4<sup>2</sup> (covering a range from 0 to 40 acts).

Use of condom at last anal sex with a man is situated slightly past the borderline of 60% and is 8% higher than consistent condom use: 66.7% of the target reported they used a condom at last anal sex. Among those with multiple partners, the proportion of protected anal sex, of all anal sex acts is higher than registered for the overall target; the difference is however small, suggesting a high exposure of this risk group (71.1%, compared to 66.7%). Consistent condom use with commercial partner was reported highest (85.0%); followed by consistent condom use with a casual partner (78.8%). With regular partners, consistent condom use is the lowest (53.1%), the gap between this value and the other two mentioned above is clearly illustrated. Sex with regular partners constituting the majority in the sample, protection in

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<sup>1</sup> See annex 2 for diagrammatic presentation of PSI's behavior change framework

<sup>2</sup> Other descriptive values for this indicator: Median=4.0; Mode=0

anal sex with regular partners gives also the overall value: 55.9% of respondents reported using a condom at all anal sex acts in the last 30 days. The pattern does not contradict the expectations, showing that sex with regular partners is the lowest protected and, at the same time, the hardest to be addressed.

The MSM reported fairly high rates of having ever gone to a health service for a HIV test (over 50%) and most of them have had the test in the last 12 months (67% of those who have ever had a HIV test). Almost all tested respondents got their result. Counselling prior or after the testing seems to be not so familiar among the target analysed and probably at the moment, in Romania: only 33.0% of respondents that got tested received both pre and post testing counselling.

Opportunity was measured by variables related to quality of care (scale on a single dimension), and social norms. Even if quality of care did not obtain the best results, this area seems not to be problematic among MSM: it was registered an average scales score of 3.2, 4 representing the maximum positive. Social norms, measured as general beliefs about condom use, are more favourable in case of casual sex, than in case of sex with a long-term partner. A 3.4 mean score for casual sex, compared to 2.7 for sex with a long-term partner illustrate intensity of belief that “it’s strange to use condom when you have sex”. Similar, a mean score of 3.7, compared to 2.9 show respondents agreement with “the normality” of using condom: “Using condom with casual partner/ respectively long-term partner is normal nowadays.” Another social norm that was monitored refers to the belief that most of the men who have sex with other men use condom at anal sex: the mean value obtain is within the same range as for casual sex: 2.7 on a scale from 1 to 4. It is to be noted this last mentioned social norm constitutes a differentiation between consistent condom users and non-users with both regular and casual partner (*as per the segmentation analysis in the next section*).

Ability was measured through knowledge (mostly of HIV/AIDS) related factors and social support, both for condom use and for health services use. Knowledge included three different areas, results being also different. First area is knowledge on how to reduce the risk of getting HIV/AIDS and aspects related to social attribution: respondents reported high knowledge levels on all these indicators – “by using a condom every time you have sex” (92.5%); “by having sex with only one uninfected monogamist partner” (84.4%; however this might prove dangerous); most of respondents know that a healthy-looking person can have HIV (99.1%). The target scored lower within the second knowledge area: 34.4% mentioned all and only the correct ways in which the HIV virus can be transmitted. The rate is however high, when compared to knowledge of the overall Romanian young population. Values higher than expected are noticed in the last knowledge area: 26.3% of the target personally know someone gay or bi

who is infected with HIV or has died of AIDS, whereas 6.4 were more closely exposed to such experiences, having close relative or friends in this situation.

Social support was measured by scale scores on perception of peer norms or on interaction with a friend. The results on this indicator do not pass the 3<sup>rd</sup> point of the scale (4 being maximum positive). The MSM report a higher support for condom use than for health services use: 2.8, compared to 2.4.

Motivation refers to items relating to intention to use condoms; attitudes, beliefs and subjective norms related to condom use; perceived threat; locus of control. All of these variables show scores close to the positive extreme of the measurement scale: values between 3 and 4, where 4 is maximum. However, only the perceived risk surpasses the limit of 3.5: an overall scale score of 3.7 and a 3.6 mean score of agreement with the fact that “HIV/AIDS is a problem among MSM in Romania.” Lower scores are reported for intention to use condoms (scale score of 3.5) and beliefs related to condom use and HIV (scale score of 3.4). The lowest score among motivation factors are noticed for locus of control – condom use and health status – and subjective norms related to condom use (a scale score of 3.2 for each). Considering the reversed interpretation of the scale score, the value of 1.8 reported for attitudes toward condom use – referring to self-efficacy and motivation – illustrates a similar situation.

**Segmentation Table 1: Condom Use at Last Anal Sex among men who have sex with men, baseline survey, Romania, 2008**

**Risk Group: Men who have sex with men, aged 18-34, from 10 cities in Romania** (Bucharest, Brasov, Cluj – Napoca, Constanta, Craiova, Galati, Iasi, Buzau, Targu Mures, Timisoara)

**Behaviour: Condom Use at Last Anal (n=334)**

| SEGMENTATION TABLE   | Non-users<br>(36.5%) | Users<br>(63.5%) | ORs  | Sign. |
|--|----------------------|------------------|------|-------|
| MOTIVATION   | % or mean            | % or mean        |      |       |
| Intention to use condom (s)  | 3.3 (m)              | 3.6 (m)          | 4.07 | ***   |
| Subjective norms related to condom use (s)   | 3.0 (m)              | 3.3 (m)          | 2.52 | ***   |
| HIV/ SIDA it's a problem between men who have sex with men in Romania.                       | 3.7 (m)              | 3.5 (m)          | 0.56 | *     |
| Perceived threat/risk – condom use (s)   | 3.8 (m)              | 3.7 (m)          | 0.32 | **    |
| Attitudes toward condom use – self-efficacy and motivation (s) £                             | 1.9 (m)              | 1.7 (m)          | 0.54 | *     |
| ABILITY  |                      |                  |      |       |
| <i>Knowledge</i>   |                      |                  |      |       |
| Knows they can reduce the risk of getting HIV/AIDS by using a condom every time you have sex | 88.3                 | 94.7             | 2.93 | *     |
| <i>Social Support</i>  |                      |                  |      |       |
| Social Support for condom use (s)  | 2.6 (m)              | 2.9 (m)          | 1.99 | **    |

\*=p<0.05; \*\*=p<0.01; \*\*\*=p<0.001; † = p<0.10. Hosmer and Lemeshow Test: Chi-square=10.051, df=8, Sig=0.261; Omnibus Test: Chi-square=101.453, df=10, p<0.001; R squares: Cox & Snell Rsquare=0.265, Nagelkerke Rsquare=0.363

Each variable is adjusted for all other variables in the model. The study design was controlled through region and data collection type (online interviews and computer assisted telephone interviews).

(m) = mean; (s) = scale score

£ Reversed interpretation of the scale score: the higher the score is, the riskier the attitude is (closer to the negative extreme)

### Segmentation Analysis 1

#### Condom use at last anal sex

Segmentation is the process of dividing a heterogeneous population into a homogenous audience; in other words, the population is divided into those who practice the desired behaviour and those who do not, e.g., condom users and non-users. Then each group is profiled according to the barriers to behaviour change that were captured in the surveys, which, in turn, can allow programmers to design and implement behaviour change interventions.

Respondents who declared using a condom at last anal sex with men differ from non-users on several motivation related factors. The first mentioned category is more likely to declare they intend to use condoms (a 3.6 scale score, compared to 3.3; where 1=lowest scale point; negative and 4=highest point scale; positive). In terms of odd ratios, one point higher intention to use condoms means likelihood 4.07 times higher to use a condom; the existence of intention is thus emphasised as an important step in the behavioural change process.

Condom users at last sexual act show stronger subjective norms than non-users (3.3, compared to 3.0). People with stronger positive norms related to condom use – believing to a higher degree that their friends support condom usage) are more likely to use condom when having anal sex (one point increase in subjective norms turns into a 2.52 times higher likelihood to use condoms).

At the same time, there were fewer condom users that agreed HIV/ SIDA is a problem between men who have sex with men in Romania (3.5, compared to 3.7) and fewer condom users that perceived themselves at risk/ in a threatening situation (3.7, compared to 3.8; however high levels for both categories). Both of these variables related to risk sustain the paradoxical hypothesis that protection is higher among those that perceive lower risk they are exposed at.

As expected, non-users are more likely than users of condoms to believe it is difficult to insist on condom use in various situations (with a well known partner, with a partner one has feelings for etc), to believe in the lack of usefulness or worthiness of using a condom (a 1.9 scale score, against 1.7).

Ability is also relevant in differentiating the two categories of respondents: those that agree the risk of getting HIV can be reduced by using condoms are 2.93 times more likely to use condoms than the opposite category. Those that used a condom at last anal sex were more likely to report a stronger social support, similar peer norms related to condom use and HIV testing (2.9, compared to 2.6).

**Segmentation Table 2: HIV testing among men who have sex with men, baseline survey, Romania, 2008**

**Risk Group: Men who have sex with men, aged 18-34, from 10 cities in Romania** (Bucharest, Brasov, Cluj – Napoca, Constanta, Craiova, Galati, Iasi, Buzau, Targu Mures, Timisoara)

**Behavior: HIV testing ever (n=335)**

| SEGMENTATION TABLE  | No test<br>(44.8%) | Tested<br>(55.2%) | ORs   | Sign. |
|---|--------------------|-------------------|-------|-------|
| OPPORTUNITY   | % or mean          | % or mean         |       |       |
| <i>Social Norms</i>   |                    |                   |       |       |
| I think that most of the men who have sex with other men use condoms when they have anal intercourse. | 2.8 (m)            | 2.6 (m)           | 0.70  | *     |
| ABILITY   |                    |                   |       |       |
| <i>Knowledge</i>  |                    |                   |       |       |
| Knows correct ways in which the HIV virus can be transmitted  | 28.2               | 39.2              | 1.73  | *     |
| Personally knows someone gay or bi who is infected with HIV or has died of AIDS                       | 13.1               | 37.3              | 4.44  | ***   |
| <i>Social Support (s)</i>   |                    |                   |       |       |
| <i>Social Support VCT (s)</i>   | 2.3 (m)            | 2.6 (m)           | 1.68  | **    |
| POPULATION CHARACTERISTICS  |                    |                   |       |       |
| Mean number of known MSM  | 30.4 (m)           | 47.3 (m)          | 1.004 | *     |

\*=p<0.05; \*\*=p<0.01; \*\*\*=p<0.001; † = p<0.10. Hosmer and Lemeshow Test: Chi-square=3.915, df=8, Sig=0.865; Omnibus Test: Chi-square=66.568, df=9, p<0.001; R squares: Cox & Snell Rsquare=0.183, Nagelkerke Rsquare=0.244

Each variable is adjusted for all other variables in the model. The study design was controlled through region and data collection type (online interviews and computer assisted telephone interviews).

(m) = mean; (s) = scale score

## Segmentation Analysis 2

### Having ever got a HIV test

HIV testing seems to be associated with opportunity and ability factors, as well as with the MSM network size, respondents that have got a HIV test knowing, in average, a higher number of men who have sex with men than those not tested (a mean of 47.3, compared to 30.4).

The opportunity factor negatively associated to HIV testing is the following social norm: respondents that had at least one test are less likely to think that most of the MSM use condoms when they have anal intercourse than those not tested (2.6, compared to 2.8). This may suggest that high-risk individuals often do not perceive the real risk.

Ability factors were measured by variables relating to knowledge and scales on social support. Both of these areas were found to be significantly associated to HIV testing, with the strongest relation to this behaviour. In terms of odds ratios, people that know correct HIV transmission ways are 1.73 times more likely to have a HIV test than those not aware of all these correct ways. People that know one additional gay or bi infected with HIV or dead because of this virus are 4.44 times more likely to get tested.

Respondents who had ever been tested were more likely to know correct ways in which HIV virus can be transmitted than those never tested (39.2%, compared to 28.2%). They know as well a higher number of gay or bi-sexual people who is infected with HIV or has died of AIDS (a mean of 37.3, compared to 13.1). Social support VCT has also a strong positive influence on HIV testing: those that got tested benefited from a stronger social support related to health service use than those not tested (a scale score of 2.6, compared to 2.3).

**Segmentation Table 3: Consistent Condom Use at Last Anal Sex with Regular Partners among men who have sex with men, baseline survey, Romania, 2008**

**Risk Group: Men who have sex with men, aged 18-34, from 10 cities in Romania** (Bucharest, Brasov, Cluj – Napoca, Constanta, Craiova, Galati, Iasi, Buzau, Targu Mures, Timisoara)

**Behavior: Consistent Condom Use in last 30 days with Regular Partners (n=224)**

| SEGMENTATION TABLE  | Non-users<br>(46.9%) | Users<br>(53.1%) | ORs  | Sign. |
|---|----------------------|------------------|------|-------|
| OPPORTUNITY   | % or mean            | % or mean        |      |       |
| <i>Social Norms</i>   |                      |                  |      |       |
| I think that most of the men who have sex with other men use condoms when they have anal intercourse. | 2.4 (m)              | 2.7 (m)          | 1.70 | *     |
| <b>MOTIVATION</b>   |                      |                  |      |       |
| Attitudes toward condom use – self-efficacy and motivation (s) £                                      | 1.9 (m)              | 1.7 (m)          | 0.27 | ***   |
| Intention to use condom (s)   | 3.4 (m)              | 3.6 (m)          | 2.44 | **    |
| Subjective norms related to condom use (s)  | 3.1 (m)              | 3.3 (m)          | 2.09 | *     |
| <b>POPULATION CHARACTERISTICS</b>   |                      |                  |      |       |
| Feeling comfortable with own sexual orientation (scale from 1=minimum to 5=maximum)                   | 4.5 (m)              | 3.7 (m)          | 0.51 | ***   |

\*=p<0.05; \*\*=p<0.01; \*\*\*=p<0.001; † = p<0.10. Hosmer and Lemeshow Test: Chi-square=8.094, df=8, Sig=.424; Omnibus Test: Chi-square=78.844, df=9, p<0.001; R squares: Cox & Snell Rsquare=0.297, Nagelkerke Rsquare=0.396

Each variable is adjusted for all other variables in the model. The study design was controlled through region and data collection type (online interviews and computer assisted telephone interviews).

(m) = mean; (s) = scale score

£ Reversed interpretation of the scale score: the higher the score is, the riskier the attitude is (closer to the negative extreme)

### Segmentation Analysis 3

#### Consistent condom use in last 30 days with regular partners

Opportunity, motivation and feelings about own sexual orientation (as a population characteristic) were significantly associated with consistent condom use with a regular partner.

Consistent condom users are less likely than non-users to feel comfortable with own sexual orientation, this characteristic being negatively associated with the behaviour measured: a 3.7 scale score, compared to 4.5, where 1="I don't like that I have sex with other men and I would like to change if possible" and 5="I am ok that I have sex with other men and I don't want to change."

Regarding the opportunity factor as measured by the social norms, consistent condom users (with regular partners) are more likely to believe that most of the MSM use condoms when they have anal intercourse than non-users (a mean score of 2.7, compared to 2.4). Thus, the behaviour is sustained by the norm reproducing "the normality" in their point of view.

As identified in the analysis of condom use at last sex, the following motivation factors achieve statistical significance also in the model of consistent condom use with regular partners: intention to use condoms, subjective norms related to condom use and attitudes toward condom use (self-efficacy and motivation).

The consistent condom users are more likely to mention they intend to use condoms (a 3.6 scale score, compared to 3.4). Looking at odd ratios, one point higher intention to use condoms increases 2.44 times the likelihood to use a condom.

Users manifest stronger subjective norms than non-users (3.3, compared to 3.1). Stronger subjective norms double the likelihood to use condoms at all sex with a regular partner.

Consistent condom users show a higher trust in their ability of influencing partners to use condoms and understand to a higher degree the usefulness of using a condom. Thus, they manifest a less riskier attitude toward condom use the opposite category: a 1.7 scale score, compared to 1.9 (as per the measurement scale - the higher the score is, the riskier the attitude is, being closer to the negative extreme).

**Segmentation Table 4: Consistent Condom Use at Last Anal Sex with Casual Partners among men who have sex with men, baseline survey, Romania, 2008**

**Risk Group: Men who have sex with men, aged 18-34, from 10 cities in Romania** (Bucharest, Brasov, Cluj – Napoca, Constanta, Craiova, Galati, Iasi, Buzau, Targu Mures, Timisoara)

**Behaviour: Consistent Condom Use in last 30 days with Casual Partners (n=170)**

| SEGMENTATION TABLE  | Non-users<br>(21.2%) | Users<br>(78.8%) | ORs   | Sign. |
|---|----------------------|------------------|-------|-------|
| OPPORTUNITY   | % or mean            | % or mean        |       |       |
| <i>Social Norms</i>   |                      |                  |       |       |
| I think that most of the men who have sex with other men use condoms when they have anal intercourse. | 3.0 (m)              | 2.6 (m)          | 0.47  | *     |
| MOTIVATION  |                      |                  |       |       |
| Subjective norms related to condom use (s)  | 2.6 (m)              | 3.3 (m)          | 11.91 | ***   |

\*=p<0.05; \*\*=p<0.01; \*\*\*=p<0.001. Hosmer and Lemeshow Test: Chi-square=7.258, df=8, Sig=0.509; Omnibus Test: Chi-square=47.968, df=6, p<0.001; R squares: Cox & Snell Rsquare=0.246, Nagelkerke Rsquare=0.382

Each variable is adjusted for all other variables in the model. The study design was controlled through region and data collection type (online interviews and computer assisted telephone interviews).

(m) = mean; (s) = scale score

#### Segmentation Analysis 4

##### Consistent condom use in last 30 days with casual partners

Only two factors were identified as significantly related to consistent condom use with casual partners: social norms and subjective social norms related to condom use. This and the Omnibus test results may suggest a lower predictive power of the model, than other models performed: determinants of this behaviour seem to be more complex, than measured in the current research.

The subjective norms seem to have the strongest influence on the behaviour analysed: those with stronger subjective norms are more likely to use condoms at all sex with casual partners. One point increase on the subjective norm scale might turn into likelihood 11.9 times higher. Consistent condom users show thus a stronger belief that their partners and friends would approve them using condoms for every anal sex act: a 3.3 scale score, compared to 2.6.

Regarding opportunity factors, one of the social norms measured is negatively related to consistent condom use (statistical significant relation). Consistent condom users with casual partners are less likely to think that most of the MSM use condoms when they have anal intercourse than non-users (2.6, compared to 3.0), showing thus a responsible behaviour.

### Programmatic Recommendations

- The findings show medium values on the key behaviours measured: 55.9% of respondents reported using a condom at all anal sex acts in the last month (the value comes mainly from sex with regular partner, that represents the majority in the sample – 66% of the target); 55.2% on ever use of health service for HIV testing. The lowest protected is sex with regular partners (53.1% declared consistent condom use in this situation), compared with values over 75% in case of casual sex or sex with a commercial partner. MSM might be highly exposed when having sex with regular partners, other arguments being the high trust in their long time partners and perception of themselves in a monogamist relationship.
- Segmentation tables show subjective norms as a common significant predictor of condom use in the analysis performed: condom use at last anal sex, consistent condom use with regular partner, consistent condom use with casual partner. Subjective norms are stronger related to condom use than social norms. Even if the difficulty of addressing these subjective norms is acknowledged, the high potential of this factor in influencing consistent condom use with casual partners has to be noted.  
Influence what MSM believe about their partners, friends in relation to condom use; challenge self-efficacy and motivation.
- Intention to use condoms is emphasised as an important step in the behavioural change. Further inquiry into what drives the intention can be considered worthy.
- MSM reported relative high knowledge levels on both general and specific knowledge: over 80% are aware of ways to reduce the risk of getting HIV; 34.4% recognised all (and only) the correct ways in which HIV could be transmitted. A relevant indicator (as highlighted in the segmentation analysis of *ever tested for HIV*) is to personally know an infected person: 26.3% of the target reporting themselves in such a situation.  
In case of HIV testing, knowledge related factors and social support are main drivers of the desired outcome: knowing someone infected, knowing correct ways in which HIV can be transmitted are significant determinants of this key behaviour; as well as social support for health service use.

## Methodology

**Sample Characteristics** The sample was defined as men who have sex with men, aged 18-34 years old and living in one of the 10 cities included in the intervention, as well as in the study: Bucharest, Brasov, Cluj – Napoca, Constanta, Craiova, Galati, Iasi, Buzau, Targu Mures, Timisoara. In order to be included in the study, respondents had to: 1) be of the appropriate age; 2) have been sexually active in the last 6 months – have had anal sexual contacts with a male partner.

**Sampling Methodology and Data Collection procedures<sup>3</sup>:** Data was planned to be collected through RDS sampling approach and telephone interviewing; information from gay websites with personal profiles separable by city were used to estimate geographic area sizes and create the sampling frame.

The sample size calculations were performed using the change-over-time formula, with 95% precision and 80% power, setting the desired behaviour change at 15% from baseline to follow-up. The resulting sampling size was set at 320 respondents, split per city according to the following quota plan:

**Table 1. Initial quota plan and final distribution of respondents**

| Region (cities)                          | Number of planned interviews | Number of achieved interviews (convenience sampling) |
|--|------------------------------|--|
| Bucharest                                | 80                           | 99   |
| Centre (Brasov, Cluj, Targu Mures)       | 80                           | 102  |
| South – West (Timisoara, Craiova, Buzau) | 80                           | 79   |
| South – East (Iasi, Galati, Constanta)   | 80                           | 57   |
| <b>Total</b>                             | <b>320</b>                   | <b>337</b>   |

The number of respondents to be interviewed at each location was planned to be recruited through their peers using the system of coupons. At each site the original recruiters (*seeds*) were selected by PSI from MSM residing in different cities of the selected sites. These individuals were meeting the criteria defined for this study and their number was considered not likely to exceed 9 individuals per site. Even if it was recommended to select representatives of various

<sup>3</sup> See annex 3 for methodological details and fundamentals of the decision to change the methodology.

sub-groups of MSM, i.e. young versus older; lower SES versus higher SES; active in the gay scene versus more closeted, for practical reasons, this was not possible. The seeds were recruited completely randomly **through a take-all approach**: messages were sent to internet profiles per each site and the people who responded first, with their consent for participation to the study, were included in the study. The RDS sampling become thus a snow-ball sampling due to impossibility to select the initial seeds according to the RDS requirements.

**The same take-all** approach was used in the second phase of the study, when interviews continued through online interviewing. Finally, most of the data was collected using this approach.

Data was thus gathered in two phases: snowball sampling and telephone interviewing over a period of 8 weeks (20<sup>th</sup> of October – 12<sup>th</sup> of December, 2007); convenience sampling and online interviewing over a period of 5 weeks (29<sup>th</sup> of January – 4<sup>th</sup> of March, 2008). Details are presented below:

**Table 2 – Distribution of interviews by data collection type (counts and percentages)**

|               | Total | Regional total | CATI | Internet |
|---------------|-------|----------------|------|----------|
| Bucharest     | 99    | 99             | 16   | 83       |
| Brasov        | 23    |                | 10   | 13       |
| Cluj – Napoca | 63    |                | 27   | 36       |
| Targu Mures   | 16    | 102            | 10   | 6        |
| Timisoara     | 63    |                | 32   | 31       |
| Craiova       | 7     |                | 3    | 4        |
| Buzau         | 9     | 79             | 7    | 2        |
| Galati        | 17    |                | 7    | 10       |
| Iasi          | 22    |                | 7    | 15       |
| Constanta     | 18    | 57             | 9    | 9        |
| Total         | 337   |                | 128  | 209      |

| Percentages from total (337) | Total | Regional total | CATI | Internet |
|------------------------------|-------|----------------|------|----------|
| Bucharest                    | 29%   | 29%            | 5%   | 25%      |
| Brasov                       | 7%    |                | 3%   | 4%       |
| Cluj – Napoca                | 19%   |                | 8%   | 11%      |
| Targu Mures                  | 5%    | 30%            | 3%   | 2%       |
| Timisoara                    | 19%   |                | 9%   | 9%       |
| Craiova                      | 2%    |                | 1%   | 1%       |
| Buzau                        | 3%    | 23%            | 2%   | 1%       |
| Galati                       | 5%    |                | 2%   | 3%       |
| Iasi                         | 7%    |                | 2%   | 4%       |
| Constanta                    | 5%    | 17%            | 3%   | 3%       |
| Total                        | 100%  | 100%           | 38%  | 62%      |

**Detailed description of the data collection procedure:****A. Seeds and referrals**

The 128 interviews obtained by this procedure included 43 seeds and only 85 referrals (interviewed only after coupon validation).

*Coupons and Incentives*

The original recruiters were offered 2 coupons which they could share among their MSM peers to come for an interview at locations established for each city. No interviews were conducted with MSM who did not have a coupon. The coupons had 3 parts: one to be given out by recruiter to the recruited person; another one to be kept by the recruiter himself/herself; the third one to stay with the project. The coupon included a contact phone number and was numbered so that tracing interview referrals back to the recruiter was possible. Coupon code consisted of the following sections: the section with the code for the city, followed by a 3-digit consecutive number.

For each successful referral, the recruiter received a reward in the form of gift coupons (30 RON value). In addition to recruitment rewards, the respondent received a similar set of rewards for his undergoing the interview. The coupons were valid only for the duration of the study and recruiters were told that their recruitees who come after the deadline specified in the coupon would be ineligible for interviewing and rewards.

*Venue*

The interviews were conducted by phone. The seeds who gave their consent to participate in the study gave their phone numbers to the agency operators who called them at a later date to conduct the interview. Then, the interviewees were invited to meet a local operator who gave each of them 2 unique coupons for their friends. After receiving the coupon, the friend text a message or call the research agency, this conducted the interview by phone.

*Personal Codes, Client Registration, Biometric Data*

To ensure their anonymity, no information that would allow positive identification of respondents was requested. Instead, respondents were requested to submit the last 6 digits of on their ID cards (numerical personal codes). Personal codes of respondents, and numbers of coupons given out to them and personal codes of their recruitees were recorded using the CATI system. No biometric data was collected, as the 6 digit series from the personal codes are unique.

*Screening protocol*

Before starting interview, the information on the coupon received by the respondent was checked to make sure the respondent was really referred by someone who already took part in the survey.

*Voluntary Consent and Network Questionnaire*

The research team ensured that respondents' participation in interviews and in recruitment was completely voluntary.

*Tracking and changing the approach*

After detailed analysis of the coupons and ramifications, an extremely low success rate of the seeds and coupon system was identified, the approach being at the same time cost and timing inefficient. Potential causes: reluctance and available time of the respondents, lack of trust in general, impossible to penetrate the community in some small cities (probably different culture and subjective norms). This approach was abandoned and the interviewing continued through the Internet.

**Table 3 – Analysis of referral network**

| City          | Successful interviews | Have the coupon, but no referral | Have the coupon; successful interviews with referred persons | No coupon taken |
|---------------|-----------------------|----------------------------------|--|-----------------|
| Bucharest     | 14                    | 7                                | 3  | 4               |
| Brasov        | 11                    | 4                                | 5  | 2               |
| Cluj - Napoca | 27                    | 4                                | 13   | 10              |
| Targu Mures   | 10                    | 1                                | 6  | 3               |
| Timisoara     | 33                    | 6                                | 17   | 10              |
| Craiova       | 3                     | 3                                | 0  | 0               |
| Buzau         | 7                     | 3                                | 3  | 1               |
| Galati        | 7                     | 5                                | 1  | 1               |
| Constanta     | 9                     | 3                                | 4  | 2               |
| Iasi          | 7                     | 2                                | 3  | 2               |
| Total         | 66                    | 22                               | 28   | 16              |

**B. Online**

The link conducting to the questionnaire was promoted by PSI through various means, most of the respondents (84%) accessing the survey from specific web sites (e.g. [www.pareri.ro](http://www.pareri.ro), [www.beanangel.ro](http://www.beanangel.ro), [www.gayone.ro](http://www.gayone.ro), [www.queer.ro](http://www.queer.ro)), through MIRC or by messenger, where they received the link from a friend or directly from PSI.

**Table 4 – Answers distribution to question “Q1d. How did you find out about this survey?” (asked for online respondents)**

|  | Counts | Percentages |
|--|--------|-------------|
| Respondents who completed the questionnaire online     | 209    | 209         |
| <b>I entered on a web site and clicked on a banner</b> | 53     | 25%         |
| <b>On mIRC</b>   | 77     | 37%         |
| I received a note in a club                            | 18     | 9%          |

|                                |    |      |
|--------------------------------|----|------|
| I received a link on messenger | 45 | 22%  |
| I received an email            | 13 | 6%   |
| From a friend                  | 1  | 0.5% |
| Don't remember                 | 2  | 1%   |

All eligible and willing respondents could access the link and complete the questionnaire; unique ID were attributed by the scripting soft and respondents were also checked for duplicates. At the end of the interview they were asked to recommend other friends, enabling thus the snow-balling approach. However, only a small part of the online interviews were achieved this way (6%).

**Survey instrument** The survey instrument was a structured questionnaire, with approximately 60 items, covering the following topics: socio-demographic characteristics, including screening questions; level of exposure to the gay scene; condom use behaviours; HIV testing behaviours; OAM factors related to condom use and HIV testing, DALY measurement questions. The questionnaire administered by telephone and that applied online in the second phase were tailored to each data collection procedure, but were otherwise identical. The survey took about 25 minutes to complete, in case of each methodology.

The questionnaire was pre-tested by conducting approximately 20 interviews with MSM recruited in Bucharest, in order to check for easiness to understand questions and procedures for conducting interviews. The questionnaire was afterwards revised based on the following points: ease or difficulty of statement, comprehension, confidence in response, level of discomfort and social desirability, the dimensionality of scales and assessment of the reliability of scales. MSM that participated in the questionnaire pilot were excluded from participation in the actual study.

**Analytic technique** The data were analysed using SPSS (version 15.0). Data was examined through univariate statistics (frequencies, distribution) and scales reliability analysis for: *quality of care; social support for condom use; social support for health services use; attitudes toward condom use – self-efficacy and motivation; beliefs related to condom use; intentions to use condoms; locus of control; subjective norms related to condom use; perceived threat/risk.* Detailed scales description (after reliability analysis) is presented below:

|  |
|--|
| <b>OPPORTUNITY</b>   |
| <i>Quality of Care</i>   |
| It's easy for me to go to an HIV testing clinic                                      |
| The HIV testing clinic is for people like me   |
| The sexual behaviour of patients it isn't criticised by the HIV testing clinic stuff |
| The medical stuff from testing clinic were very friendly                             |

|   |
|---|
| Nobody could hear the conversation between me and my doctor   |
| When i got tested no one could see the interaction between me and my doctor being examined  |
| I trust my doctor keeping confidentiality of my test result   |
| When I got tested I was treated with respect  |
| When I got tested the doctor gave me good explanations  |
| <b>ABILITY</b>  |
| <b><i>Social Support</i></b>  |
| <i>Social Support for condom use</i>  |
| My friends talk a lot about using condoms   |
| Me and my friends encourage each other to use condoms when we have anal sex   |
| If a friend of mine knows that I have anal sex would be interested to use condoms or not.   |
| If I hear a friend has a date and I think he could have anal sex I would ask him if he has a condom with him.                                       |
| Sometimes I give my friends condoms.  |
| I receive condoms from my friends sometimes.  |
| <i>Social support VCT – for health services use</i>   |
| My friends talk a lot about testing for HIV.  |
| Me and my friends encourage each other to do the HIV test periodical.   |
| If a friend knew I had unprotected sex would tell me to go and do the HIV test.   |
| Sometimes I go together with my friends for testing for HIV.  |
| <b>MOTIVATION</b>   |
| <i>Attitudes toward condom use – self-efficacy and motivation</i>   |
| It's hard for me to insist to use condom with someone I know for a long time.   |
| It's hard to insist to use condom when I have sex with someone I had unprotected sex before.  |
| It's hard to insist to use condom when I have sex with someone for whom I have strong feelings.   |
| It's worth it to have anal sex without condom even if I can get HIV if pleasure is bigger.  |
| It's no use to use condom with someone I never used it before.  |
| I think it's ok to use condom. (r)  |
| <b><i>Beliefs related to condom use and HIV</i></b>   |
| I think it's not necessary to use condoms with a man I trust. (R)   |
| I think it's no use to use condoms with a healthy man. (r)  |
| Even healthy and well-dressed men pose a risk for HIV infection (r)   |
| I think it's no use to use condom with a clean and well dressed man. (r)  |
| If I know a man's previous sexual partners its no need to use condoms (r)   |
| It isn't necessary to use condoms with someone I had anal sex without condom all the time until now and I didn't contact any diseases with him. (r) |
| Although my friend/partner it's a good man he could pose a risk for HIV infection   |
| Because I can see people, I can tell when someone is safe and I don't need to use condoms with him. (r)   |
| If a sexual partner says he uses condoms when he has sex with others then it isn't necessary to use condoms when I have sex with him. (r)           |
| <b><i>Intention to use condom</i></b>   |
| I will use condom next time when I'll have anal intercourse.  |
| If i will have anal intercourse with someone I don't know very well I will use the condom.  |
| I will use condom next month I will have anal intercourse.  |
| I will use condom next time I will have anal intercourse with a casual partner.   |
| I will not have anal sex with someone who refuses to use condom.  |
| <b><i>Locus of Control – condom use and health status</i></b>   |
| I can risk having unprotected sex because if something bad is meant to happen it will happen anyway. (r)  |
| No matter what I do if I am going to get sick I will get sick. (r)  |
| Most of the things that affect my health happen to me by accident. (r)  |
| I am in control of my health  |
| I am the one to blame if I get a sexual disease.  |
| My good health is largely a matter of good fortune (r)  |
| The main thing which affects my health is what I myself do.   |
| I f i take care of myself I can avoid sexual diseases.  |
| If it's meant to be I will stay healthy. (r)  |
| If i take the right actions I can stay healthy.   |

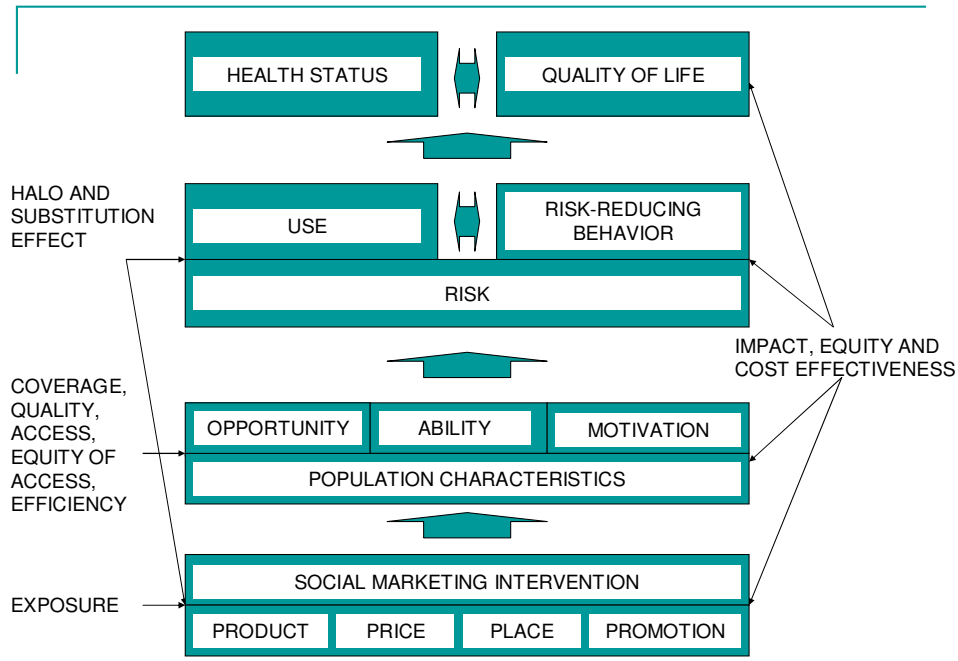
|   |
|---|
| <b><i>Subjective norms related to condom use</i></b>                                |
| My long term partner would agree to use condom every time we have anal intercourse. |
| My friends (pals) would agree to use condom every time I have anal intercourse.     |
| My casual partners would agree to use condoms every time I have anal intercourse.   |
| <b><i>Perceived threat/risk – condom use</i></b>                                    |
| HIV/ SIDA it's a problem between men who have sex with men in Romania               |
| Anyone can pose a risk for HIV/AIDS   |
| HIV/AIDS can cause serious diseases   |
| AIDS causes death   |
| You can get in contact with HIV/AIDS if you have unprotected anal sex.              |

The monitoring table present means – scale score means or mean scores for simple questions/statements – and proportions.

For segmentation tables, correlation matrices were examined first; then logistic regression for survey data was used to obtain final models, and the proportions presented in the tables were calculated using the adjusted proportions command (adjusting for all other variables in the model and controlling for the study design through region and data collection type – online interviews and computer assisted telephone interviews).

#### **Improvements for Next Study Round**

- Consistent data collection procedure during the entire fieldwork. We recommend using online interviewing and related sampling procedures.



Given MSM are an extremely hard to reach population in Romania, a study design based on Respondent-Driven Sampling (RDS) methodology was planned for this baseline survey. Execution of the recruitment, interview and referral processes of the study demonstrated deviation from RDS methodology as outlined in the study design. This document details the rationale for this deviation and highlights lessons learned from this study.

**A. *Planned Study Design***

Sampling Strategy

Respondent-Driven Sampling (RDS) allows for data gathering from a large sample size through a small number of research team members given that recruitment is done by respondents themselves. RDS relies on the assumption that given sufficiently long referral chains (i.e. 3-6 waves), the sample composition becomes stable (i.e., reaches “equilibrium”) and results in a probability sample of hard-to-reach populations.

Sample Selection

The sample size determined for this study was to ensure that a 15% change in key behaviours could be detected. A total of 320 respondents from four zones (Bucharest, Central, Southeast and Southwest) were to be interviewed. A goal was established of recruiting at least 3 seeds from each city.

Criteria for Selection of Original Recruiters (Seeds)

- Age: 18-34
- Presence/”Outness” in MSM Scene: Range from closeted to socially active
- SES: Full range of income and educational levels

Recruitment

PSI/Romania was to provide the contacts for the original recruiters (seeds) according to the criteria described above. The seeds would answer the questionnaire by phone, then meet with a project staff person at a specified location and be handed 2 referral coupons for their friends, as well as an incentive reward. Upon successful referrals, when recruitees call in to respond to the questionnaire and meet the project staff person to hand in their coupon as well as receive their incentive reward, the initial respondent would be asked to meet the same project staff person to

be handed two more incentives. The respondents were requested to submit the last 6 digits of their social security number by showing their ID cards, which allows for the unique identification of each respondent while ensuring their anonymity.

***B. Executed Study***

Recruitment

Due to insufficient time and resources (human, infrastructural and financial), the selection of seeds according to pre-set criteria through local contacts, gatekeepers and personal recommendations was not possible. Instead, seeds were contacted by sending messages on a gay-oriented website with personal ads. The ads were divided by city and allowed for collection of information on the reported age of the respondent. A take-all approach was used – respondents who answered the ad and were willing to participate were included as initial seeds. As initial seeds were not screened fully for the aforementioned criteria, a convenience sample was thus used. This was due to these criteria not being able to be applied to such personal ads, and approximately half of the cities not listing too many ads. However, despite the small number of messages received from people who were willing to participate in the study, sufficient seeds were recruited in order to start data collection.

Given this recruitment process, the seeds did not have the aforementioned diverse characteristics of the pre-established criteria of age, presence/outness in MSM scene, and SES background. Although some screening questions which referred to the age and the city of residence of the respondents did filter out respondents who were not part of the scope of the study, there were no other mechanisms to ensure that the respondents were really part of the target group (MSM), as it is recommended by the standard RDS methodology.

Data Collection

The data collection process was scheduled to last 6 weeks. Two weeks into the process, PSI and the research agency convened to analyze the progress up to that point. The analysis indicated that the rate of completing interviews was too slow for the following reasons:

- a. Some respondents provided their phone number and answered the questions. However, they did not come at the appointed time and to the specified location to pick up their incentive reward and the two referral coupons;

- b. Some respondents provided their phone number, responded to the questionnaire, showed up for the appointment to pick up their incentive reward and referral coupons, but they did not produce any referrals.

In response to the above findings, PSI and the research agency set up a series of procedures to speed up the process and mitigate future losses:

- a. After being invited to an appointment, respondents would receive follow-up calls to confirm their attendance.
- b. At the end of the interview, interviewers included additional motivational messages to encourage respondents to effectively refer their friends.
- c. If, after 6 days, a respondent did not produce any referrals, he would get a phone call from the agency to remind him of the process.
- d. A few additional questions were added at the end of the questionnaire to investigate the perceived value of the incentives and to understand why the referral system did not yield the anticipated results.

These procedures seemed to have a somewhat positive effect on the number of completed interviews, yet the rate of progress was again too slow, with recruitment spreading out farther from the initial seeds and happening only in a few of the ten cities. This may also suggest that in some cities, perhaps network sizes or the MSM populations are very small.

With regard to the additional questions at the end of the interview, most respondents stated that the value of the incentive was motivating enough and that the effort to go at the appointed time and to the specified place to collect their incentive and referral coupons was not too great. However, some also said that the reasons why they could not produce referrals was because either their friends did not trust them enough and were not “out” enough to take part in the study, or because they simply did not have many MSM friends to refer.

### Results

During the period of 8 weeks from October through December 2007, 128 total interviews were conducted, and 186 referral coupons were distributed, out of which 85 became successful interviews. Interviewees represented all the cities targeted in the study: Timisoara, Craiova, Buzau, Cluj-Napoca, Tirgu Mures, Brasov, Constanta, Galati, Iasi, and Bucuresti.

**C. *Analysis and Lessons Learned***

Despite a study period longer than initially planned (8 vs 6 weeks), data collection results yielded 192 interviews less than anticipated, with the recruitment process for seeds not complying with the planned RDS methodology but necessitating a “take-all approach.”

We interpret the lack of success of the application of the RDS methodology as being a combination of several factors:

- a. Despite the responses to the additional end-of-questionnaire prompts, the situation in Bucharest is likely to have been a barrier for respondents showing up for appointments to pick up incentives and coupons. The extremely heavy traffic during the evening in Bucharest during the study period meant a trip of up to 1 hour and 30 minutes to an appointed location in the center of the city. Such a long trip could easily have diminished the motivation of respondents to come to the meeting place.
- b. Considering the respondents’ answers to the prompt for reasons why the referral system was slow, it can be assumed that the target community is in a deeper state of fragmentation and isolation than initially thought. This makes it difficult for people to gain the appropriate amount of trust in order to give their phone numbers to complete a questionnaire, even if it is their friends who make the recommendation. Also, online recruitment of seeds seems to have yielded quite a few people who were not part of solid MSM social networks, which means that it was difficult for them to identify friends who would respond to the questionnaire.
- c. No training was provided to the research agency on RDS. The agency had never used the methodology before and did not fully appreciate the efforts that were needed to manage data collection. The recruitment of the seeds was left with program staff, who did not fully appreciate the importance of adhering to the seed diversification. The study was employed across a number of cities, making it difficult to manage and to find initial recruits.