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Research paper

Injecting behaviour and service use among young injectors in Albania, Moldova, Romania and Serbia

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ABSTRACT

Background: This study examines socio-demographic profiles, injecting risk and use of health services among young injectors (15–24) in Albania, Moldova, Romania and Serbia. The objective was to provide age-disaggregated data to identify differences between adolescents (<18) and youth (18–24), and help fill the gap in knowledge on the youngest injectors in this region.
Methods: Cross sectional surveys were conducted in each country using chain-referral sampling to reach diverse networks of people who use drugs (PWID). In Albania and Romania, surveys were conducted in the capitals, respectively, Bucharest and Tirana. Respondents were recruited from 3 cities in Moldova (Chisinau, Balti and Tiraspol) and Serbia (Belgrade, Novi Sad and Nis). Data were collected on risk behaviours, service use and contact with police and other authorities. Analysis focused on associations between unsafe injecting behaviour and key determinants including demographic background, source of needles/syringes, use of harm reduction services and interactions with law enforcement.
Results: Although drug use and health-seeking varied across settings, sources of injecting equipment were significantly associated with sharing needles and syringes in Moldova, Romania and Serbia. Obtaining equipment from formal sources (pharmacies, needle-exchange programmes) reduced likelihood of sharing significantly, while being stopped by the police or incarcerated increased it. Adolescents relied on pharmacies more than public sector services to obtain equipment.
Conclusion: Adolescents comprise a small proportion of PWID in this region, but have poorer access to harm reduction services than older peers. Engaging young PWID through private and public sector outlets might reduce unsafe practices, while use of the justice system to address drug use complicates efforts to reach this population.

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Background

Eastern Europe has one of the fastest growing HIV epidemics, and unsafe injecting practices among drug users remains a key driver, responsible for close to half of new infections in 2010 (ECDC, 2010; Lazarus, Bollerup, & Matic, 2006). Young people who inject drugs (PWID) have attracted particular attention as up to a third of new HIV infections occur among 15–24 year-olds (UNICEF, 2010), and evidence suggests that younger injectors can be at higher risk for HIV (Fennema, Ameijden, Hoek, & Coutinho, 1997), hepatitis C (HCV) (Garfein et al., 2007) and overdose (EHRN, 2009). This reflects younger users' more recent initiation of injecting, which is associated with riskier practices (Miller & Schleifer, 2008). Younger injectors also exhibit higher rates of sexual risk-taking (Kral, Lorvick, & Edlin, 2000; Latkin & Knowlton, 2005), and often do not self-identify as PWID, resulting in lower HIV awareness and risk perception (Kleinman, Goldsmiths, Friedman, Hopkins, & Des Jarlais, 1990). Growing popularity of amphetamine-type stimulants (ATS) among young people in the region may introduce injecting at younger ages (EHRN, 2009). Some studies have also found links between ATS and increased sexual risk-taking as well as an independent association with HIV acquisition, although the causal pathway remains unclear (Degenhardt et al., 2010).

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Legal restrictions on providing harm reduction services to minors (under 18) exacerbate young PWID's vulnerability by limiting their access to health and social services, while punitive measures by police and child protection institutions engender distrust of authorities (Curth, Hansson, Storm, & Lazarus, 2009; Merkinaite, Grund, & Frimpong, 2010; Ti, Wood, Shannon, Feng, & Kerr, 2013). In many countries of Eastern Europe the main strategy for dealing with young injectors is through the adult criminal justice system (EHRN, 2009; Merkinaite et al., 2010). Police harassment and the threat of detention may discourage young people from contact with authorities (Debeck et al., 2011), while even among those who are willing to obtain sterile injecting equipment from harm reduction services, aggressive policing has been shown to be a structural driver of unsafe injecting practices as PWID look for an opportunity to inject as quickly as possible after obtaining drugs, even if they have not obtained clean equipment (Ti et al., 2013).

Despite growing concern, there remains a dearth of information on young PWID (Aceijas et al., 2006). Age disaggregated data on injecting risk behaviours is especially scarce, and has been highlighted as a priority (HRI, 2012). This study describes the characteristics and behaviours of PWID aged 15–24 in four Eastern European countries: Albania, Moldova, Romania and Serbia. We focus on results that can be compared between adolescents (<18) and youth (18–24), and present factors associated with unsafe injecting practices for young injectors in these four countries, highlighting implications for intervention programmes.

Methods

The research was conducted as part of a regional UNICEF programme for reducing HIV vulnerability among most at risk adolescents (MARA), funded by Irish Aid. Studies were conducted by the Institute for Public Health (Albania), the Dr. Milan Jovanovic Batut Institute of Public Health (Serbia), the National Centre of Health Management (Moldova), and the Faculty of Sociology and Social Work at the University of Bucharest (Romania), with technical assistance from the London School of Hygiene & Tropical Medicine (LSHTM). Ethical approval was obtained separately from each country's National Ethics Committee through the Ministry of Health or national Institute of Public Health, based on country-specific study protocols and instruments.

Sampling

Young PWID (<25) were recruited into cross sectional surveys in each country using a form of chain-referral sampling based on respondent driven sampling (RDS). In each country, 8–10 initial "seeds" were purposively selected to reflect diversity in PWID by gender, ethnicity and age, and requested to pass recruitment vouchers to 2 other PWID (3 in Serbia) in the eligible age range who met inclusion criteria. Not all seeds were aged 15–24, as formative research indicated that older PWID would be familiar with locations in which younger injectors could be found, had the confidence to approach them, and could be considered respected older community members (Rhodes et al., 2011). While the minimum recruitment age varied between sites, we restrict analysis to respondents 15–24 to facilitate cross-country comparison and reflect the fact legal restrictions in Serbia and Romania, where needle and syringe distribution is prohibited to anyone younger than 15 (HRI, 2012). Respondents were provided with incentives including pre-paid phone cards, canned food, cosmetic products, or small cash payments. Guidelines produced by UNICEF for research and programming among most-at-risk adolescents were followed to ensure adherence to international child protection and ethical standards (Homans, 2008; UNICEF, 2002).

Three hundred PWID were recruited in Romania, 121 in Albania, 350 in Moldova and 248 in Serbia. In Romania and Albania surveys were conducted in the capital cities, respectively Bucharest and Tirana. Respondents were recruited from 3 cities in both Moldova (Chisinau, Balti and Tiraspol) and Serbia (Belgrade, Novi Sad and Nis) to ensure adequate sample sizes.

Questionnaire

LSHTM developed a core questionnaire that included modules covering a range of socio-demographic and behavioural indicators, including age, ethnicity and educational background; migration and living conditions; duration and frequency of injecting; types of drugs injected; sexual behaviour with long-term, casual and commercial partners; knowledge of HIV risk factors; use of locally available health and harm reduction services; experience of violence; and history of incarceration, child protection services and police harassment. Questionnaires were translated and adapted to local programming needs by changing or adding questions beyond the core indicators.

Locally trained fieldworkers administered the questionnaires during interviews conducted in private in a range of private settings, including mobile clinic vehicles, office space, rented flats and cafes or isolated street locations. Information about the study aims, objectives, and topics of enquiry were explained to respondents, who were asked to provide informed consent (choice of written or verbal and witnessed by interviewer). No identifying information was recorded. Surveys were conducted between October 2007 and May 2008, and subsequent delays in national-level data analysis, government validation, and in-country dissemination meant that we did not obtain access to all four data sets until 2009.

Analysis

Data from the four countries were merged into one dataset and standardised variables compiled using STATA 11. Although the chain-referral recruitment approach was based on RDS methods to maximise access to hard-to-reach populations, samples from different cities were combined to create country profiles and increase sample sizes (particularly for adolescents). Thus we did not adhere to the statistical principles of RDS, but adopted its sampling approach after judging it to be best suited to our study contexts (McCreesh et al., 2012; Stormer et al., 2006). We appreciate the biases this may introduce and do not claim that these samples are representative of young PWID in the four counties (White et al., 2012), but we were able recruit adolescent PWID with no prior contact with health or social services, thus increasing contact compared with other forms of convenience or location-based sampling (Magnani, Sabin, Saidel, & Heckathorn, 2005; Yeka, Maibani–Michie, Prybylski, & Colby, 2006).

First, characteristics and risk behaviour were compared between adolescents (<18 years), and young adults (18–24 years) for each country, using Fisher's exact test. Percent distribution, median age and total numbers (N) in each age group are presented in Tables 1 and 2. We did not use the WHO definition of adolescence (10–19) (Ross, Dick, & Ferguson, 2006) but 15–17 instead, for the following reasons: (1) national research guidelines prevented us recruiting respondents younger than 15 in several countries, and (2) all four countries use 18 to mark legal adulthood, with implications for access to services and treatment by the criminal justice system (EHRN, 2009).

Second, to explore factors associated with high risk injecting, we pooled data across the age groups due to the small number of adolescent respondents. While this limited the amount of

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