Why Teens Are Vulnerable to HIV, and What to Do About It

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Nearly a fourth of new HIV infections are among adolescents or people in their early 20s. An adolescent AIDS expert tells how their management should differ from that of adult patients infected with HIV.

A recent report from the Centers for Disease Control found that youth 13-24 years of age accounted for a quarter of new HIV infections in 2010, with a prevalence of nearly 70 per 100,000 by the end of 2009. Yet more than half of those infected (59%) were unaware of their status.

As with HIV prevalence rates in adults, the majority of HIV-infected youth are black/African American males according to CDC figures for new HIV infections among Americans aged 13 to 24 in 2010 (see chart below.) A large majority are gay, with 72.1% of all new HIV infections among youths attributed to male-to-male sexual contact. Nationally, 57% of diagnosed infections in 2009 were attributed to male-to-male sexual conduct.¹

“The MMWR report just revealed what we’ve been seeing on the ground among adolescents,” said Donna Futterman MD, who directs the Adolescent AIDS Program at Children’s Hospital at Montefiore in New York City.

This is when kids begin to explore their sexuality, she said, and yet “we are not giving the most vulnerable kids the kind of information they need through the channels they would see it.”

In a way, she said, this is the result of the transformation of HIV/AIDS from an always-fatal disease to a treatable, chronic condition. “The first generation of gay men saw their friends dying,” she said. “So there was a huge mobilization [on prevention] in the community. But we have drifted away from that over the past 30 years.” That’s resulted in a dearth of information on prevention targeted at youth.

Add the stigma still present around homosexuality, which prevents many youth from being open about their sexual preferences, and “it’s not a surprise that we see HIV resurfacing among the most
vulnerable kids.”

The “devastatingly high rates” in young black men, she said, reflect the healthcare disparities and higher rates of poverty in that population.

What’s needed is a national campaign to “market” HIV prevention and testing in much the same way companies market Coke or McDonalds, she said.

The campaign should include routine testing of every young person who comes in contact with the medical community. “Relying on who is at risk does not work,” she said, noting that her group receives at least one referral a month of an adolescent who was found positive on routine testing. Yet only between a third and a half of teens and young adults who see a primary care providers are offered testing and tested. A recently published study of 967 college students found that just 42% had ever been tested for HIV. The CDC report found that just 12.9% of all 9th-12th graders had been tested for HIV, just a fifth of those who had ever had sexual intercourse.

Testing should also be offered at every visit to youth who tested negative. “In our experience, gay boys who tested positive had an average of five prior negative tests,” Dr. Futterman said. A 2011 CDC report found that 59% of youth diagnosed with HIV had a negative test at some point prior to their diagnosis, while 41% were diagnosed at their first test.

Getting kids to agree to testing and to share their sexual practices isn’t easy, she conceded. One recent study found that just half of 200 sexually experienced adolescents agreed to testing. However, the likelihood of testing increased if a clinician offered the testing and the youth had a higher perceived risk of HIV infection.

Clinicians need to understand that “when kids see a doctor they’re not going to tell the truth even if you explicitly ask them if they are having unprotected sex,” Dr. Futterman said. Plus, they may be in the process of coming out, or not even be aware of their sexual orientation. That’s because adolescents often explore their sexuality before solidifying an identify, meaning that many gay boys may still be having sex with girls.

“In our group, two-thirds of patients identify as gay and one-third as bisexual, but two-thirds are having sex with women,” she said. That is why rates are also increasing in young women, she added. Indeed, the CDC report found that 20% of infections in this age group were due to heterosexual contact. Nationally, 31% of infections in 2009 were attributed to heterosexual contact.

The other part of the prevention/testing strategy must be explicit and targeted outreach in settings that attract young gay and bisexual men, such as social networks, school clubs and other venues.

Once individuals test positive for HIV, it is important to link them to care. Studies find early treatment not only improves outcomes, but reduces viral transmission and improves the likelihood that the patient will reduce risky behavior. Thus every provider should have a referral source and, if possible, dedicated staff to follow up on the referrals. In Dr. Futterman’s experience, she said, only about half of those who test positive and are referred to care actually follow up. Barriers include stigma, mental health issues, substance use and transportation.

Adherence to treatment in adolescents and young adults is as much, if not more, of a problem as with older adults. A recent study found the top three barriers are forgetting, not feeling like taking medication and not wanting to be reminded of HIV infection.

The home situation is another barrier, said Dr. Futterman, since not all youth with HIV are ready to share that information with their parents. Yet if they live at home and/or are dependent on their family for financial support, it’s difficult to obtain and take their medications as directed. Thus, she said, it important that providers realize “it’s not just the patient in front of you, but their whole social setting that requires consideration.” For instance, a much higher percentage of homeless adolescents are gay than in the general population, because many have been rejected by their families. Treating this population requires a more comprehensive approach than treating a youth living at home with supportive parents.
Another reason for nonadherence is that few teenagers can conceive of long-term circumstances. So if they don’t feel sick, and yet the medication has side effects and is challenging to take on schedule, they stop taking it. Teenagers also have “chaotic schedules,” Dr. Futterman said, which change on a daily basis.

Strategies to help get patients into care and remain adherent include helping them identify with their peers. For instance, clinicians could schedule their adolescent HIV patients for back-to-back appointments on the same day, so the youth meet each other in the waiting room. However support groups typically don’t succeed, Dr. Futterman said.

Overall, the clinical provider needs to spend more time and provide more supportive services for HIV-infected youth than for adults, Dr. Futterman advised. Despite the bad news inherent in the CDC report, she concluded, “we are grateful for the attention on this, because it helps shine a light on what we’ve been seeing for many years.”

References: REFERENCES


Links: