

Position paper

HIV infection and AIDS in adolescents: An update of the position of the Society for Adolescent Medicine

Summary

- The Society reaffirms its call for accurate and comprehensive monitoring of HIV infection in youth.
- The Society endorses efforts to expand knowledge of HIV infection to youth from all countries and recognizes that priorities in this regard need to be based on local needs, not externally developed policies.
- The Society supports research into HIV care and treatment initiatives that are focused on youth.
- The Society supports expansion of testing and counseling efforts that utilize state-of-the-art techniques and an immediate linkage to comprehensive care for positive or concerned youth.
- The Society endorses community based HIV/AIDS prevention and education that recognizes the importance of abstinence but that is comprehensive and sensitive to the needs of all adolescents, including those who are gay, lesbian, bisexual, transgender or questioning.
- The Society supports continued research focusing on the antecedents of HIV infection and important preventive tools such as microbicides and vaccines.

The Society for Adolescent Medicine issued its first position paper on the subject of HIV/AIDS in adolescents in 1994 [1]. In the ensuing decade, great progress has been made in our scientific understanding of the virus at the root of this 25-year pandemic, in the diagnosis and treatment of people living with HIV, and in the prevention of perinatal transmission. However, great challenges remain for those of us working to prevent HIV/AIDS in adolescents and young adults and to provide treatment and care and support for those who already are infected.

In the developing world, improved treatment and care have decreased the number of new cases of HIV/AIDS among children and increased the number and proportion of infected children surviving to and through adolescence, but the number of newly acquired cases among adolescents and young adults continues to rise. In the developing world, there is a growing crisis. In 2003, approximately 50% of

new HIV infections worldwide were in individuals between the ages of 15 and 24, or 6000 new infections daily, and there are 12.4 million teens and young adults living with HIV/AIDS worldwide, with at least half of them being female [2–4]. Despite the continued transmission of HIV infection to and within this age group, new information has altered our approaches to prevention and treatment, whereas behavior change and consistent use of barrier methods remain the goal of prevention efforts worldwide. As the epidemic enters its second 25 years, the Society for Adolescent Medicine seeks to revisit and reemphasize its position and critical focus on HIV infection and AIDS among adolescents and young adults.

As of December 31, 2003, almost 38,500 cases of AIDS had been reported in adolescents and young adults 13–24 years old in the United States of America [5]. Previous studies demonstrating that the risk of AIDS increased with the age at infection suggest that a large proportion of people developing AIDS in their third decade of life became infected with HIV as teens [5–7]. More recent immunologic research has suggested that the thymic reserve of adolescents acquiring HIV during their teen years may improve their potential for both long-term survival and response to treatment [8]. The Centers for Disease Control and Prevention (CDC) still estimates that as many as 50% of new infections with HIV in the USA occur in individuals under the age of 25 [9]. The majority of these infections continue to occur disproportionately among youth of color, particularly African American and Latino youth. Among adolescents and young adults with HIV or AIDS, most infections are acquired by having sex with HIV-infected men.

In the past few years, more jurisdictions have mandated the reporting of cases of HIV infection as well as cases of AIDS. Although incomplete, this reporting will ultimately reflect more accurately the prevalence in certain ethnic and behavioral groups. In 2003, young women accounted for 50% of HIV cases reported among 13–19-year-olds, and 37% of cases among 20–24-year-olds in the 33 states whose HIV reporting is included in CDC surveillance [4]. The Society reaffirms the need for continued epidemiologic monitoring of HIV infection in adolescents and young

adults and emphasizes the need for extending this monitoring and utilizing the most scientifically valid method to ensure accurate and comprehensive reporting of individuals with HIV infection prior to their being defined as a case of AIDS. Such surveillance has recently shown concerning increases in HIV incidence among young men who have sex with men (YMSM), and a disproportionate lack of awareness and disclosure of HIV status among YMSM of color [10,11]. In a similar fashion, the Society endorses improved methods of calculating the growing numbers of adolescents and young adults living with HIV/AIDS who were initially reported as pediatric cases (diagnosed before the age of 13 years) in an effort to help in understanding the scope and needs of this challenging population.

The Society appreciates and endorses efforts to understand the nature of HIV infection globally in youth as well as within the United States. Although the Society realizes that there will be many similarities between the epidemic of HIV infection in youth in the United States and in other countries, the Society acknowledges that there will be many differences as well and that these differences will need to be fully appreciated in a true global context [12]. Continuing efforts to find cost-effective prevention and treatment modalities and to improve both resources and the infrastructure needed to reduce HIV on a global scale are essential. This will necessitate great multilateral cooperation with nations, foundations and agencies that have expertise and financial resources to lead these efforts overseas. The Society supports this collaboration and recognizes the importance of locally determined priorities for prevention and treatment efforts that are not dictated by external ideological considerations.

Much information on the clinical, laboratory and behavioral profile of adolescents with HIV infection and/or AIDS has been forthcoming in the past decade from studies such as those conducted by the Adolescent HIV/AIDS Research Network (REACH, Reaching for Excellence in Adolescent Care and Health) [13–18] and the Hemophilia Growth and Development Study [19]. Nonetheless, there continues to be a need to define adolescent-specific illness patterns and to develop clinical trials that will demonstrate ways in which adolescents may differ from children or adults. At the same time, it will be important to identify ways to provide services that will ensure comprehensive care for HIV-infected adolescents and young adults in a setting that best serves them and aids both primary and secondary prevention efforts. This will include the continued need for psychological and social and institutional support for these patients and their caregivers. Further, increasing numbers of children infected perinatally are reaching sexual maturity and will ultimately require intense anticipatory counseling related to the initiation of sexual activity and other risk behav-

iors, as well as the potential for childbearing and productive adult lives [20].

This complex medical and psychosocial care is usually best provided by collaboration between an HIV specialist and strongly adolescent-oriented or adolescent-specific primary health care services, or by transitioning these adolescents to adolescent-specific HIV practitioners, where all of their various needs can be better addressed. These clinical services must be supported by ongoing outreach, case management, and mental health support to connect and retain young people in care [21,22]. In addition to these counseling and support services, the most current treatment modalities for HIV infection must also be readily available and knowledgeably utilized to benefit the patient. The Society, therefore, reemphasizes the need for state-of-the-art adolescent- and young-adult-specific treatment and care and effective prevention interventions and supportive services for youth infected with or at risk of infection by the human immunodeficiency virus.

Central to prevention and treatment efforts should be a comprehensive program for HIV counseling and testing. Testing should be readily available without financial barriers to any youth who desires it. Consistent with local legal requirements, all efforts should be made to protect an individual's privacy and to ensure confidential care. All youth at risk on the basis of current or past behaviors, especially youth who reside in areas with high prevalence rates, should be identified and urged to undergo testing. Offering testing and effective risk reduction counseling and assistance should be part of the routine care of sexually active youth. Given the availability of non-invasive, point-of-care rapid HIV antibody testing [23], and the availability of nucleic acid testing methods to identify virus during symptomatic seroconversion, it is imperative that any agency or health care professional offering counseling and testing should also be willing and able to facilitate immediate linkage to care and support for both infected and uninfected individuals. However, as was true a decade ago, the specter of testing without the expressed permission of each individual to be tested remains unacceptable. Although different approaches to obtaining this permission should legitimately be explored, no individual should be tested without their knowledge or against their will. Efforts to ensure that communities and at-risk individuals are able to fully participate in and help shape the testing environment should continue.

The Society continues to endorse community-based prevention and education activities. Many of these activities will take place in schools and youth-serving organizations. All such activities should be scientifically grounded and evidence-based and focus on the development of both resilience and decision-making and be inclusive of ethnically and behaviorally diverse youth of all types of sexual orientation or behaviors [24,25]. Absti-

nence and delay of sexual initiation should be an important component of all preventive education approaches, especially for young adolescents and for adolescents of all ages who are already infected. The Society does not endorse this as an exclusive approach, however. Concrete education and training about the use of barrier methods and safer sex negotiation skills for all modes of sexual contact must remain an essential component of prevention education for youth. Access to confidential family planning services, STD diagnosis and treatment, and substance use treatment must be linked to *all* HIV prevention efforts among youth. Particular attention should be focused on providing services targeting gay, lesbian, bisexual, transgender and questioning youth, as well as youth who are homeless, runaway, or made vulnerable by learning, emotional or family challenges. If not included in the above groups, youth in state protective custody or the justice system all need focused attention for preventive efforts. Concentrated and continuing efforts must be made to reach these often difficult to access at-risk youth and to continue efforts to develop, adapt and implement effective interventions.

Finally, the Society acknowledges the significant gains that have been made in understanding the contributory causes of the spread of HIV infection in adolescents and young adults through the success of targeted research efforts. Efforts such as the NIH-supported REACH study and the Adolescent Trials Network for HIV/AIDS Interventions are contributing greatly to our understanding and effectiveness. Further efforts to define the antecedents of HIV infection in youth in order to formulate creative approaches to prevention and treatment must continue. These approaches should include strategies to develop, test and provide vaccines to adolescents when and if these become available. Ideally, this research in young people in the United States of America and other resource-rich nations will ultimately involve youth throughout the world and be applicable to those areas where HIV/AIDS continues to be the major public health problem.

Postscript

Opinions do not represent the positions of the agencies or institutions at which the individual authors are employed.

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