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Getting to Zero HIV Among Youth: Moving Beyond Medical Sites

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Dramatic advances have occurred in biomedical treatments for both preventing and treating HIV infection. Adherence to antiretroviral therapies (ARV) improves the health and longevity of people living with HIV, and reduces the lifetime risk of transmitting HIV by up to 96%.¹ Additionally, pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) – preventive strategies that involve taking ARV medications before or immediately after potential HIV exposure - have been shown effective in preventing HIV infection among persons at high-risk of acquiring HIV. Given these breakthroughs, the number of people living with HIV (PLH) has declined 8% from 2010–2015¹, leading policy makers in many states and counties to make plans to “Get to Zero” HIV infections.

Despite reductions in national rates, HIV has doubled among youth in the last 15 years, with youth at highest-risk (YAHR) including African-American and Latino young men who have sex with men (YMSM), transgender youth and, increasingly, African-American women, especially in the Southeast, and resurgent outbreaks among people who inject drugs transitioning from prescription opioid use.¹ According to the Centers for Disease Control and Prevention (CDC)¹, only 10% of high school students and 21% of YMSM have been tested for HIV. At best, half of YLH aged 12–24 years old know they have HIV.¹ Compared to older adults, YLH are less adherent to ARV treatment and do not stay retained in care.² While the Food and Drug Administration (FDA) has authorized use of PrEP for those over 77 lbs¹, only about 8–9% of YMSM utilize PrEP.³ Thus, we are failing to reach and engage both YLH and YAHR.

One of the major reasons for youth to be unaffected by the advances in prevention and care is that federal HIV funds have been increasingly reallocated from community settings to medical care settings. In 1998, 53% of federal HIV funds went to medical settings. Today, 78% of domestic HIV funding is in medical settings. To get to zero HIV transmission among youth, it will be necessary to move outside of medical care settings for several reasons.

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Conflicts of Interest

The authors declare no conflicts of interest.

First, youth in general and especially sexual and gender minority youth do not access medical care routinely. About 40% of youth never see a provider for any preventative care during adolescence, and 62% do not get services when ill.⁴ Cost and access to care is one limiting factor, exacerbated by stigma and, increasingly, fears of arrest and deportation among undocumented Latino youth for themselves or their parents. Second, providers do not routinely ask about sexual behavior, sexual orientation, or gender identity. Many providers are uncomfortable bringing up sexuality. One-third of all adolescents had annual visits without any mention of sexuality issues, and when they occur, physicians spend about 36 seconds per patient on the topic of sexuality and gender identity.⁵

Finally, YAHR face multiple challenges. About one in four LGBTQ youth, including YMSM, attempt suicide related to the process of coming out (although they are not more likely to complete suicide).⁶ YAHR are also overrepresented among youth in foster care. LGBTQ youth are often bullied by fifth grade, far before they “come out”. When LGBTQ youth and YMSM do disclose their sexual orientation, 42% of parents eject them from home.⁶ In addition to YMSM, homeless youth, youth with mental health and substance abuse disorders, and youth who consistently engage in bartering sex are also at higher relative risk of acquiring HIV.^{1,6} Thus, YLH and YAHR often face many challenges that involve multiple sectors: social services, housing, substance abuse treatment, mental health, employment, and the criminal justice system. Youth coping with multiple problems are unlikely to proactively seek medical care⁶ and medical settings are not typically able to mobilize wrap-around, integrated care.

Horizontally-integrated services outside of medical care are needed for YLH and YAHR. Outreach programs at shelters, schools, criminal justice settings, hook-up settings, and social media sites associated with risk behaviors (i.e., dating apps) are likely places to access YAHR and YLH. Therefore, HIV testing, referrals, and engagement with PrEP, PEP, or ARV treatment programs for YAHR and YLH need to be expanded from medical sites to community venues.

Moving beyond medical sites also suggest engaging youth through mobile technologies; youth are the highest utilizers of mobile technologies with nearly 90% of youth aged 13–17 years old having mobile phones. Texting and private messaging are particularly important for youth; 90% of those with phones text, typically receiving and sending 30 texts or private messages each day.⁶ Almost all youth (92%) go online daily, typically checking their phones 76 times a day.⁶ Much of this online activity is driven by social media, particularly via smartphones, with over 70% of adolescents under 18 using social media platforms such as Facebook, Instagram, and Snapchat.⁶ This is true for all youth, including African-American and Latino youth, who have higher rates of Internet use via smartphones than White youth.⁶ Ownership, access, and use rates of mobile technologies are similar for homeless youth and other YAHR, although with less consistency than other youth. The broad proliferation of mobile technologies and social media offer an opportunity to reach, monitor, intervene, scale, and broadly diffuse programs to offer routine HIV testing and access to youth-friendly health care to YAHR and YLH. At home or in meet-ups, youth can be offered rapid diagnostic tests (RDT) for HIV, sexually transmitted infections (STI), and drug use, with indicated linkages via active referrals to appropriate prevention and treatment services with a

time and place scheduled while sitting with a youth, and same-day treatment for STI. Even more important, these engagement strategies can be implemented by trained paraprofessionals and do not require the high infrastructure costs of services offered within medical settings.

‘Getting to Zero’ HIV infections is possible among youth, but it will require innovation in broadly implemented services. One strategy is to provide outreach workers and wrap-around services to YAHR in community sites. Long-term reductions in risk through repeated testing, increased uptake of PrEP or PEP among YAHR, and sustained ARV adherence and retention in care by YLH remain to be demonstrated, but are going to need broadly implementable interventions that stand beyond typical healthcare settings. As states, counties, and health systems plan how to Get to Zero, we encourage them to reallocate resources locally from medical care to a horizontally integrated system of community providers and health systems to ensure that we stop HIV among young people.

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