What are the unique issues of adolescence that put all adolescents and young adults at risk for HIV/AIDS and other STDs?

- Sense of immortality
- Risk taking is the norm
- Emerging sense of identity
- Emerging sense of autonomy and independence
- Challenging authority figures
- Experimentation with sex and gradual development of sexual identity
- Experimentation with substance use
- Peer pressure

What are the unique issues that put specifically Young Black MSM at risk for HIV/AIDS and other STDs?

- Marginalization of Black identity by larger society
- Marginalization of sexual identity by Black community
- Devalued personhood: "Abomination"
- Messages from faith community
- HIV stigma
- Impact of the Larger Societal & Cultural Influences
- Marginalization of Black identity by larger society
- Societal homophobia
- Devolved prenthood
- HIV stigma
- Impact of Black Cultural Influences
- Marginalization of sexual identity by Black community
- Rejection by family and other support systems
- "Abomination" messages from faith community

Special Healthcare Needs of YMSM/Gay Youth

- Outreach to "ballroom" community and other venues for MSM/gay male youth are necessary to bring youth into care settings
- Disclosure of sexuality in general as well as how it relates to engagement in care and HAART or PrEP adherence
- Mental health issues: increased suicide rates, social isolation, peer support
- High rates of homelessness
- Clinical expertise in dealing with syphilis, anal STDs (e.g., Condyloma, anal Pap smear/dysplasia/HPV anoscopy, Herpes, GC/chlamydia, etc.)
The House Ball community is composed of groups of individuals attending and participating in dance and fashion competitions known as balls, which have been a long-standing feature of the NYC nightlife.

The House Ball community is predominantly made up of Black and Latino MSM, transgender women and others.

Though the community as a whole is defined by the competition at balls, the social networks that form among groups of individuals or “houses” vary in composition, size and organization. Houses can also be seen as alternative family structures with “mothers”, “fathers” and “children”.

House and Ball communities represent a critical access point for engaging these youth, both those at high-risk for HIV infection and those already infected.

For many youth, the house/ball community provides a much needed social structure, support, and sense of family.

Many youth participate in the House Ball community through the “kiki” houses.

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Healthcare Outreach to the House Ball Community

- The House Ball community is composed of groups of individuals attending and participating in dance and fashion competitions known as balls, which have been a long-standing feature of the NYC nightlife.
- Though the community as a whole is defined by the competition at balls, the social networks that form among groups of individuals or “houses” vary in composition, size and organization. Houses can also be seen as alternative family structures with “mothers”, “fathers” and “children”.
- House and Ball communities represent a critical access point for engaging these youth, both those at high-risk for HIV infection and those already infected.

Core Elements of A Successful Adolescent Care Program

- Culturally competent providers who enjoy working with youth and are familiar with YMSM issues
- Staff that can relate to the “world” youth live in
- Youth friendly space in a discrete location
- Comprehensive and multidisciplinary services
- “One Stop Shopping” principle vs. care by referral
- Grant funding
- Outreach materials culturally relevant to YMSM

Core Elements of A Successful Adolescent Care Program (cont.)

- Institutional support
- Removal of barriers youth face when seeking to independently access health care services
- Free or low cost care especially for laboratory tests and pharmaceuticals
- Essential community linkages to ensure bilateral referrals of youth for services — “meet the youth where they are” (CBO’s, churches, schools, informal youth networks, etc)
- Provide on-site and venue based HIV counseling and testing
- On-site prevention services

Multidisciplinary Team—each discipline requires its own expertise in working with YMSM

- Adolescent Medicine Medical Providers- Physician, PAs or Nurse Practitioners
- Nursing
- Mental Health Providers- Psychologist, Psychiatrist, Social Worker
- Case Management
- Outreach- Outreach Coordinators, Navigators, Peer Educators
- Research

HIV Counseling and Testing for YMSM in the HBC Setting

- Confidential space within the house ball environment
- ESTABLISH RAPPORT!!!!!!!!
- Make youth feel comfortable to answer or not answer questions
- Set a non-judgmental tone
- Fully define terms of confidentiality before asking any specific personal information including partner notification and exceptions to confidentiality
- Abuse, suicidal/homicidal ideation
- Explain a minor’s right to consent if <18 years of age
Youth Rights to Consent and Confidentiality in New York State

- STD screening and treatment
- Family planning/birth control
- Prenatal care
- Termination of pregnancy
- HIV counseling and testing
- HIV care
- Substance abuse treatment
- Mental health services

HIV Counseling and Testing for Youth (cont.)

- Assessment of any current HIV-related symptoms, especially those that might suggest acute infection (within past 6 months)
- Any other significant medical history including sources of medical care, major illnesses, medications, psychiatric history, hospitalizations, other
- Social history: living situation, emotional and social support, identification of supportive adult to whom adolescent can disclose confidential HIV and non-HIV related information, “coming out” to family; house ball community affiliation

HIV Counseling and Testing for Youth (cont.)

- Substance Use History: use of alcohol, tobacco, marijuana, ecstasy, cocaine, crack, “crystal meth”, opiates, steroids, hormones, heroin, and other substances (ketamine, GHB, “club drugs”); youth attitudes towards substance use

Mental Health History: brief self esteem description; history of anxiety or depression; history of suicidal ideation/gestures/attempt; sexual abuse or assault; history of receiving counseling services

HIV Counseling and Testing for Youth (cont.)

- Sexual history
  - Age at initiation of sexual intercourse
  - Pattern of sexual relationships, number and gender(s) of sexual partners
  - Disclosure to partner(s) of known HIV status
  - Sexual orientation – sexual behavior vs. sexual identity
  - Types of sexual experiences, specifying oral, vaginal, and anal intercourse; don’t be afraid to ask very specific questions; use vernacular terms such as “top”, “bottom”, “verse”
  - Hx of STDs

HIV Care Setting Matters!!!!!!!
Adolescent HIV Care Model

Adolescent:

- Youth-centered and multidisciplinary care; provider may have minimal to no relationship with parent/care giver
- Primary care approach integrated into HIV care
- Youth often does not disclose HIV status or sexuality to family
- Issues of confidentiality and consent; care usually offered in discreet, teen-friendly and intimate setting
- Teen services core to clinic-sexuality, pelvic examinations/Pap smears, STD screening and Tx, reproductive health, substance use, rights to confidentiality and consent, treatment education and adherence approaches
HIV Care Setting Matters!!!!!!!!!!!
Adult HIV Care Model

**Adult:**
- adult-oriented care based on strict medical model
- adult medical providers more often ID specialists than are pediatric or adolescent providers
- young person's transitional issues usually not given any systematic specialized focus
- adult expectations for self-management
- clinics tend to be very large and easy for transitioning patients to "slip through the cracks" unless very motivated

New York City Agencies/Clinics with Y MSM Services
- Ali Forney Center
- Adolescent Aids Program-Montefiore
- Audre Lorde Project
- Callen Lorde HOTT Program
- The Door
- FACES NY
- FIERCE
- Gay Men of African Descent (GMAD)
- Gays and Lesbians of Bushwick Empowered (GLOBE)
- Harlem United
- HEAT
- Hetrick Martin Institute
- Mount Sinai Adolescent Health Center
- PATH Center-Brooklyn Hospital
- Project STAY
- Safe Space
- The Lesbian, Gay, Bisexual & Transgender Community Center YES Program

Life Skills That an Adolescent Needs for Successful Transition to an Adult Clinic
- Knowing when and how to seek medical care for symptoms or emergencies
- Using one's primary care provider appropriately
- Making, canceling, and rescheduling appointments
- Coming to appointments on time
- Calling ahead of time for urgent visits
- Refilling of prescriptions on time
- Maintenance of one's health insurance
- Negotiating multiple subspecialty providers

HEAT Responds to the Problem of HIV/AIDS in Young MSM of Color:
- Outreach
- HIV counseling and testing
- Prevention
- HIV care
- PrEP services
Case 1
BJ, a 17 3/4 year old male who identifies as gay, presented to the HEAT Program at Downstate after meeting with a HEAT outreach staff member at a presentation about HIV pre-exposure prophylaxis (PrEP) in a community based location. He states that he has frequently engaged in unprotected anal sex and didn’t have very specific reasons for not using condoms stating “I don’t mind using them”. He reports having become sexually active at age 15 and that he has had 12 lifetime male partners, some of them in their late 20’s. He has never asked any of his partners about their own HIV status and feels uncomfortable bringing the subject up with them.

He has not disclosed to his parents that he identifies as gay, reporting that they are religious and that the pastor in his family’s church often preaches about the “evils of homosexuality”. He states that he has never been tested for HIV or STD’s before because he was not sure where to go and did not feel comfortable going to his family pediatrician to request this. He denies any symptoms or other significant medical history.

Case 1 (continued):
At baseline, he consents to HIV testing and STD screening consistent with a minor’s right to consent for these services under New York State law. He thinks he is covered by Medicaid but does not have his health insurance information with him. He has no physical findings suggestive of HIV or STDs. He has specimens sent for HIV and syphilis screening (blood) and pharyngeal, urethral and anal swabs sent for Gc/chlamydia NAAT testing.
Case 1 (continued):
He was very interested in starting tenofovir/emtricitabine as PrEP. It is explained to him that he needs to get parental consent to start PrEP as these medications are used as HIV prevention, which is not covered as “STD treatment” under New York State law which allows a minor to consent on their own for this without parental knowledge. He is not happy about this as he does not feel comfortable seeking parental consent to take PrEP, mostly because he does not want to have to disclose anything about his sexuality to them.

Case 1 (continued):
When he is also informed that he has to have insurance to pay for the PrEP prescription, he says that he thinks he is covered by Medicaid and he thinks he can get access to his Medicaid card from his mother’s wallet for this purpose.

Case 1 (continued):
He returns a week later for the follow up to the baseline visit. His HIV test was negative. His Gc/chlamydia NAAT tests all come back negative. His RPR is 1:256. He agrees to syphilis treatment with benzathine penicillin G and receives a dose. His sexual history does not yield any clues as to the length of time he has been infected with syphilis so he is informed that he must receive a total of 3 weekly doses to complete the therapy. He provides the names of two sexual partners for the purposes of partner notification services.

Case 1 (continued):
He is still very interested in PrEP but is adamant that he cannot disclose anything about his sexuality to his parents to get consent to start. He has his Medicaid card with him. When he is told that parental consent is still required, he states that he will be turning 18 years old in 3 months and will return on his birthday to start. He returns the next 2 weeks for follow up syphilis treatment doses and is given an appointment for his birthday to start the PrEP.

Case 1 (continued):
He does not return on his birthday for the PrEP initiation visit event though he confirmed the appointment by phone both a week before and the day before. He does not respond to attempts to reach him by phone or text. He presents 6 months later without an appointment stating that now that he is 18 years old, he wants to start PrEP immediately. He states that he continues to engage in unprotected receptive anal intercourse but says he uses condoms “a little more”. When asked why he didn’t come back on his birthday or respond to outreach, he says “I was in school that day”.

Case 1 (continued):
Given the lapse in time since the first baseline evaluation, all the lab tests are require repeating before starting PrEP. He is given an appointment to come back the next week. The repeat HIV test is negative. His repeat RPR is 1:4. He is completely cleared to start PrEP but does not return the following week. He does not respond to phone calls or text messages to reschedule him for the PrEP initiation visit.
Case 2:
BM was referred to the HEAT Program in 2006 at age 16 years after testing positive for HIV at a community health clinic in Queens. He gave a sexual history of having 30 male partners since age 13 years and claims to have “always” used condoms. He lived with his mother and two younger siblings.

He reported that he had disclosed his sexuality to his mother previously and that “she did not respond well to that”. For that reason, he did not disclose his HIV status to her and asked to be able to consent for his own care. His reasons were well documented in his medical record during several visit notes and he was allowed to consent as a minor for his own care.

Case 2 (cont):
His baseline CD4 count and viral load in 12/06 were 515 and 115,000 respectively. By 3/07, his CD4 count dropped precipitously to 249 so it was repeated. The repeat result in 4/07 was 187 and an AIDS diagnosis was made. His viral load at that time was 125,000. He was appropriately concerned about the results and was agreeable to initiating antiretroviral therapy.

He still did not want to disclose his HIV status or AIDS diagnosis to his mother, fearing being judged at home. He expressed a clear understanding of the nature of his medical status and the need for treatment. He initiated treatment soon after with TDF/FTC/EFV. He has remained on this treatment since then with CD4 counts consistently above 400 and undetectable viral loads.

Case 2 (cont): His mother died from metastatic breast cancer in July 2009. Shortly before her death, she disclosed to him that she was HIV+. He reported that he was pretty sure that she did, in fact, have breast cancer but that he didn’t have any other information about her HIV related health issues, including CD4 count, use of HAART or history of opportunistic infection. He also reported that he had been suspicious that she might be HIV+ when he had earlier applied for HASA benefits and was told he was ineligible because his mother already received HASA benefits.

Case 2 (cont):
Given her disclosure to him, he disclosed to her at that time of his HIV+ status. She responded that she already knew that he had HIV. He feels that she must have “done what mothers do” and gone through his things, finding his HIV medication. His brother informed him that he was also aware that he knew of BM’s HIV+ status (presumably through the mother).

He is currently 23 years old, has graduated college, and is attending a Masters degree program in journalism at a prestigious university. He remains clinically in good health with stable CD4 counts and undetectable viral loads.

Case 2 (cont):
He has been treated twice in the past year for syphilis. He reports that he almost never uses condoms during sex and states that he does not have to disclose his HIV status to his partners since, with an undetectable viral load, he does not pose an infectious risk to them. He feels that since he is protecting them from catching HIV from him by being adherent to his HIV medication, that there is no need to disclose his status to them.

He was invited to this conference to speak as a panelist but declined stating he did not feel comfortable disclosing his HIV status in front of a crowd.