Preventing HIV Among Young People: Research Priorities for the Future

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Preventing HIV among Young People: research priorities for the future

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Abstract

Objective—To review the current state of knowledge on the prevention of sexual transmission of HIV in adolescents and to highlight existing gaps and priority areas for future research.

Background—A disproportionate burden of HIV infections falls on adolescents, a developmental stage marked by unique neural, biological, and social transition. Successful interventions are critical to prevent the spread of HIV in this vulnerable population.

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Methods—We summarized the current state of research on HIV prevention in adolescents by providing examples of successful interventions and best practices, and highlighting current research gaps.

Results—Adolescent interventions fall into three main categories: biomedical, behavioral, and structural. The majority of current research has focused on individual behavior change, while promising biomedical and structural interventions have been largely understudied in adolescents. Combination prevention interventions may be particularly valuable to this group.

Conclusions—Adolescents have unique needs with respect to HIV prevention and, thus, interventions should be designed to most effectively reach this population with information and services that will be relevant to them.

Keywords
Adolescence; HIV; Prevention

Introduction
Young people are disproportionately affected by HIV globally; 25% of infected persons are between 10-24 years (1). Those aged 15-24 comprise 35% of new infections, resulting in 900,000 new infections annually (2). The greatest burden of HIV among young people is in sub-Saharan Africa (SSA). Here, young women have almost eight times the HIV prevalence as same-age men (2) and their annual HIV incidence is an estimated 8%(3, 4). By contrast, in the US and Europe, young men who have sex with men (YMSM) are at greatest risk of infection, particularly YMSM of color (2). While in much of Eastern Europe and Central Asia, young injection drug users and their sexual partners have the highest risk (2). Clearly, adolescents are a heterogeneous population; risk factors for HIV depend both on individual characteristics and social/environmental contexts. This diversity must be addressed in interventions.

In this paper, we highlight the unique needs of adolescents with respect to biomedical, behavioral and structural interventions that present the greatest promise in preventing sexual transmission of HIV. We also highlight existing gaps and priority areas for future research. We use the terms ‘adolescent’, ‘youth’ and ‘young people’ synonymously, defining adolescence as the developmental stage between the ages of 13-24.

Why are adolescents a unique population?
Adolescence has been described as ‘a period of momentous social, psychological, economic and biological transitions’(5). It is a time when substantial brain development occurs including the capacity for complex, conceptual thinking (6). The combination of a heightened responsiveness to rewards coupled with immaturity in the behavioral control areas of the brain may lead to the risky decisions and emotional reactivity that characterize adolescence (7). The exploration and formation of identity is considered by many to be the primary developmental goal of adolescence (8, 9). Socially, adolescents are searching for a sense of belonging from peers, who influence behavior (10-12). Adolescence is also marked by social transitions such as finishing school, finding employment, independent living, first sexual relationships, pregnancies, and marriage. These milestones occur during a period of decreased adult supervision when young people still have limited knowledge, self-confidence and life skills, which can lead to engagement in behaviors that heighten HIV risk.
HIV Prevention Among Adolescents

Numerous risk and protective factors operate at multiple levels; including the individual-, dyad- (peer/partner/parent), community- (e.g., school environment) and societal-level. Identifying determinants of risk and protective behaviors is necessary to ensure interventions are appropriate to the population and context where they are delivered. The need for combination HIV prevention strategies, incorporating interventions that address biological, behavioral and structural factors, has been emphasized as central to impacting the epidemic(13). Research is needed on selecting and optimizing these combinations for greatest effect, particularly among adolescents. Significant gaps in HIV prevention knowledge for adolescents remain (Table 1).

Biomedical Interventions

Recent successes in HIV prevention have been predominately biomedical, and include antiretroviral therapy (ART) for prevention, voluntary medical male circumcision (VMMC), and vaginal microbicides(14-19). Both treatment as prevention (TasP) (ART taken by HIV infected individuals to reduce HIV transmission) and pre-exposure prophylaxis (PrEP) (ART taken by HIV negative individuals to prevent HIV acquisition) demonstrate effectiveness in preventing HIV acquisition or transmission. While PrEP has been found to be effective in one randomized controlled trial (RCT) among MSM(18), results from four trials among heterosexual individuals have been mixed with two trials showing that PrEP was effective(15, 20) and two trials finding no effect(21, 22).

There are numerous reasons why the results of trials among heterosexual individuals may be conflicting, although adherence is likely one of the most important drivers of efficacy (23). In fact, in the VOICE trial, adherence, as measured by drug levels in blood, was particularly low (29%) despite the fact that self-reported adherence and pill count suggested good adherence (90%). Being over the age of 25 was a significant predictor of drug detection in the blood. In contrast, data from the Partners PrEP trial found that daily oral Tenofovir (TDF) and emtricitabine/tenofovir (FTC/TDF) was as efficacious in young women under the age of 30 as among all women. Specifically, the efficacy of TDF among women <30 years of age was 77% (95%CI 29.92) and the efficacy of FTC/TDF was 72%, (95% CI 25.90) compared to all women in which efficacy of TDF was 71% (95% CI 37.87) and FTC/TDF was 66% (95% CI (28,84)(24).

While adherence to ART is critical for treatment and prevention, taking medication long-term is challenging. Adolescents with HIV are less likely than adults to be adherent to ART (25-29). A literature review examining medication non-adherence among adolescents suggests that simple solutions remain elusive(30-34). For HIV uninfected youth, low HIV risk perception may result in a lack of interest in or poor adherence to interventions such as PrEP or microbicides (35). Furthermore, adolescents are often not in long-term relationships; it is unclear how partnership characteristics affect adherence to prevention interventions. More research is needed among adolescents to: understand testing, linkage to and retention in care; and understand factors affecting uptake of biomedical prevention interventions.

Vaginal and rectal microbicides, applied topically prior to sex, may be appropriate for young women and men who have sex intermittently. While one trial of coitally dependent vaginal tenofovir was found to show signs of efficacy among women in South Africa(19), use of daily topical tenofovir was found to not be effective in a second trial in Africa(22). The explanation for differences in the studies has been attributed to women not using the product, again stressing that adherence is critical to the efficacy of these interventions(23). Two safety and acceptability trials of a tenofovir gel-based microbicides in adolescent
women are planned in the United States (36) and South Africa (37). A phase II trial of
rectally-applied tenofovir gel among men and transgendered women will begin enrollment
soon and would benefit from bridging studies to adolescents following sufficient safety
signals (38). Research evaluating how best to support uptake, delivery, and adherence will be
required to facilitate wide-spread implementation.

Given high levels of unplanned pregnancy and unmet need for contraception among many
young women in high-prevalence settings, multi-purpose technologies (MPTs), methods that
could prevent HIV, other STIs and pregnancy, are urgently needed. (39) Some products are
in development, but their acceptability and safety for adolescent women is unknown.
Interventions integrating provision and uptake of sexual and reproductive health services
with HIV prevention need to be evaluated.

Voluntary medical male circumcision (VMMC) reduces HIV risk by approximately 65%
and reduces risk of STI acquisition and transmission (16, 17, 40). An additional benefit of
encouraging early VMMC is that it is almost invariably preceded by HIV testing and
counseling (HTC). Given low uptake of HTC in young men in some settings, there is a need
to better link adolescent VMMC with interventions to encourage healthy behaviors
including regular HIV testing.

Special Considerations

Most of the research on biomedical interventions has been conducted in adults, partly due to
the ethical complexities of research in minors. Although there is increasing recognition of
the importance of engaging children and adolescents in research, there remain ethical, legal
and logistical challenges (41, 42). Inclusion of minors in clinical research is governed by
ethical principles that vary globally, but generally consider need, risk, benefit, and
consent (43, 44). Who consents for adolescent involvement is typically governed by the age
of majority by state and/or country with some exceptions. There are also important
considerations of appropriate timing of adolescent involvement in research of the clinical
development of a product or intervention. Excluding adolescents from these studies may
delay access to prevention interventions. It is essential that biomedical prevention
interventions be implemented with better understanding of behavioral and contextual factors
that impede uptake and adherence. Clearer guidance around safety bridging studies, and
when extrapolation to adolescents is acceptable versus when efficacy and/or effectiveness
should be demonstrated, is vital for newly developed biomedical interventions (45).

Behavioral Interventions

Behavioral interventions have been used with the aim of reducing risk for HIV by delaying
sexual debut, promoting condom use, and/or reducing concurrency, partner change, or
substance use. Numerous behavioral interventions have been evaluated; however, few have
HIV endpoints and those that have, have not shown a reduction in HIV incidence (46-48).
The US Centers for Disease Control and Prevention (CDC) has identified interventions with
good or best evidence for HIV risk-reduction based on their impact on proximate
determinants of incidence (49). However, there is the need for critical consideration of the
role of these interventions in high prevalence settings. Interventions offered in group
settings, such as schools, may be most feasible in resource-constrained environments.

Schools are often used to deliver behavioral interventions because they reach a large number
of youth, often prior to sexual debut. Of the three published adolescent HIV prevention
RCTs conducted with HIV incidence endpoints, two have been school-based (50-52). None
of the studies found an impact on HIV and results were mixed for sexual behavior. Overall,
those with greatest success were curriculum-based, adult-led, and followed specific
guidelines (‘Kirby characteristics’) (53, 54). Combining modalities to deliver biomedical interventions, such as HCT, in schools may lead to greater program uptake.

Understanding the larger context of behavioral interventions is critical to their success(55). Many school-based interventions were implemented in settings where massive gender and power inequities may undermine programs’ success (51). Further, issues related to proper intervention implementation and fidelity likely compromised efficacy (56).

There is increasing emphasis on addressing prevention issues with HIV-infected individuals. Positive health dignity and prevention interventions (PHDP) help people living with HIV lead complete and healthy lives and reduce HIV transmission. PHDP involves systematic delivery of a range of combination, behavioral, and sociocultural services within local communities (57). Although the core components of PHDP have been defined, evidence is required to tailor these for use with adolescents in diverse settings and evaluate cost effectiveness.

**Structural/Contextual Interventions**

At the structural and contextual level, important drivers of adolescent risk are poverty, discrimination, gender and power inequities, stigma, and environments that are not youth-friendly (48, 58). Few interventions address these structural factors. Given the high prevalence of rape in SSA (59), and that HIV transmission in the context of gender-based violence is common (60), we must examine approaches that tackle HIV prevention within the broader context of gender inequity.

Structural barriers to accessing care need to be addressed for adolescents. Youth-friendly reproductive health services can attract and retain youth in care (61). Health facilities that are successful in making services more adolescent-friendly have consistently included provider training and community activities (54). Given the central role of HTC and biomedical interventions in the prevention landscape, we need to identify the successes of reproductive health services and adapt and/or integrate HIV prevention in these services. Models for youth-friendly services offering testing have been developed (62-64); however, adolescents’ uptake of HTC is not well understood. Research to explore how to increase HTC uptake, disclosure of serostatus, and linkages to prevention (e.g. PrEP) and care (e.g. TasP) is required.

It is critical to address limited education and poverty that increase risk for HIV infection (65-68). A recent trial among young women in Malawi showed cash transfers lowered HIV and HSV-2 prevalence and demonstrated positive changes in age of sex partner and frequency of sex acts (69). Providing cash to young women may have allowed them to change partnership characteristics, reducing their risk of HIV infection; however, the mechanism through which such programs work is still unclear. Several large RCTs examining cash transfers with HIV incidence endpoints are currently underway and may help identify the mechanism of action of such interventions (70, 71). There is a need to explore a range of interventions to reduce poverty and improve the financial independence of young people.

Other structural approaches that change social norms through media campaigns or community mobilization can reach large numbers of adolescents. Messages that target larger audiences and work to reinforce HIV prevention and care messages play a key role in normalizing HIV testing and uptake of newer prevention technologies (72). The role of community mobilization to increase uptake of HTC or VMMC is promising, yet understudied. Ultimately, interventions combining multiple strategies with sufficient community coverage are likely to have greatest impact.

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Youth are the greatest users of Internet and mobile devices globally (73, 74), with high usage reported even in developing countries (75)(76). Use of such methods should easily and cost-effectively reach a large youth population using this medium and develop tailored programs to make messages relevant to each recipient (77). Early computer-based interventions showed potential to improve sexual health outcomes for youth (78-80). Current interventions are harnessing the interactive power of social media sites like Facebook and Twitter with promising results (81)(82, 83). Mobile phones can also be used as a platform to deliver preventive interventions (84, 85), or to improve adherence to ART (86). There is a need for rigorously evaluated interventions that effectively link technology to clinic-based efforts to foster safer sexual health behaviors and treatment adherence (77).

Conclusions

Despite the high risk of HIV transmission among young people, few rigorously designed prevention interventions with HIV endpoints have been evaluated. Many interventions focus on changing individual-level behaviors rather than addressing the larger contextual and structural landscape within which young people live. Further, few studies have explored the use of biomedical interventions among young people. While biomedical prevention offers considerable promise, further research is needed to determine the applicability, safety and efficacy of these approaches among youth. The factors affecting HIV risk are complex and will require a combination approach incorporating a supportive behavioral, structural and/or biomedical intervention. Developing a prevention menu where adolescents, depending on their phase of transition and sexual activity, may tailor their individual prevention package, would represent a major advance in preventing HIV among youth.

Acknowledgments

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## Table 1
### HIV Prevention Research Gaps for Adolescents

<table>
<thead>
<tr>
<th>Area</th>
<th>Knowledge Gap</th>
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| Biomedical    | • Methods to enhance monitoring and measurement of adherence to biomedical interventions  
• Interventions to enhance adherence to biomedical interventions  
• Acceptability and safety of biomedical interventions  
• How to enhance uptake of biomedical interventions among adolescents who will benefit from them  
• How adolescents choose biomedical prevention interventions  
• How fertility desires and intentions affect uptake and acceptability of biomedical interventions  
• How sero-status of a couple affects uptake and acceptability of biomedical interventions  
• Social marketing of biomedical interventions.  |
| Behavioral    | • Undertaking formative work to develop culturally appropriate behavioral interventions rather than adapting those based on western psychological models  
• Understanding how to maintain intervention effects overtime (durability of effect)  
• Understanding sexual relationship patterns (i.e., longitudinal partnership formation, types of partners, frequency of sex)  
• Methods to obtain valid self-reported risk behaviors and risk perception  
• How to best use new technologies and media for prevention and care  
• Partner level interventions- Ability to identify main sexual partners and engage in interventions or refer for care  
• Adaptation and extension of best-evidence interventions in the US to high-prevalence settings |
| Structural    | • How to effectively and acceptably integrate HIV prevention with other youth friendly services  
• Role of school health in HIV prevention  
• Structural barriers to HTC and linkage to care  
• HTC models and methodologies  
• Integrated sexual and reproductive health packages  
• Socio-economic interventions  
• Interventions that address gender inequity/GBV  
• Community mobilization to increase uptake of HIV prevention  
• Utilization of technology (e.g., cell phones or computer) in interventions |
| Positive Prevention | • Enhancing linkage and retention to care  
• Greater understanding of the treatment cascade in adolescents  
• Interventions to assist with disclosure  
• Integrated reproductive health services, in particular contraception and PMTCT  
• How best to support the transition from pediatric to adult services  
• How to tailor clinical services and monitoring for adolescents |
| Ethico-legal   | • Licensure for biomedicals- efficacy or extrapolation and safety  
• Age to roll down to and when in the licensure pathway |
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<tr>
<td></td>
<td>• Issues of consent and consent waiver</td>
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| Cross-cutting Practice/Research | • Translating interventions from theory/formative research to practice-implementation science  
|                              | • Cost-effectiveness                                                           |
|                              | • Modeling of effect sizes and potential impact of various interventions       |
|                              | • Combination prevention interventions                                         |