

AMBULATORY CARE OF HIV-INFECTED ADOLESCENTS

Editor's Note

Please note that this chapter is currently under revision. In an attempt to disseminate updated information as soon as possible, we are posting updates to the immunization sections, Section VI: Immunizations, and Appendix D: Information for Immunizing Adolescents and Young Adults 13 to 24 Years of Age, in advance of the rest of the chapter. Please check back for further updates.

What's New — January 2010 Update

Section VI: Immunizations

Appendix D: Information for Immunizing Adolescents and Young Adults 13 to 24 Years of Age
--

I. INTRODUCTION

December 2004 - Under Revision

The American Academy of Pediatrics defines adolescence as 13 to 21 years of age. The recommendations in this chapter pertain to both adolescents and young adults because many adolescent clinicians follow patients from 13 to 24 years of age.

The epidemiology of HIV infection and AIDS in the adolescent population in New York State reveals a diverse population that requires a wide range of expertise to provide specialized primary medical, mental health, and case management services. The adolescents that comprise this population include both perinatally infected adolescents and adolescents infected through high-risk sexual or drug-using behaviors; straight, gay, lesbian, bisexual, and transgender adolescents; pregnant and/or parenting adolescents; adolescents in school and not in school; domiciled and homeless adolescents; and substance-using and non-substance-using adolescents. The actual seroprevalence of HIV infection in adolescents in New York State is currently unknown.

In the United States, it is estimated that the incidence of new infections among male and female adolescents is approximately equal. Heterosexual transmission is predominant in female patients, whereas same-sex transmission is predominant in male patients. Although intravenous drug use is a risk factor among adolescents, few adolescent intravenous drug users with HIV present for care. Racial minorities are disproportionately represented.¹

New York City AIDS surveillance data through March 2000 show that 12% of all adult cases are in the 20- to 29-year-old population (n = 14,669).² Given the clinical latency of HIV disease from the time of initial infection until the time of AIDS diagnosis, most persons in this age range would likely have been infected with HIV as adolescents.

With the improvements in AIDS survival rates in recent years, the growing population of long-term survivors of perinatal HIV infection reaching adolescence adds to the diversity of the adolescent HIV-infected population in New York State. In New York City through March 2000, perinatal infection was identified in 12.6% of all reported AIDS cases in the 13- to 19-year-old population (n = 54). However, given the decrease in the number of both HIV-exposed newborns in New York starting in the early 1990s and decreased HIV perinatal transmission rates in recent years, it is expected that, within 10 years, fewer adolescents with perinatal HIV infection will be identified.^{2,3}

II. IDENTIFICATION OF HIV-INFECTED ADOLESCENTS

December 2004 - Under Revision

RECOMMENDATIONS:

Clinicians should provide HIV counseling for all adolescents and recommend HIV testing to sexually active adolescents when they present for care.

Clinicians should obtain a sexual risk history at the annual physical examination.

Clinicians should assess risk issues, including sexual activity and substance use, as well as home environment, history of violence, involvement in foster care, family history, and school, for those in care or undergoing HIV pre- and post-test counseling. Questions regarding physical and sexual abuse, sexual assault, and suicidal ideation, gestures, or attempts should be asked.

An adolescent who exhibits symptoms of major depression or symptoms of other severe psychiatric disorders during pre-test counseling should be referred immediately for mental health services. If there is an acute risk of suicidal behavior, HIV testing should be deferred until the risk has been appropriately addressed.

Clinicians should be knowledgeable about New York State laws pertaining to adolescent consent and confidentiality and should educate their patients about these laws. For more information on a minor's rights regarding consent and confidentiality, refer to Appendix A.

Clinicians who care for HIV-infected youths should develop referral agreements with testing sites where youths are initially diagnosed with HIV disease.

The clinician should identify a supportive adult to whom the adolescent can safely disclose HIV-related information.

In New York State, a minor's right to consent for or refuse HIV testing is based on his/her capacity to understand what an HIV antibody test actually tests for, the implications and consequences of being HIV infected, and why he/she is at risk for HIV. The minor's ability to understand is of more significance than chronological age. More information can be found in the New York Civil Liberties Union's *Teenagers Health Care & the Law: A Guide to the Law on Minors' Rights in New York*⁴ and in *Comprehensive Adolescent Health Care*.⁵

Clinicians working with adolescents should be familiar with the broad variety of issues involved in identifying cases of HIV infection in this age group and should have linkages with organizations that perform outreach counseling and testing for the purposes of case finding.

Because most youths initially test positive for HIV infection in a setting where comprehensive medical services are not provided [e.g., Health Department test sites, mobile testing vans, sexually transmitted infection (STI) clinics], the linkage to HIV care is an essential component in the continuum of care. Clinicians seeking to link the highest-risk youths to care should develop referral agreements with community-based organizations with marginalized youth populations at high risk for HIV infection, such as homeless youths, drug-using youths, pregnant adolescent girls, and gay youths. Referral agreements with local health department HIV counseling and testing sites are also an important component of an effective referral network for HIV-infected youths.

A supportive adult to whom the adolescent can safely disclose HIV-related information should be identified. The medical team should encourage the adolescent to keep this person involved in discussions concerning his/her care and other related issues. This person does not need to be a parent or legal guardian.

An adolescent who exhibits symptoms of major depression or symptoms of other severe psychiatric disorders during pre-test counseling should be referred immediately for mental health services. A number of depression screening tools are now available to facilitate identification of severely depressed youth. Please refer to the [Mental Health Guidelines](#) for more information.

III. BASELINE MEDICAL HISTORY OF HIV-INFECTED ADOLESCENTS

December 2004 - Under Revision

RECOMMENDATIONS:

During baseline visits, clinicians should obtain a complete medical history (see Table 1).

The sexual history of a sexually active adolescent patient should focus on risk assessment, including the number of recent sexual partners, whether the patient currently has any sexual partners, and, if so, whether or not there are multiple partners or one stable partner. Clinicians should offer assistance with partner notification if needed.

Youths should be informed of the New York State Partner Notification Law as it pertains to HIV-infected individuals during HIV pre-test counseling and prior to obtaining consent for testing (see Appendix B). Providers should also offer assistance in disclosing HIV status to partners.

**TABLE 1
ELEMENTS OF A BASELINE HISTORY FOR HIV-INFECTED ADOLESCENTS**

Reason for referral

Reason for choosing to have an HIV test or length of time that the adolescent has been aware of his/her HIV status and has been in care.

Assessment of current HIV-related symptoms. The clinician should also identify symptoms that might suggest acute HIV infection.

Past medical history, including major and childhood illnesses, medications, psychiatric history, hospitalizations, allergies, immunizations, and history of tuberculosis (TB) or TB exposure.

Sources of past medical care

Review of systems, including menstrual history

Growth and development

Social history

- Living situation
- Sources of emotional and social support, including social service agencies and counselors and, if relevant, persons who know of HIV status; identification of a supportive adult with whom adolescent can disclose and discuss HIV-related information
- Family medical and psychological history, including access to health care and custody arrangements
- Peer relationships
- Education, learning disabilities
- Employment status
- History of violence
- Legal status (emancipated^a)
- Legal problems
- Citizenship, immigration status

Sexual history

- Age at initiation of sexual intercourse
- Pattern of sexual relationships, number and gender(s) of sexual partners
- Sexual practices (oral, anal, vaginal)
- Disclosure to partner(s) of known HIV status^b
- Contraceptive history and current practices, specifying frequency and condom use
- Self-assessment of safer sex practices
- Pregnancy history
- Sexual abuse (personal or family)
- STIs

continues...

Tobacco use history

Substance use history, history of use and abuse of alcohol, marijuana (THC), cocaine, crack, methamphetamines, ecstasy, opiates, steroids, hormones, and other substances, including identification of type, route, specifying injection history—amount, frequency, and treatment history

Dietary history

^a In New York State, examples of when a minor might be considered emancipated are as follows: if he/she is married, he/she is in the armed forces, he/she has established a home and is financially independent.

^b If HIV status has not yet been disclosed to partner(s), the clinician should offer assistance with partner disclosure.

Although clinicians may obtain all the elements of a comprehensive history over the first few visits to the clinic, it is important to address the issue of sexuality during the initial clinical encounter. Clinicians should note that although the patient may choose not to disclose all pertinent personal information during the first visit, an empathetic and non-judgmental attitude can help establish the therapeutic bond and trust necessary to facilitate discussion of sensitive issues. It is also important to stress the confidential nature of the interaction. Patient disclosures of these issues should be at the time when the patient feels safest and most comfortable to do so. When talking about sexual issues, embarrassment can be bi-directional; clinicians should be aware of their own discomfort related to specific sexual issues before the initial patient interactions occur.

While obtaining the sexual history of a sexually active adolescent patient, clinicians should focus on risk behaviors. Labels to which the patient may not relate, such as lesbian, homosexual, or gay, should be avoided. Questions should relate to the patient's behavior and not to "sexual identity." Information regarding types of behavior is more useful to the clinician and less threatening to many at-risk patients. For example, when talking to an adolescent male patient, the clinician should ask: *Do you have sex with other males?* and not *Are you a homosexual?* or even *Are you gay?*, because the patient may not identify with the labeled words homosexual or gay. Clinicians should regard adolescent men who have sex with men (MSM) as a heterogeneous group.

The purpose of the sexual history and risk behavior assessment is to enable the clinician to provide appropriate risk reduction education, including a discussion of safer sex practices. The intention of this counseling is to prevent further HIV transmission as well as the possible acquisition of resistant HIV. Clinicians should offer assistance with partner notification if needed.

IV. BASELINE PHYSICAL EXAMINATION FOR HIV-INFECTED ADOLESCENTS

December 2004 - Under Revision

RECOMMENDATIONS:

During baseline visits, the clinician should perform a full physical examination with emphasis on HIV-associated manifestations (see Table 2). The examination should include an external genital, breast, and axilla examination using the Tanner rating scale for sexual maturity and perianal inspection of male and female patients. A pelvic examination including STI screening is indicated for female patients who have had sexual intercourse, ask for a pelvic examination, or have an unexplained gynecologic problem.

A mental status examination should be performed, which includes assessment of general mood, depression, suicidal ideation and attempts, and an abbreviated examination for cognitive function. Refer to [Mental Health Care for People With HIV Infection](#) for further guidance.⁶

TABLE 2 HIV-SPECIFIC ELEMENTS OF A COMPREHENSIVE PHYSICAL EXAMINATION FOR HIV-INFECTED ADOLESCENTS	
Vital signs, including assessment of pain	
Dermatologic examination	
- Examine for all skin conditions, including the following:	
• seborrheic dermatitis	• psoriasis
• maceration of the gluteal cleft	• Kaposi's sarcoma
• molluscum contagiosum	• onychomycosis
• diffuse folliculitis with pruritus	
Lymph node examination	
- Examine for the following:	
• supraclavicular and axillary nodes	• clusters of large nodes
• asymmetric nodes	• sudden increase in size or firmness of node
Funduscopy examination	
- Examine for the following:	
• cytomegalovirus retinitis	• HIV-related retinopathy
Oral examination	
- Examine for the following:	
• oral candidiasis (thrush)	• hairy leukoplakia
• Kaposi's sarcoma	• gingival disease
• aphthous ulcers	• periodontal disease
• oral herpes simplex	
	<i>continues...</i>

Chest examination

- Examine for the following:
 - heart rhythm
 - heart murmur, click, or rub
 - lung fields for wheezes, rhonchi, rales, or dullness

Abdominal examination

- Examine for the following:
 - hepatosplenomegaly
 - increased visceral fat
 - multiple lipomata in the subcutaneous fat

Genital examination

- Examine for the following in both males and females:
 - venereal warts (HPV)
 - classic and atypical herpes simplex virus (HSV)
 - ulcerative genital disease
- Perform a careful pelvic examination and Papanicolaou (Pap) test in females
- Assess sexual maturity according to Tanner scale

Rectal examination

- Rectal examination for visible anal lesions or evidence of skin abnormality around the anus
- Consider obtaining an anal Pap test in men and women with visible anal lesions or evidence of skin abnormality around the anus

Neurologic examination

- Examine for sensory and motor abnormalities, cerebellar function
- Mental status examination, including cognitive assessment, orientation, registration and recall, attention/calculation, and language (naming, repetition, command)
- Screen for depression and anxiety

V. BASELINE LABORATORY EVALUATION

December 2004 - Under Revision

RECOMMENDATIONS:

When performing laboratory tests for HIV-infected adolescents, clinicians should follow guidelines for adults.^{7,8}

Clinicians should perform baseline laboratory tests for HIV-infected adolescents which include immunologic and virologic assessment, evaluation for tuberculosis, STI screening, hepatitis antibody panels, and other baseline tests listed in Table 3.

TABLE 3
BASELINE LABORATORY TESTS FOR HIV-INFECTED ADOLESCENTS

HIV antibody test

Retesting should be provided if written documentation of the positive test result or detectable viral load is not available, if an initial positive test has not yet been confirmed, or if the patient requests it

Immunologic assessment

CD4 lymphocyte count, both absolute count and percentage; to produce reliable results, the same testing laboratory should be used consistently

Virologic assessment

- Quantitative HIV-RNA testing for viral load assessment (performed twice using the same testing method)
- Genotypic resistance testing should be performed 1) prior to initiating treatment in ARV therapy-naïve patients to determine whether they were infected with drug-resistant virus, and 2) in patients experiencing virologic failure or incomplete viral suppression while receiving ARV therapy

Tuberculosis evaluation

- PPD skin test, 5TU (not necessary for a patient with a known positive or previously documented TB)
- Chest x-ray if PPD is positive

Additional baseline tests

- Urinalysis
- Complete blood count (CBC), including differential
- Serum liver enzymes, creatinine, blood urea nitrogen (BUN), total protein, and albumin
- *Toxoplasma gondii* antibody screening
- Hepatitis A antibody screening for men who have sex with men, injecting drug users, those from an endemic area, and those with liver disease
- Hepatitis B antibody screening
- Hepatitis C antibody screening
- Varicella antibody screening
- Serum CPK, amylase and lipase, cholesterol levels, and triglycerides (if not initiating ARV treatment, these tests can be deferred)

Tests for sexually active adolescents^a

- Cervical Pap test^b
- Culture or DNA amplification test for gonorrhea (depending on the sexual behaviors reported or suspected, oral and anal cultures may be indicated, as well as cervical or urethral cultures)
- RPR or VDRL for syphilis with verification of positive test by confirmatory FTA-Abs or MHA-TP
- Immunofluorescence or DNA amplification test for chlamydia
- Wet preparation for trichomonads, clue cells, and leukocytes
- Herpes simplex virus cultures as indicated
- KOH preparation for "whiff" test and *Candida hyphae*
- Pregnancy test as indicated

continues...

^a STI screening is equally important for both male and female adolescents.

^b The NYSDOH AI recommends that Pap tests be performed at least annually in HIV-infected women as long as the results are normal. Women with abnormal Pap tests should receive more frequent follow-up, with repeated Pap tests every 3 to 6 months until there have been two successive normal Pap tests.^{9,10} The Centers for Disease Control and Prevention (CDC) and the Agency for Health Care Policy recommend that HIV-infected women receive a gynecological evaluation with pelvic examination and Pap test, a repeat examination at 6 months, and then annually thereafter.¹¹ The American College of Obstetrics and Gynecology (ACOG) recommends Pap test every 6 months for HIV-infected women.¹²

For patients with abnormal Pap test, colposcopy during follow-up examination should be performed. Active STIs should receive appropriate follow-up treatment.

VI. IMMUNIZATIONS

Updated January 2010

Immunizations against infectious diseases are an important component of care for all patients, including those with immune suppression. Concerns regarding vaccinations in HIV-infected individuals include:

- An increased risk of adverse effects from live virus vaccines
- Insufficient response to vaccine in immunocompromised patients

In general, the more intact the immune system is, the more effective and safe the vaccines are. Live virus vaccines are generally used when an inactivated version does not exist and when the risk of the disease clearly outweighs the theoretical risk of vaccination. Table 4 lists recommended immunizations for non-pregnant HIV-infected adolescents.

For more information regarding immunizations, including immunizations for pregnant HIV-infected women, refer to the [HIV Prevention Guidelines: Prevention of Secondary Diseases](#) and Appendix D. Additional information about vaccines and specific CDC recommendations are available at: www.cdc.gov/vaccines

TABLE 4
RECOMMENDED IMMUNIZATIONS FOR ADOLESCENTS AND YOUNG ADULTS
13 TO 24 YEARS OF AGE^a

Vaccine	Indications	Schedule
Tetanus, Diphtheria, and Pertussis	For all patients	<ul style="list-style-type: none"> • <u>Patients who have not received the primary series:</u> Administer 1 dose of Tdap (tetanus and diphtheria toxoids and acellular pertussis), followed by a dose of Td (tetanus and diphtheria toxoids) at 1 month, and another dose of Td 6 months later • <u>For young adolescents who have already received the primary series, except for the 11- to 12-year-old Td booster:</u> Administer 1 dose of Tdap • <u>For older adolescents who have already received the primary series, including the 11- to 12-year-old Td booster:</u> Administer 1 dose of Tdap at 16-17 years of age
Human Papillomavirus (HPV)	For female patients between the ages of 9 and 26 years ^b	Administer 3 doses (at 0, 2, and 6 months) if not previously immunized
Meningococcal	For all patients	Administer 1 dose of meningococcal conjugate vaccine (MCV4) if not previously immunized with MCV4
Pneumococcal polysaccharide	For all patients	Administer 1 dose, followed by one revaccination after 5 years
Influenza^c	For all patients	<ul style="list-style-type: none"> • Administer 1 annual dose of inactivated vaccine intramuscularly • <i>Do not use intranasal live attenuated vaccine (FluMist) for HIV-infected patients, although it may be used in non-infected household contacts</i>
Hepatitis A	For all patients	Administer 2 doses (0 and 6-12 months) if not previously immunized.
Hepatitis B	For all patients	Administer 3 doses (0, 1 to 2, and 6 months) if not previously immunized and neither HBsAg-positive (HBV carrier) nor HBsAb-positive (immune to HBV); test for HBsAb response 1-2 months after last vaccine dose; if HBsAb is not protective (<10 mIU/mL), repeat 3 dose series
Inactivated Poliovirus	For patients who were not previously immunized	Administer 3-dose IPV series (0, 1, and 2 months) <i>continues...</i>

Measles, Mumps, Rubella (MMR)	For patients who were not previously immunized and who are not severely immunosuppressed (defined as CD4 count of <200 cells/mm ³ or <15%)	<ul style="list-style-type: none"> • Administer 2 doses >1 month apart to non-severely immunosuppressed patients who have not been immunized • Administer 1 dose to non-severely immunosuppressed patients who have not yet received a second dose • <i>Do not administer MMR vaccine to patients with severe immunosuppression (CD4 count of <200 cells/mm³ or <15%)</i>
Varicella	For patients who were not previously immunized and who are not severely immunosuppressed (defined as CD4 count of <200 cells/mm ³ or <15%)	<ul style="list-style-type: none"> • Administer 2 doses >1 month apart to non-severely immunosuppressed patients who have not been immunized • Administer 1 dose to non-severely immunosuppressed patients who have not yet received a second dose • <i>Do not administer varicella vaccine to patients with severe immunosuppression (CD4 counts of <200 cells/mm³ or <15%)</i>
<p>^a Appendix D provides detailed information regarding these vaccines. Information about other vaccines, as well as the Vaccine Injury Compensation Program, is available at: www.cdc.gov/vaccines</p> <p>^b The Food and Drug Administration (FDA) has approved the HPV vaccine Gardasil for use in boys and men 9 to 26 years of age. A recommendation regarding vaccination for HIV-infected boys and men is currently under consideration by the Committee for the Care of Children and Adolescents With HIV Infection and is not yet addressed in these guidelines.</p> <p>^c Up-to-date information regarding H1N1 influenza can be accessed at: www.hivguidelines.org/Module.aspx?moduleID=239</p>		

VII. TREATMENT: HIGHLY ACTIVE ANTIRETROVIRAL THERAPY

December 2004 - Under Revision

RECOMMENDATIONS:

The clinician should educate the adolescent about ARV therapy and seek to make the adolescent a “partner” in the decision-making process.

The clinician should assess a youth’s readiness to start and ability to adhere to treatment prior to dispensing any medications.

Decisions pertaining to ARV therapy should be weighed against clinical factors (e.g., CD4 count, viral load, and HIV-related symptoms) as well as non-clinical factors (e.g., living environment, mental health, HIV disclosure to others, pregnancy, and health beliefs).

Adolescents beginning ARV therapy should be seen at least 1 month after starting therapy to monitor adherence, toxicity, and proper dosing.

For adolescents, medical interventions may include a range of current prophylactic, therapeutic, and ARV treatments for HIV-related infections and illnesses. The dosage, route of administration, and duration of treatment may differ from those for young children. As a general guideline, adolescents in Tanner growth stage I, II, or III should be started on pediatric dose schedules and those in Tanner stage IV or V on adult schedules. Adolescents in Tanner stages I, II, or III should be monitored particularly carefully because they are in the midst of growth-spurt hormonal changes. Adolescents who are pregnant should receive ARV therapy to treat their disease and prevent perinatal transmission in the same manner as adult women. For further information, refer to the New York State Department of Health AIDS Institute's *Management of HIV-Infected Pregnant Women Including Prevention of Perinatal HIV Transmission*.¹³

Some adolescents may need to be seen sooner than 1 month after starting therapy (i.e., 1 or 2 weeks after beginning therapy) to monitor adherence, toxicity, and proper dosing. As the regimen may be complicated, the adolescent may need further guidance in taking the medication properly and may need additional and earlier support during the initiation of treatment. Some patients may benefit from the use of surrogate pills (e.g., large vitamin pills) as a training regimen prior to starting the antiretroviral regimen.

When starting ARV medications with an adolescent, many clinicians recommend using regimens with a low number of pills and a low frequency of administration. Combination pills, such as Combivir and Kaletra, work well with adolescents for this reason. When possible, drugs should be prescribed on daily or twice daily dosing schedules. Because an adolescent's ability to adhere is often a major concern, Combivir in combination with non-nucleoside reverse transcriptase inhibitors (NNRTIs) (e.g., nevirapine or efavirenz) works well with adolescents because of the low pill burden and easy dosing schedules. Recommendation of this combination should be balanced with clinical factors, such as CD4 count and viral load as well as concerns that poor adherence will lead to resistance to this class of medications. Efavirenz is contraindicated in pregnant women because teratogenicity studies resulted in congenital anomalies in 3 of 20 monkeys with *in utero* exposure to it. A recent case report of a neural tube defect in an infant exposed to it during only the first 4.5 weeks of gestation highlights the need for caution when prescribing efavirenz to women of childbearing capacity. Adolescent girls should be informed of the possible risk to an unborn fetus and should be strongly advised to use effective birth control or an alternative medication should be prescribed.

For further information about ARV therapy, refer to the New York State Department of Health AIDS Institute guidelines and the federal guidelines.^{7,8,14}

VIII. TREATMENT ADHERENCE

December 2004 - Under Revision

RECOMMENDATIONS:

Prior to offering medications, the clinician should educate the adolescent about ARV medications and how they work.

Once an adolescent has initiated ARV therapy, the clinician should assess treatment adherence at routine visits.

Clinicians should become familiar with the availability of treatment adherence services in their area and should use them when appropriate.

For psychosocial reasons, many adolescents may not be initially ready or will refuse to start ARV therapy despite clinical indicators, such as low CD4 counts and high viral load. Some adolescents will initially be more successful in adhering to opportunistic infections (OI) prophylaxis and only later accept ARV therapy. The ability to successfully engage an adolescent in a dialogue about ARV therapy requires that the clinician addresses the complexities of the psychosocial issues the adolescent faces in his/her daily existence.

Some adolescents may require frequent clinic visits to monitor adherence. Modalities to improve treatment adherence in adolescents include message beepers, medication alarms, and peer support groups. Many private pharmacies and visiting nurse agencies provide treatment adherence support as well.

IX. ONGOING MEDICAL EVALUATIONS

December 2004 - Under Revision

RECOMMENDATIONS:

Adolescents should receive a comprehensive annual examination including a complete physical examination.

Adolescents should be seen for routine visits at least every 3 months. An interim history of HIV-related symptoms, ongoing risk behaviors, and psychosocial issues should be obtained during each routine visit.

Laboratory evaluations should occur on a routine basis as defined in Table 5.

The clinician should regularly discuss birth control, safe sex, and partner disclosure with patients, and should offer to assist with partner disclosure.

When ARV therapy is indicated but the youth chooses not to accept it, each routine visit should be viewed as an opportunity to review treatment options.

Routine laboratory evaluations should include CD4 counts, viral load testing, complete blood counts (CBC) with differential, expanded serum chemistries (to include serum liver enzymes, total protein/albumin), syphilis serology screening, and urinalysis (see Table 5). If a significant change in CD4 is noted, the test should be repeated for confirmation. Viral loads may be elevated after an acute illness or immunization; therefore, caution should be taken when interpreting results from a sample that is obtained after an acute illness or a vaccination. Pregnancy tests should be considered for all sexually active female patients.

An assessment of treatment adherence to previously prescribed medications should be performed. Treatment education should be repeated prior to writing any prescriptions.

TABLE 5 ONGOING LABORATORY TESTS
<p>Immunologic assessment (every 3 to 4 months) CD4 lymphocyte count and percentage; to produce reliable results, the same testing laboratory should be used</p> <p>Virologic assessment (every 3 months) Quantitative HIV-RNA testing for viral load assessment (this should be performed more frequently if clinically indicated); the same testing method should be used. HIV genotypic/phenotypic resistance testing is indicated when treatment failure is suspected</p> <p>Tuberculosis evaluation (annually)</p> <ul style="list-style-type: none"> • PPD skin test • Chest x-ray for patients known to have a history of TB or known to be PPD positive <p>Tests for sexually active adolescents (every 6 months or if STI-related symptoms are present)</p> <ul style="list-style-type: none"> • Pap test*; colposcopy, if dysplasia is noted • Culture or DNA amplification test for gonorrhea • Immunofluorescence, or DNA amplification test for chlamydia • RPR or VDRL screening test for syphilis (at least annually) • Wet preparation for trichomonads, clue cells, and leukocytes • KOH preparation for "whiff" test and <i>Candida hyphae</i> • Pregnancy test, as indicated <p>Complete blood count (every 3 months)</p> <p>Serum creatinine, BUN, total protein, albumin (every 3 months)</p> <p>Additional ongoing tests for patients receiving ARV therapy - Serum CPK, serum liver enzymes, amylase, lipase, cholesterol levels, triglyceride</p>
<p>* The New York State Department of Health AIDS Institute recommends that a Pap test be performed at least annually in HIV-infected women, and those with a history of an abnormal Pap test should receive more frequent follow-up with repeated Pap tests at least every 6 months.^{9,10} The Centers for Disease Control and Prevention (CDC) and the Agency for Health Care Policy recommend that HIV-infected women receive a gynecological evaluation with pelvic examination and Pap test, a repeat examination at 6 months, and then annually thereafter.¹¹ The American College of Obstetrics and Gynecology (ACOG) recommends Pap test every 6 months for HIV-infected women.¹²</p>

X. ONGOING PSYCHOSOCIAL EVALUATIONS

December 2004 - Under Revision

RECOMMENDATIONS:

The clinician should play a central role in coordinating a multidisciplinary care approach for the HIV-infected adolescent.

Ongoing assessments of the adolescent's housing situation, education, family, sexual partners, safe sex practices, drug use (if applicable), and the adolescent's parenting skills (if applicable) should be integrated into the adolescent's medical care.

When making referrals to drug treatment programs, community-based organizations, and counseling and support programs, the clinician should try to identify agencies with adolescent-focused services.

Clinicians should be familiar with New York State laws pertaining to an adolescent's right to consent for certain forms of health care.^{15,16}

A multidisciplinary team should work with each adolescent and should include professionals such as nurses, nurse practitioners, physicians' assistants, psychologists, psychiatrists, social workers, and case managers who have expertise in working with adolescents.

Age-appropriate and developmentally appropriate psychosocial interventions for support and risk reduction include individual counseling, family counseling, and group therapy. Many adolescents who are HIV infected are estranged from their parents or do not want to disclose their HIV status to their families. They should be encouraged to identify a supportive adult to whom disclosure can be made.

XI. SPECIAL POPULATIONS

December 2004 - Under Revision

RECOMMENDATIONS:

Clinicians working with HIV-infected youths should develop skills to work with adolescents with special needs, including adolescents who are perinatally infected, gay, transgendered, pregnant, substance-users, and homeless.

Clinicians, whether they are pediatricians, family practitioners, or internists, should have the sensitivities and skills required to work with HIV-infected youths. These skills can be developed by establishing a relationship with an adolescent medicine specialist. Important components of adolescent medicine training and expertise include risk behaviors, chronic disease, emerging sexuality, contraception, pregnancy, mental illness, substance use, violence, and trading sex for drugs, money, or shelter. Adolescent medicine specialists can be a valuable resource for clinicians from other disciplines who want to develop their own expertise in working with adolescents.

A. Perinatally Infected Adolescents

RECOMMENDATIONS:

Perinatally infected adolescents should be assessed for HIV transmission risk behaviors regardless of their developmental stage. The interventions employed for risk reduction should be individualized for the adolescent's developmental stage.

Perinatally infected adolescents have the capacity to understand the meaning of an HIV diagnosis and should be informed of their diagnosis if disclosure has not already occurred during childhood.

The clinician should begin to shift from discussing treatment with the family/caregivers to directly discussing treatment with the perinatally infected adolescent in an age-appropriate manner.

If an adolescent makes an educated informed decision to discontinue treatment the clinician should respect that decision.

Sexuality, contraception, substance use, gynecology, and adolescent treatment adherence patterns, should be discussed.

Pediatricians caring for perinatally infected adolescents should provide or refer for certain clinical services, including gynecologic examinations, contraception/family planning, STI screening, substance use assessment and treatment, and adolescent-focused mental health services.

Perinatally infected patients do not need to be segregated from behaviorally infected youths in peer support groups, with the exception of perinatally infected patients who are developmentally delayed. Although such developmentally delayed youths may engage in the same adolescent risk behaviors as other teens, they do not mix easily with other teenagers. As a result, peer support groups for this population need to address issues relevant to these adolescents.

Disclosure and knowledge of HIV diagnosis is an essential component to the perinatally infected adolescent's care. The multiple reasons for this include issues involving medication adherence, counseling about sexuality, mental health, and ethical reasons. Many families object to informing a youth of his or her HIV status. These families should be engaged as early as possible in counseling regarding disclosure issues because lack of disclosure can have deleterious implications for the health and well-being of the non-disclosed perinatally infected adolescent.¹⁷ Many families choose to have the clinician, psychiatric support persons, and other family members present during disclosure.

Many perinatally infected adolescents have been heavily exposed to ARV medications in the past. As a result, the clinician is often faced with a patient who has exhausted all ARV treatment options. If a particular ARV treatment regimen fails, the list of available treatment options may be short. In this situation, the clinician is faced with recommending a more complicated regimen (e.g., greater pill burden, greater number of times per day taking medication) for an adolescent who may not be adherent with medications.

Some perinatally infected adolescents will request to stop ARV therapy. Such adolescents should be questioned for their reasons, and patients' families should be included in the discussion when appropriate. Reasons for requesting to stop therapy may include excessive medication and pill burden, futility of care, clinical depression, acting-out behavior, and other issues. In such circumstances, the clinician may suggest temporarily interrupting all medications until the issues can be resolved. Mental health interventions may facilitate resumption of treatment. If a perinatally infected adolescent has requested that treatment be stopped, the clinician should assess whether the adolescent understands the potential adverse consequences of this decision. If the adolescent clearly understands the consequences of his/her decision, the clinician should respect this decision, advise the adolescent that he/she may change his/her mind at any point in the future, and continue to provide routine care. The topic of restarting treatment should be addressed at future clinic visits. Clinicians may need to counsel or mediate with families in situations in which the adolescent's desire to stop treatment does not coincide with those of the parent/guardian.

B. Gay Adolescents

RECOMMENDATIONS:

Clinicians should perform a comprehensive psychosocial assessment of gay adolescents and should facilitate referrals for mental health care when indicated.¹⁸⁻²⁰

The clinician should be part of a support network for a gay adolescent who is more likely to experience feelings of alienation, rejection, and ostracism as compared to his/her same-age peers.

The clinician should be able to counsel the gay adolescent about issues of disclosure of his/her sexuality as well as his/her HIV status. If necessary, the clinician should facilitate safe disclosure to parents and other family members.

Clinicians should be able to counsel gay youths on risk reduction in a manner that is non-judgmental and is consistent with the youth's sexuality.

Clinicians should screen gay youths for sexually transmitted diseases yearly and more often if necessary.

Clinicians should be able to detect the warning signs of adolescent suicide by directly asking questions about whether patients are feeling depressed or isolated, whether they have supportive individuals to whom they can turn, and whether they have had any recent suicidal ideation or gestures.

In New York State and other epicenters of the AIDS epidemic, males having sex with other males continues to be the leading risk transmission category among adolescents infected with HIV.^{1,20} This requires clinicians to become competent in addressing gay adolescents' needs. Same-sex behavior and same-sex identity are often separate phenomena for adolescents, and many youths are unsure of sexual identity at this age. Mental health issues are at the forefront of these needs, as gay youths experience their sexuality in a developmental context and may be confused. The risk of adolescent suicide may be higher in this population, and the clinician needs to be able to detect the warning signs for this. The clinician should directly ask gay adolescents questions about whether they are feeling depressed or isolated, whether they have supportive individuals to whom they can turn, and whether they have had any recent suicidal ideation or gestures. Those assessed to be at high risk for suicide should be referred for appropriate mental health services. Referral to peer support groups for gay youths can play an invaluable role in building a supportive network.

Infections such as human papilloma virus, hepatitis A, intestinal parasites, and syphilis occur with greater frequency in males having sex with other males and require a certain level of expertise for the purposes of both detection and treatment.

More information concerning gay adolescents can be found at the following sites:

- www.glma.org
- www.glbthealth.org

C. Transgendered Adolescents

December 2004 - Under Revision

RECOMMENDATIONS:

Clinicians working with transgendered youths should be capable of addressing the specific issues associated with this population, such as mental health, gender identity, hormonal therapy, and sexuality needs.

Clinicians should obtain a gender identity assessment and inquire about hormone use in transgendered patients.

Many transgendered youths may be taking injectable hormonal therapy that has been bought on the street and may be engaging in needle-sharing practices. The risks from these behaviors are multiple, including HIV transmission, hepatitis B and C transmission, drug interactions among HIV-related medications and illicit hormones, and adverse reactions to illicit hormones that are being used in an unmonitored setting.

Clinicians should become familiar with community-based organizations that provide services to transgendered individuals.

More information concerning transgendered issues can be found at the following sites:

- www.wpath.org
- www.isna.org
- www.ifge.org

D. Pregnant Adolescents and Adolescent Parents

RECOMMENDATIONS:

Clinicians should discuss options with patients who are making decisions about carrying pregnancy to term or terminating pregnancy.

Clinicians should advise pregnant adolescents who choose to carry pregnancy to term about the benefits of ARV therapy in reducing perinatal transmission.^{12,21}

Clinicians should have referral agreements with obstetrical services that can provide care to HIV-infected women during pregnancy; however, the clinician may want to continue to be the primary care provider for the adolescent during the pregnancy (refer to the New York State Department of Health AIDS Institute's *Management of HIV-Infected Pregnant Women Including Prevention of Perinatal HIV Transmission* for further guidance¹³).

The time of pregnancy is often when heterosexually HIV-infected adolescents are identified as being HIV positive. The recommendation for the practice of universal testing of all pregnant women, either prenatally or through expedited perinatal testing,

has facilitated the identification of HIV infection in adolescent girls who become pregnant. Many HIV-infected adolescents lack the appropriate parenting skills to care for an infant or child. This situation is further complicated when an infant or child is HIV infected and may require ARV therapy. The adolescent clinician should work in conjunction with the infant's pediatrician to provide access to parenting skills training and other necessary services, including housing for these patients. Clinicians are mandated to report child abuse or poor supervision.

Treatment during adolescent pregnancy raises multiple issues and should be provided by a clinician experienced in care of HIV-infected pregnant patients.

E. Adolescent Substance Users

RECOMMENDATIONS:

Clinicians should be familiar with programs that provide drug detoxification and maintenance as therapeutic modalities.

Clinicians should be able to detect alcohol and marijuana use and should be able to provide counseling as well as referral for treatment.

Clinicians should be familiar with both harm reduction-based and abstinence-based drug treatment programs for the purposes of referral.

Clinicians should be aware of drug interactions between HIV-related medications and illicit drugs.

The clinician should develop expertise in managing substance use among HIV-infected adolescents. Clinicians need to be able to detect substance use and be able to provide counseling as well as referral for treatment. Studies reflect significant alcohol and marijuana use among HIV-infected adolescents.²² Alcohol and marijuana use, although not a direct risk for HIV transmission, may often be present in situations in which the HIV-infected adolescent may be sexually active. Intoxication from these substances impairs the adolescent's ability to negotiate condom use with partners, which not only increases the risk of pregnancy and other STIs but also increases secondary transmission of HIV infection. Youths who are known to be heavy alcohol and marijuana users also may have problems with school, employment, and personal relationships. For adolescents receiving ARV therapy, there is a risk of drug interactions among recreational drugs and ARV drugs. In addition, clinicians should be aware that methadone interacts with NNRTIs.

Substance use with "harder" drugs (e.g., nasal or crack cocaine and heroin) poses a different set of clinical issues. Obtaining these addictive drugs may cause the adolescent to become involved in criminal activity or sex for drugs. Some youths may benefit from programs that provide drug detoxification and maintenance as therapeutic modalities. Some youths may require long-term residential treatment. Clinicians should counsel intravenous drug-using youths about their options for drug treatment as well as HIV

transmission reduction and should make a serious attempt to refer these youths for drug treatment. Youths should be referred to local syringe exchange programs (see Appendix C).

F. Homeless Adolescents

RECOMMENDATION:

Clinicians should work closely with case managers and social workers to help homeless youths find appropriate housing.

Many adolescents with substance use problems are homeless and are involved in trading sex for drugs, money, or shelter (survival sex). A transient living situation will likely interfere with or greatly challenge medication adherence in an adolescent. Underlying mental health and substance use issues should be addressed as well.

XII. RESOURCES FOR CONSULTATION

December 2004 - Under Revision

Clinicians who need additional information concerning care for adolescents can refer to the following websites:

- <http://prch.org/arhepdownloads>
- www.cdc.gov/reproductivehealth/AdolescentReproHealth/index.htm
- www.aap.org/sections/adol/default.cfm
- www.ama-assn.org/ama/pub/physician-resources/public-health/promoting-healthy-lifestyles/adolescent-health.shtml

REFERENCES

1. Centers for Disease Control and Prevention. *HIV Surveillance*. June 2000.
2. New York City Department of Health AIDS Surveillance Update, First Quarter, 2000.
3. New York State Public Health Law § 2500-F.
4. Feierman J, Lieberman D, Chu Y. *Teenagers, Health Care & Law: A Guide to the Law on Minors' Rights in New York*. New York, NY: New York Civil Liberties Union Reproductive Rights Project. Available at: www.nyclu.org/files/thl.pdf
5. English A. Legal and ethical concerns. In: Friedman SB, et al., eds. *Comprehensive Adolescent Health Care*. St. Louis, MO: Mosby; 1998:109-113.
6. New York State Department of Health AIDS Institute Mental Health Guidelines Committee. *Mental Health Care for People With HIV Infection*. Albany: NYSDOH AI; 2001. Available at: <http://hivguidelines.org/Content.aspx?pageID=261>
7. New York State Department of Health AIDS Institute Medical Care Criteria Committee. *Guidelines for the Use of Antiretroviral Therapy*. In: Criteria for the Medical Care of Adults With HIV Infection. Albany: NYSDOH AI; 2003. Available at: <http://hivguidelines.org/GuideLine.aspx?pageID=257&guideLineID=10>
8. Guidelines for the Use of Antiretroviral Agents in HIV-infected Adults and Adolescents. Department of Health and Human Services and Henry J. Kaiser Family Foundation; 2002.
9. *Promoting GYN Care for HIV-infected Women: Best Practices from New York State*. New York, NY: New York State Department of Health AIDS Institute; 2000.
10. New York State Department of Health AIDS Institute Women's Health Committee. *Anogenital Neoplasia*. Albany: NYSDOH AI. In preparation.
11. Kurman RJ, Henson DE, Herbst AL, et al. Interim guidelines for management of abnormal cervical cytology: The 1992 National Cancer Institute Workshop. *JAMA* 1994;271:1866-1869.
12. American College of Obstetricians and Gynecologists. ACOG Technical Bulletin 169. June 1992:581.
13. New York State Department of Health AIDS Institute Women's Health Committee. *Management of HIV-Infected Pregnant Women Including Prevention of Perinatal HIV Transmission*. Albany: NYSDOH AI. In press.

14. New York State Department of Health AIDS Institute Committee for the Care of Children and Adolescents With HIV Infection. *Pediatric Antiretroviral Therapy*. Albany: NYSDOH AI; 2003.
15. New York State Public Health Law § 27850(5) (1993).
16. New York State Public Health Law § 2504(4) (1993).
17. American Academy of Pediatrics Committee on Pediatrics AIDS. Disclosure of illness status to children and adolescents with HIV infection. *Pediatrics* 1999;103:164-166.
18. Gionsiorek J. Mental health issues of gay and lesbian adolescents. *J Adolesc Med* 1989;9:114-122.
19. Ramafedi G. Cognitive and behavioral adaptations to HIV/AIDS among gay and bisexual adolescents. *J Adolesc Med* 1994;15:142-148.
20. Ryan C, Futterman D. *Lesbian and Gay Youth: Care and Counseling*. New York, Columbia University Press; 1998.
21. Public Health Service Task Force. Recommendations for the Use of Antiretroviral Drugs in Pregnant HIV-1-Infected Women for Maternal Health and Interventions to Reduce HIV-1 Transmission in the United States, August 30, 2002.
22. Rogers AS, Futterman DK, Moscicki AB, et al. The REACH Project of the Adolescent Medicine HIV/AIDS Research Network: Design, methods, and selected characteristics of participants. *J Adolesc Health* 1998;22:300-311.

APPENDIX A

HIV TESTING, PARTNER NOTIFICATION, AND ACCESS TO HIV CARE WHEN MINORS ARE INVOLVED

HOW INFORMED CONSENT FOR HIV TESTING, HIV PARTNER NOTIFICATION BY PNAP/CNAP, AND ACCESS TO HIV PRIMARY CARE ARE HANDLED WHEN MINORS ARE INVOLVED*

* This document can be accessed at:

www.nyhealth.gov/diseases/aids/regulations/notification/hivpartner/minorqa.htm

I. INFORMED CONSENT FOR HIV TESTING

1. Can a minor (age less than 18 years) consent to his or her own HIV test?

In New York State the capacity to consent to an HIV test (ether confidential or anonymous) is determined without regard to age. Informed consent for minors varies, depending upon the minor's situation. Situations are described below:

Infants and Very Young Children

Infants and very young children do not have the capacity to consent because they do not yet have the ability to understand or make informed decisions about the test. The person authorized pursuant to law to consent to health care for the child has the right to decide whether the child may be tested and to consent on behalf of the child. In intact families, the biological parents generally have the legal authority to consent. The consent form must be signed by one or both parents.

Foster Care

When the infant or child is in foster care, special rules apply. Consent for an HIV test must be obtained from the child's biological parents, if possible, and/or from the local Social Services Commissioner responsible for overseeing foster care placements only if the foster care child does not have the capacity to consent to an HIV test. Please note that the local commissioner does not have authority to consent to medical care for all categories of foster children. The local commissioner has a legal right to consent for children who are freed for adoption and the local commissioner is the legal guardian, abused or neglected children in accordance with §383-b of the Social Services Law, and other foster children where the parent has delegated the right to consent to the local commissioner. In New York City, the Administration for Children's Services has this responsibility. Neither the foster parents nor the foster care agency can legally give consent for an HIV test for a foster child.

Adopted Children

When a child has been adopted, the adoptive parents assume all parental rights; therefore they, not the biological parents, have legal authority to consent to health care for and HIV testing for the adopted infant or young child.

Capacity to Consent is Required and is Not Based on Age Alone

The capacity to consent is defined in the Public Health Law as the: ability, determined without regard to the individual's age, to understand and appreciate the nature and consequences of a proposed health care service, treatment, or procedure, or of a proposed disclosure of confidential HIV related information, as the case may be, and to make an informed decision concerning the service, treatment or disclosure (Public Health Law Section 2780.5).

Once a minor has the capacity to consent, he or she alone has the right to decide whether or not to be tested. An individual under age 18 may not have the capacity to consent and, thus, the right to decide whether to be tested. A medical provider ordering the test must conduct an individualized assessment of every older child's or adolescent's actual ability to understand the nature and consequences of being tested for HIV and to make informed decisions about whether to be tested.

Married Minors and Minor Parents Have the Right to Give Consent

NYS Public Health Law Section 2504(1) provides that any person, even if under the age of 18, who has married or is the parent of a child may give consent for health care for himself or herself, and the consent of no other person shall be necessary. Therefore, a minor who is married or is a parent is generally the only person who has the right to decide whether to consent to an HIV test. If a married minor or minor parent decides not to be tested, his/her parent or legal guardian generally cannot override that decision.

Pregnant Minors

NYS Public Health Law Section 2504(3) provides that any person who is pregnant may give effective consent for "medical, dental, health and hospital services relating to prenatal care." Therefore, a pregnant minor generally has the ability to provide consent for her own HIV test.

Testing a Child of Minor Parents

NYS Public Health Law Section 2504(2) provides that any person, even if under age 18, who has been married or who has borne a child may give consent for "medical, dental, health and hospital services for his or her child." The minor has the right to decide whether his or her child should undergo an HIV test.

II. HIV PARTNER NOTIFICATION BY PNAP/CNAP

2. How do PNAP/CNAP approach dealing with minors?

PNAP/CNAP's approach is to deal directly with minors, rather than their parents, unless the minors specifically indicate that they want their parents contacted.

3. How often do PNAP/CNAP notifications involve minors?

This rarely occurs. The most common interactions with minors involve youth who are somewhat independent from their parents and are voluntarily sexually active.

4. Do PNAP/CNAP automatically inform a minor's parents if their child has an STD or HIV or has been named as a contact?

No, HIV and STD partner notification do not include telling the parents. Partner notification services are confidential; therefore no parental notification occurs when a minor receives services unless the minor specifically requests that his/her parents be involved or contacted.

5. What training do PNAP/CNAP staff receive for dealing with situations involving minors?

PNAP/CNAP staff receive intensive training in how to conduct client interviews. This training includes instruction on how to communicate with and provide services to minors. During staff orientation, the potential for child abuse or maltreatment situations is discussed and staff are instructed on how to recognize situations which involve child abuse or maltreatment. PNAP/CNAP staff are trained to create an atmosphere of trust where minors are treated with respect, courtesy and professionalism.

6. What steps will be included in the testing and partner notification process to ensure that the notification of a minor or a minor's partner would not have a severe negative affect on the physical health and safety of the minor?

When a minor is the index patient or reported contact, PNAP/CNAP will work very closely with the care provider, to ensure that domestic violence screening is done and to determine the best option for notification, to ensure the safety of all parties. PNAP/CNAP staff have been trained to be particularly sensitive to cases which present the possibility of parental or partner violence.

The issue of domestic violence will be included during the informed consent process for HIV testing. It will be discussed during post-test counseling of HIV-positive clients as part of the discussion of partner notification options and before names are elicited.

Young people will be fully informed of all options available for partner notification assistance as well as all relevant provisions of the law, including rights of HIV-infected

persons. The voluntary nature of partner notification must be made clear and fears regarding reporting of the minor's name to the Health Department must be addressed. Decisions and timing regarding partner disclosure must be individualized for each young person.

Screening for risk of domestic violence will take place on a partner-by-partner basis as partner names and other locating information are elicited. This will provide the young person with an opportunity to express concerns about the potential for violence related to the notification of a specific partner, including another minor, an adult, a parent or another relative. Domestic violence screening of minors related to HIV partner notification needs to incorporate assessment of potential domestic violence from family members related to partner notification, as well as sexual and/or needle sharing partners. Potential for homelessness needs to be a component of the screening process.

Even if a minor's parent or guardian consented to the HIV test, partner elicitation and domestic violence screening should still be conducted in a private, safe, and confidential fashion without any others, including the parent or guardian, present.

7. What happens when a case involves suspected child abuse or maltreatment?

Medical providers are required, by the NYS Social Services Law, to report situations involving suspected child abuse or maltreatment, including adult sexual activity with children age 12 and younger. Most often, by the time PNAP/CNAP receives a report, the medical provider has already recognized and reported the abuse or maltreatment (see Social Services Law § 413, § 415).

8. Is there a specific age below which sex with a minor is statutory rape?

Yes, rape, including statutory rape, is defined in the NYS Penal Law as follows:

Rape in the first degree: A man is guilty of rape in the first degree when he engages in sexual intercourse with a female by forcible compulsion; or who is incapable of consent by reason of being physically helpless; or, who is less than eleven years old.

Rape in the second degree: A person is guilty of rape in the second degree when, being eighteen years old or more, he or she engages in sexual intercourse with another person less than fourteen years old to whom he/she is not married.

Rape in the third degree: A person is guilty of rape in the third degree when he/she engages in sexual intercourse with another person to whom he/she is not married who is incapable of consent by reason of some factor other than being less than seventeen years old; or, being twenty-one years old or more, he/she engages in sexual intercourse with another person to whom he/she is not married who is less than seventeen years old.

9. Are PNAP/CNAP required to report cases of suspected statutory rape to the police?

No. PNAP/CNAP are not required to report such cases to the police. They do make such reports.

III. ACCESS TO HIV PRIMARY CARE

10. Can an HIV-infected minor consent to his or her own treatment?

In general, parental or guardian consent is required for a physician to treat a minor for HIV/AIDS, including in-school-based clinics. Family planning clinics can provide only family planning related care to minors with the minors' consent. Minors who are married can consent for their care, as can minors who are pregnant/parenting (see earlier discussion of NYS Public Health Law, Section 2504).

APPENDIX B

SUMMARY – HIV REPORTING AND PARTNER NOTIFICATION

Chapter 163 of the Laws of 1998 amended Public Health Law (PHL) Article 21 ("Control of Acute Communicable Diseases") to require the reporting of persons with 1) HIV, 2) HIV-related illness and 3) AIDS by New York State physicians and other medical providers (physician assistants, nurse practitioners, midwives) who make diagnoses and by laboratories performing diagnostic tests. (Note: HIV tests performed for research purposes only are not included.) The new law also requires that the reports contain names of spouses and sexual or needle-sharing partners known to the medical provider or whom the infected person wishes to have notified.

The law reflects the recognized need, given new pharmaceuticals which delay the progression from HIV to AIDS significantly, to better track the epidemic in order to target resources and plan services appropriately. AIDS reporting alone is no longer an effective public health tool. Also, provisions requiring notification of exposed persons reflect a traditional public health intervention to limit the spread of communicable disease.

Briefly, the regulations (10 New York Code Rules and Regulations Part 63) and protocols provide that:

- Physicians, nurse practitioners, physician assistants and midwives are required to report identifying information including patient name on standard forms to the New York State Commissioner of Health, except in New York City where medical provider reports are to be sent to the New York City Department of Health and Mental Hygiene (following the established protocol for AIDS reporting which has been in effect since 1985).
- Clinical laboratories (including blood banks) will electronically report HIV tests to the New York State Department of Health Commissioner. For the purpose of the regulation, reportable HIV tests include: HIV antibody tests, HIV nucleic acid detection tests, and CD4 lymphocyte counts <500 unless such tests are known to be performed for reasons other than HIV infection/diagnosis (e.g., related to cancer monitoring). Encryption and electronic security protocols (e.g., firewall, passwords) have been put in place for these transfers.
- Medical providers complete a timely report that 1) lists sexual and needle-sharing partners known to the medical provider (e.g., spouses) or partners whom the infected person wishes to have notified, 2) indicates whether notification of these partners has already been performed, and 3) identifies whether a domestic violence screening protocol has been conducted on the patient and/or the patient's contacts. Trained public health staff (in some cases, state employees; in other cases, county/New York City health staff) may contact providers to verify information and, when appropriate, notify partners to ensure they are aware of their exposure. Such partners will be counseled and offered HIV testing. In all partner notification activities, the name of the infected person is never to be disclosed.

- Partner names will be maintained no longer than one year after case closure.
- Anonymous testing is specifically excepted from the reporting requirement; anonymous counseling and testing services will continue to be available.
- Disclosing existing HIV information in certain listed occupational settings to persons who have been exposed to blood and body fluids is permitted under the new statute and regulations [10 NYCRR § 63.8(m)]* when:
 - the exposure incident occurred to staff/employees/volunteers in their employment or professional duties in a medical/dental office or a facility regulated by DOH, OMH, OMRDD, OCFS, OASAS, DOCS, or when the exposure incident involved an emergency response employee (e.g., fire, police).
 - the incident is documented with supervisory staff.
 - a request for disclosure stating such information is necessary for decisions on treatment is made by the provider of the exposed person.
 - the exposed person is HIV negative or has consented to an HIV test him/herself; however, if the test returns positive prior to disclosure, no disclosure will occur.
 - documentation is placed in the chart of the exposed person; however, the name of the person whose HIV test result is released is not given to the exposed person.
 - the medical provider for the source of the exposure determines that a risk of transmission is likely to have occurred.

Note: This addresses disclosure of existing HIV information in a person's record. It does NOT permit testing of the source.

- Liability provisions in PHL § 2136: good-faith reporting or disclosure shall not constitute libel or slander, or violations of the right to privacy, or protections of privileged communications. Immunity is granted with respect to civil or criminal liability for any person complying in good faith with the law.
- Disclosure of partners is a voluntary activity; no criminal or civil liability arises for non-disclosure of partners by the patient.

* Although these measures address disclosure of existing HIV information in a person's record, it does NOT permit testing of the source.

More information regarding [Public Health Law](#) relating to HIV reporting and partner notification can be found at:

www.health.state.ny.us/diseases/aids/facts/questions/publichealthlaw.htm

APPENDIX C

SYRINGE EXCHANGE AND ACCESS RESOURCES

Pharmacies registered in [New York State's Expanded Syringe Access Demonstration Program](#) (ESAP) may now sell or furnish up to 10 syringes at a time to adults, 18 years or older, without a prescription. Under this program, healthcare facilities and healthcare providers (doctors and others who can prescribe syringes) may also furnish syringes.

Possession of syringes in accordance with the Public Health Law is legal. Persons legally possessing syringes are not subject to arrest or prosecution under the Penal Law.

A Directory of ESAP Providers in New York State is listed at:

www.health.state.ny.us/diseases/aids/harm_reduction/needles_syringes/esap/provdirect.htm

Information on how to find syringe exchange programs or pharmacies participating in ESAP can also be obtained by calling the New York State Department of Health HIV/AIDS Hotlines:

English: 1-800-541-AIDS (1-800-541-2437)

Spanish: 1-800-233-SIDA (1-800-233-7432)

Deaf/TDD: 1-800-369-AIDS (1-800-369-2437)

APPENDIX D

INFORMATION FOR IMMUNIZING ADOLESCENTS AND YOUNG ADULTS 13 TO 24 YEARS OF AGE

The following information is modified from DHHS/NIH/OARAC Panel on Guidelines for Prevention and Treatment of HIV-Exposed and HIV-Infected Children, available at <http://AIDSinfo.nih.gov>

Tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap)

- Administer at age 11-12 years for those who have completed the recommended childhood DTP/DTaP vaccination series and have not received a tetanus and diphtheria toxoids vaccine (Td) booster dose.
- Adolescents aged 13-18 years who missed the 11-12 year Td/Tdap booster dose should also receive a single dose of Tdap if they have completed the recommended childhood DTP/DTaP vaccination series.

Human papillomavirus vaccine (HPV) (*Minimum age: 9 years, females only*)

- Administer the first dose of the HPV vaccine series to females at age 11-12 years.
- Administer the second dose 2 months after the first dose and the third dose 6 months after the first dose.
- Administer the HPV vaccine series to females at age 13-18 years if not previously vaccinated.
- No data are available on immunogenicity, safety, and efficacy of HPV vaccine in HIV-infected patients. However, because quadrivalent HPV vaccine is a noninfectious vaccine, it can be administered to individuals who are immunosuppressed as a result of disease or medications, including HIV-infected patients. However, the immune response and vaccine efficacy might be less than that in persons who are immunocompetent. See *MMWR* 2007;56 [No. RR-2]:1-24 and *MMWR* 2006;55 [No. RR-15]:1-48. Studies are ongoing in HIV-infected patients.
- The Food and Drug Administration (FDA) has approved the HPV vaccine Gardasil for use in boys and men 9 to 26 years of age. However, because no data are available regarding HPV vaccination in HIV-infected male patients, and because the FDA approval in this population is very recent, a recommendation that addresses vaccination in the presence of HIV infection is currently under consideration for these guidelines.

Meningococcal vaccine

- Administer MCV4 at age 11-12 years and at age 13-18 years if not previously vaccinated.
- Administer MCV4 to previously unvaccinated college freshmen living in dormitories; MPSV4 is an acceptable alternative.
- Revaccination with MCV4 is indicated for children vaccinated ≥ 3 years previously with MPSV4. See *MMWR* 2005;54 [No. RR-7]:1-21.
- Patients with HIV are likely at increased risk for meningococcal disease, although not to the extent that they are at risk for invasive *S. pneumoniae* infection.

- For persons 11-18 years who were previously vaccinated with MPSV4, revaccination with MCV4 is not indicated unless vaccination occurred 3-5 years previously and the person still remains at increased risk for meningococcal disease. For revaccination recommendations, see *MMWR* 2005;54 [No. RR-7]:1-21.

Pneumococcal polysaccharide vaccine (PPV)

- If not previously vaccinated, children and adolescents aged 7-18 years should receive the 23-valent pneumococcal polysaccharide vaccine; a single revaccination with the 23-valent vaccine should be administered after 5 years (for patients >10 years of age). See *MMWR* 1997;46[No. RR-8]:1-24 and *MMWR* 2000;49[No. RR-9]:1-35.

Influenza vaccine

Influenza vaccine is recommended annually for HIV-infected children and adolescents 7-18 years and their close contacts (including household members). Only TIV should be used for HIV-infected persons.

- For healthy close contacts aged 2-49 years, live, attenuated influenza vaccine (LAIV) may be used as an alternative to TIV.

Hepatitis A vaccine (HAV)

- The 2 doses in the series should be administered at least 6 months apart.

Hepatitis B vaccine (HBV)

- Administer the 3-dose series to those who were not previously vaccinated.
- Post vaccination testing is recommended for HIV-infected persons. Testing should be performed 1-2 months after administration of the last dose of the vaccine series using a method that allows determination of a protective level of anti-HBs (≥ 10 mIU/mL). Persons found to have anti-HBs levels of < 10 mIU/mL after the primary series should be revaccinated. Administration of 3 doses on an appropriate schedule followed by anti-HBs testing 1-2 months after the 3rd dose is usually more practical than serologic testing after one or more doses of vaccine. Modified dosing regimens, including a doubling of the standard antigen dose might increase response rates. However, data addressing response to these alternative vaccination schedules are limited.
- In HIV-infected persons, the need for booster doses has not been determined. Annual anti-HBs testing and booster doses when anti-HBs levels decline to < 10 mIU/mL should be considered in persons with ongoing risk of exposure. See *MMWR* 2005:54 [No. RR-16]:1-23.

Inactivated poliovirus (IPV)

- For adolescents who received an all-IPV or all-oral poliovirus (OPV) series, a fourth dose is not necessary if the third dose was administered at age ≥ 4 years.
- If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the adolescent's current age.

Measles, mumps, and rubella vaccine (MMR)

- For patients who have not been previously vaccinated and are eligible, administer 2 doses of MMR vaccine during any visit, with ≥ 4 weeks between the doses.

- One dose of MMR vaccine should be administered to non-severely immunosuppressed patients who have not yet received a second dose.
- MMR vaccine is recommended for all asymptomatic HIV-infected adolescents who are not severely immunosuppressed (defined as CD4 count of <200 cells/mm³ or $<15\%$) and who lack evidence of measles immunity.
- MMR vaccine for symptomatic HIV-infected adolescents should be considered if they 1) do not have evidence of severe immunosuppression (defined as CD4 count of <200 cells/mm³ or $<15\%$) and 2) lack evidence of measles immunity.
- The MMRV vaccine is not licensed for use in anyone aged 13 years or older.
- MMR and other measles-containing vaccines are not recommended for HIV-infected adolescents with evidence of severe immunosuppression (defined as CD4 count of <200 cells/mm³ or $<15\%$). See *MMWR* 1998;47 [No. RR-8]:1-57, Special Considerations for Vaccination—Persons Infected with Human Immunodeficiency Virus [HIV]).

Varicella vaccine

- Data addressing use of varicella vaccine in HIV-infected children >8 years and adolescents is lacking. However, on the basis of expert opinion, the safety of varicella vaccine in HIV-infected persons aged >8 years without evidence of severe immunosuppression (defined as CD4 count of <200 cells/mm³ or $<15\%$) is likely to be similar to that of persons <8 years with similar immune function. Immunogenicity might be lower in HIV-infected adolescents (and adults); however, vaccination (2 doses administered 3 months apart) for persons 9 to 18 years without evidence of immunity may be considered when the risk of severe disease from wild-type VZV is weighed against the potential benefit of vaccination.
- The MMRV vaccine is not licensed for use in anyone aged 13 years or older and should not be substituted for single-antigen varicella vaccine.
- Varicella vaccine is not recommended for HIV-infected adolescents with evidence of severe immunosuppression (defined as CD4 count of <200 cells/mm³ or $<15\%$).
- For evidence of immunity guidance and other details, see *MMWR* 2007;56 [No. RR-4]:1-40.