

Methods: HIV infected adolescents from five clinical sites in three urban HIV epicenters were recruited as part of Adolescent Impact, an intervention trial to improve adherence and reduce risk-taking behavior in HIV infected youth. Baseline demographic, epidemiologic, clinical, and risk behavior data were collected on all patients by record review and direct in-person or computerized interviews. Patients' CDC classifications were reviewed and comparisons made by mode of transmission. Differences were measured by univariate techniques.

Results: A total of 152 patients had sufficient clinical information to determine their CDC classification and "AIDS diagnosis status". Eighty-nine (58.6%) were perinatally infected (PIY) and 63 (41.4%) behaviorally infected (BIY). More PIY had a current CD4 count below 200 cells/mm³ (22.1% vs. 8.1%, $p < 0.02$), but viral loads were similar. PIY were more likely to have previously been diagnosed with AIDS or to have had an AIDS defining illness (57.3% vs. 15.8%, $p < 0.01$) but the percentage of all AIDS diagnoses in the two groups accounted for by CD4 < 200 was 70% and 66% respectively. PIY were more likely to have been classified in "symptomatic categories" (Category "C" or Category "B") when compared to BIY (69.7% vs. 42.8%, $p < 0.01$) and were more likely to have had multiple AIDS associated or defining health conditions (42.4% vs. 16.4%, $p < 0.01$).

Conclusion: While PIY were more likely to have a previous AIDS diagnosis and lower CD4 counts, they were similar to BIY in that they had mainly met diagnostic criteria for AIDS by immunologic criteria and currently had similar viral loads. However, differences in the past health and secondary infection status of PIY versus BIY were indeed reflected in their CDC classification. Whether these differences will translate into different outcomes now that excellent therapy is widely available remains to be seen.

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30.

WHO IS RESPONSIBLE FOR PREVENTING HIV TRANSMISSION? ATTITUDES OF HIV+ AND HIV- ADOLESCENT GIRLS

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Purpose: Attitudes about responsibility for preventing HIV transmission may affect sexual risk behavior among HIV+ and HIV-negative adolescents and may have intervention implications. This study explored HIV+ and HIV- adolescent girls' beliefs about preventing HIV transmission.

Methods: A convenience sample of participants was recruited from New York City clinics treating children and adolescents who were perinatally exposed to HIV. Eligible participants were female, ages 12-16 years, knew they had been perinatally exposed to HIV, and displayed no evidence of significant cognitive impairment. Twenty-one HIV+ girls and 10 HIV- girls each participated in a semi-structured qualitative interview that assessed factors affecting their sexual behavior. Specifically, girls were asked about which partner in a sexual scenario is responsible for making sure that condoms are used, and which partner is responsible if one person is living with HIV. Audio recordings were transcribed and texts were thematically coded and analyzed.

Results: Adolescent girls living with and without HIV reported believing that both people in a sexual partnership are responsible for ensuring condom use, even if one of those people is HIV+ and the other is not. However, several nuances emerged. For example, some girls initially identified men as the responsible party, in part because they wear the male condom. Some girls acknowl-

edged their power to protect themselves with the female condom, and many girls thought it important to negotiate condom use with male partners in order to prevent sexually transmitted infection (STI) and pregnancy. Several girls with HIV discussed their primary role in preventing HIV transmission to sexual partners, while still stating that both parties are responsible. Additionally, some girls (HIV+ and HIV-) believed that girls with HIV should inform potential partners about their HIV status, but suggested that the responsibility for condoms shifts to the partners once partners know the girl is living with HIV.

Conclusions: This research suggests many adolescent girls living with HIV may identify the importance of their role in preventing HIV transmission. Girls who were perinatally exposed to HIV but are uninfected appear to acknowledge their own role in preventing HIV, STIs, and pregnancy. All girls may benefit from behavioral skills interventions that help them act on their HIV prevention motivation. Girls living with HIV may benefit from interventions that focus specifically on skills for disclosing their HIV status to sexual partners.

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31.

HOW DO ADOLESCENT BOYS LEARN ABOUT CONDOMS? A QUALITATIVE STUDY

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Purpose: While epidemiologic data tell us when adolescent boys use condoms, little is known about how boys initially learn about condoms. We examined aspects of learning, such as sources of information, attitudes, acquisition, practice, and early condom use among 14-16-year-old boys.

Methods: As part of an ongoing IRB-approved longitudinal qualitative study of relational and contextual influences on STI, 21 14-16-year-old males were recruited from a teen clinic serving a low income community with high rates of STI. Sexual activity was not a requirement for participation. Twice a year participants completed 1 hour face-to-face semi-structured interviews and provided urine for STI testing. At baseline (16 participants) and/or the second interview (5) we asked open ended questions about condoms, including, "Where did you learn about condoms?", "What are good/bad things about condoms?" and what situations did you/did you not, or would you/would you not, use condoms. Interviews were audio recorded, transcribed, and coded for all instances where condoms were mentioned. Using an open coding approach, we identified key concepts within the "condom" index code, organized these into tentative models and tested them against subsequently collected data.

Results: Participants' mean age was 14.9 years, ethnicities included African American (18), white (2), and Latino (1), and 12 were sexually experienced at baseline. Regardless of sexual experience, 14 participants said that sex feels or would feel different (less pleasurable) with condoms and 11 suggested that condoms often break; withdrawal was often offered as an alternative. No one mentioned lubricants or condom use during oral sex. Family (mostly male relatives) were the primary source of messages about condoms, and of condoms themselves. Information from family was limited to condom use and STIs, and no one described receiving information about healthy relationships or the decision to have sex in the first place (beyond abstinence). Other information sources about condom effectiveness and STI

transmission, such as schools and peers, were often considered less trustworthy or less accurate. Nine participants described “checking out” condoms (opening them, touching them) and/or practicing putting on a condom before first use. The type of relationship influenced planned and actual condom use. Participants reported consistent condom use with casual partners, and a drop-off in condom use as relationships evolved or if they perceived themselves ready for fatherhood with that partner.

Conclusions: Improved consistency and accuracy in adolescent male condom use may require addressing existing negative perceptions of condoms, the specific relationship contexts of condom use, and the developmental need to test and try on condoms before first use.

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32.

RECENT PARTNER-SPECIFIC HIV TRANSMISSION RISK FOR YOUTH LIVING WITH HIV

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Purpose: Youth experience high rates of new HIV infection and secondary transmission remains a significant concern among HIV-infected youth. Little is known, however, about risks for the secondary transmission of HIV by youth and how these risks may differ between young HIV-infected women who have sex with men (WSM) and men who have sex with men (MSM).

Methods: During 2003-2004, HIV-infected youth, 13-24 years of age, seeking care at one of 15 Adolescent Medicine Trials Network (ATN) clinical sites were recruited. Participants completed an ACASI survey including questions about sex partners in the past year. Bivariate and multivariable regressions using generalized estimating equations were conducted to compare recent partner-specific sexual risk behaviors between WSM and MSM.

Results: Of the 409 eligible and willing participants, 91% (371) were included in this analysis with 176 females and 195 males defined as WSM and MSM respectively. A total of 92% (163 WSM and 177 MSM) provided information on characteristics of sexual partners. There were significant differences between the two groups in recent partner-specific sexual risk behaviors including: higher rates of condom non use at last sex among WSM (39% WSM vs. 22% MSM; $p = 0.0011$); a larger proportion of the sex partners of MSM reported as concurrent (56% MSM vs. 36% WSM; $p = 0.0001$); greater use of hard drugs at last sex by MSM and/or their sex partner (15% MSM vs. 2% WSM; $p = 0.0003$). When analyzing these sexual risk behaviors (plus a measure of forced sex without a condom) as a composite measure of risk for the secondary transmission of HIV, a larger proportion, 75%, of partnerships of MSM (vs. 68% of WSM) were characterized as “risky”, but this difference was not statistically significant even after adjusting for index age, race, and ethnicity ($p = 0.27$).

Conclusions: Strategies must limit missed prevention opportunities for the transmission of HIV from infected youth. These data suggest that recent partner-specific risk for HIV transmission is high among young infected MSM and WSM and support population-specific interventions to limit the secondary transmission of HIV.

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33.

RESULTS OF A RANDOMIZED CONTROLLED TRIAL OF A BRIEF BEHAVIORAL INTERVENTION FOR PELVIC INFLAMMATORY DISEASE IN ADOLESCENTS

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Purpose: Centers for Disease Control and Prevention's (CDC) outpatient treatment recommendations for pelvic inflammatory disease (PID) require that the patient and provider engage in a complex set of behaviors. In 2003, we instituted a systems-level intervention aimed at improving provider diagnosis, counseling, and treatment for PID. The intervention significantly improved provider behavior but only minimally affected patient adherence behaviors (72-hour follow-up and medication completion). The objective of this research is to examine the effectiveness of a brief behavioral intervention at the time of PID diagnosis on subsequent patient adherence behaviors among urban adolescents from an STI prevalent community.

Methods: A total of 121 adolescents with mild-moderate PID were enrolled in a multi-site randomized trial of the intervention. All participants received standardized clinical care, completed baseline audio computerized self-interviews, received a full course of medications at discharge, and were interviewed by a disease intervention specialist (DIS) after the 2-week treatment course. The intervention group also watched a 6-minute video grounded in the health belief model. Adherence measures included medication completion, temporary sexual abstinence, partner notification, partner treatment, and return for 72-hour clinical re-assessment. Data were evaluated using multivariate regression analysis.

Results: The mean age was 17.3 years (SD 1.7), 92 % were African American, 89% were recruited from an academic hospital center, and 30% had a documented STI at baseline. Sixty-four percent were located for the DIS interview. Intervention participants had higher rates of 72-hour follow-up (32 vs. 17%), and partner treatment (73 vs. 56%), in bivariate analyses at $p = 0.1$ level. There were no differences in medication completion (70 vs. 71%), sexual abstinence (77 vs. 88%), or partner notification (88 vs. 92%). Only the partner notification finding persisted as a trend in multivariate models (AOR = 2.7; 95% CI: 0.9-8.3, $p = 0.09$).

Conclusions: Among adolescents with mild-moderate PID, randomization to a brief video intervention is not sufficient to increase 2-week adherence behaviors. While both groups reported high adherence to partner notification and sexual abstinence, almost a third did not complete their medication course and/or arrange for partner treatment. Even fewer returned for clinical follow-up. Adolescent girls diagnosed with PID in acute care settings and treated as outpatients remain at risk for treatment failure. Additional structural supports may be necessary to facilitate adolescent adherence in outpatient settings.

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