

Transitioning to adult HIV care: Challenges and evidence-based practices

? Questions

- What are the challenges associated with transitioning from adolescent to adult HIV care?
- What evidence-based practices can facilitate transitioning to adult HIV care?

🔑 Key Take-Home Messages

- The transition to adult HIV care can be a vulnerable point in the care and treatment of young people living with HIV (1).
- Health outcomes of young people living with HIV post-transition—including retention in care, changes in disease markers, and mortality—appear to be poorest among individuals with unsuppressed viremia prior to transitioning to adult HIV care (2).
- For young people, HIV-related stigma can act as a barrier to developing a relationship with a new adult HIV care provider (1, 3, 4).
- Two recent clinical prediction tools, one developed in the U.S. (5) and one in South Africa (6), have been used to determine if youth are ready to enter adult HIV care.
- Transition interventions that incorporate components such as individualized care plans, communication, psychological support, health and sexual education, and mobile health (mHealth) appear to improve adherence to antiretroviral therapy, retention in care, and viral load suppression after transitioning to adult HIV care (7).

Rapid Response: Evidence into Action

The OHTN Rapid Response Service offers quick access to research evidence to help inform decision making, service delivery, and advocacy. In response to a question, the Rapid Response Team reviews the scientific and grey literature, consults with experts if required, and prepares a review summarizing the current evidence and its implications for policy and practice.

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The Issue and Why it's Important

Individuals who acquired HIV perinatally are reaching adolescence and entering adulthood as a result of successful antiretroviral therapy (8). However, the transition to adult HIV care can be a vulnerable point in the care and treatment of young people living with HIV (1). There are several factors that make the transition to adult HIV care challenging for young people: fear of status disclosure and the potential for HIV-related stigma, inconsistencies in recommended timing to begin transitioning, and mobility of young people, a factor that has implications for insurance coverage and coordination between health care teams (9).

Health care transition is traditionally defined as “purposeful, planned movement of adolescents and young adults with chronic physical and medical conditions from child-centered to adult-oriented health-care systems” (1, 8, 10, 11). Young people with chronic illness who transition to adult services can experience increased morbidity and mortality during this period of time (12). For young people living with HIV, a successful transition is especially crucial to maintain an undetectable viral load, reduce HIV transmission to others, and for overall health (1, 12). However, there does not appear to be an accepted standard for what constitutes a successful transition; generally, providers have suggested it should include assessment of clinical outcomes, a young person’s ability to complete and take responsibility for treatment-related activities (e.g. making and keeping appointments), and whether or not the young person feels a connection and trust towards the new adult care provider (13).

This review focuses on challenges faced by young people living with HIV who transition from adolescent to adult HIV care. The primary focus is on young people perinatally infected with HIV, though some studies do include young people who acquired HIV behaviourally. A range of ages and different terms are used to identify young people who are transitioning to adult HIV care, including children, youth, adolescents, and young adults; this reflects the overall lack of agreed upon recommendations as to the optimal timing of transition to adult care (9).

What We Found

The published literature on youth living with HIV transitioning to an adult care setting focuses on many different aspects of the transition process. This includes HIV-related outcomes post-transition, such as retention in care, disease markers, and mortality. The literature also examines factors that act as barriers or facilitators during the transition process. Additionally, transition readiness models and interventions to support the transition process are discussed.

References

1. Straub DM, Tanner AE. Health-care transition from adolescent to adult services for young people with HIV. *The Lancet Child & Adolescent Health*. 2018;2(3):214–22.
2. Ritchwood TD, Malo V, Jones C, Metzger IW, Atujuna M, Marcus R, et al. Healthcare retention and clinical outcomes among adolescents living with HIV after transition from pediatric to adult care: A systematic review. *BMC Public Health*. 2020;20(1):1195.
3. Barr EA, Raybin JL, Dunlevy H, Abuogi L, Jones J. Transition from pediatric to adolescent HIV care to adult HIV care and the patient-provider relationship: A qualitative metasynthesis. *Journal of the Association of Nurses in AIDS Care*. 2022;33(2):132–54.
4. Perger T, Davtyan M, Foster C, Evangeli M, Berman C, Kacanek D, et al. Impact of HIV-related stigma on antiretroviral therapy adherence, engagement and retention in HIV care, and transition to adult HIV care in pediatric and young adult populations living with HIV: A literature review. *AIDS & Behavior*. 2024;25:25.
5. Harris LR, Hoffman HJ, Griffith CJ, Lee N, Koay WLA, Rakhmanina NY. Factors associated with transition of HIV care readiness among adolescents and youth from a specialty pediatric HIV clinic in the United States. *AIDS Patient Care & STDs*. 2021;35(12):495–502.

Health outcomes

A 2020 systematic review identified 24 studies examining post-health care transition outcomes among adolescents living with HIV (aged 10–21 years), though most participants were between the ages of 17 and 22 (2). Eighteen of these studies were from high-income countries; some participants had acquired HIV perinatally, and others behaviourally (2). Outcomes across these studies were grouped into the following categories: retention in care, changes in CD4 count and viral load, and mortality (2). Authors found that generally, within two years of transitioning to adult HIV care, more than 70% of adolescents were retained in care (2). Additionally, while studies indicated that CD4 count and viral load outcomes appeared to worsen the first few years post-transition, these differences were often not statistically significant (2). Finally, within the first seven years of transition, a small proportion of study participants died (2). All outcomes were poorest for adolescents living with HIV who had unsuppressed viremia prior to transitioning to adult care (2). This finding is further supported by a UK study, published after this systematic review, which found that young people (aged ≥ 13 years) with poor markers of disease progression (e.g. low CD4 count, viral load >400 copies/mL) prior to transition had suboptimal outcomes in adult HIV care (14).

Facilitators and barriers

A 2018 review from *The Lancet* explored the barriers and facilitators young people (aged 18–25) experience when transitioning to adult HIV care (1). Individual barriers to transition included minimal life skills, poor health literacy, substance abuse, mental health challenges, stigma, or attachment to pediatric providers; clinic-level barriers included inadequate preparation of transfer and connection of young people with adult HIV care (1). Facilitators included formal life-skills training (i.e. health-related self-care), early initiation of the transition process, and assistance with logistics (1).

HIV-related stigma appears to be a prominent barrier when transitioning to adult HIV care. A 2022 review of 14 qualitative studies found that stigma was a barrier to developing a trusting relationship with a new provider when adolescents (aged 12–30) transitioned to adult HIV care (3). This is supported by another review (2024) which identified HIV-related stigma as a considerable barrier for children, adolescents, and young adults (aged 7–24) transitioning to adult HIV care (4). Both quantitative and qualitative findings from this review found that stigma negatively impacted ART adherence, engagement, and retention in HIV care (4). However, only two of the 34 studies included in this review were from a high-income setting (the U.S.) (4).

A longitudinal qualitative study at a comprehensive HIV care centre in the U.S. interviewed youth (mean age 24) pre-transition, and

6. Zandoni BC, Musinguzi N, Archary M, Sibaya T, Haberer JE. Development of a transition readiness score for adolescents living with perinatally-acquired HIV and transitioning to adult care. *AIDS & Behavior*. 2022;26(9):3131–8.
7. Jegede OE, van Wyk B. Transition interventions for adolescents on antiretroviral therapy on transfer from pediatric to adult healthcare: A systematic review. *International Journal of Environmental Research & Public Health*. 2022;19(22):12.
8. Yusuf H, Agwu A. Adolescents and young adults with early acquired HIV infection in the United States: Unique challenges in treatment and secondary prevention. *Expert Review of Anti-infective Therapy*. 2021;19(4):457–71.
9. Chew H, Desai N. Transition to adult care for young people living with HIV. *Current HIV/AIDS Reports*. 2025;22(1):21.
10. Blum RW, Garell D, Hodgman CH, Jorissen TW, Okinow NA, Orr DP, et al. Transition from child-centered to adult health-care systems for adolescents with chronic conditions: A position paper of the Society for Adolescent Medicine. *Journal of Adolescent Health*. 1993;14(7):570–6.
11. Hussen SA, Chakraborty R, Camacho-Gonzalez A, Njiemoun B, Grossniklaus E, Goodstein E, et al. Beyond “purposeful and planned”: Varied trajectories of healthcare transition from pediatric to adult-oriented care among youth living with HIV. *AIDS Care*. 2019;31(1):45–7.

several distinct themes related to the transition process emerged: reluctance to transition, unwelcoming adult care spaces, varying levels of preparation pre-transition, and expectation of autonomy in the adult clinic (15). In post-transition interviews, youth expressed inconsistencies in the transition experience, fear and anxiety surrounding the experience, and identified patient-provider communication as the most valuable factor in a successful transition (15). Another qualitative study among youth living with HIV who were attendees at a health care transition clinic in the U.S. had similar barriers: leaving trusted providers, reduced parental guidance, insufficient preparation to develop autonomy, and perceived loss of confidentiality in the adult clinic environment (16). Stigma was once again a patient-specific factor that affected transition (16).

The aforementioned 2018 review in *The Lancet* listed several factors that may contribute to a successful transition from youth HIV care to adult HIV care (1). These include:

- Development of formal, written transition policies;
- Health care provider training in adolescent development;
- Strategies to facilitate physical connection of youth with adult care clinic;
- Provision of supportive services (e.g. life skills training, patient navigators, mental health support); and
- Individualized transition plans (1).

A growing body of research has found that several factors can bridge the gap between pediatric and adult care (17). This includes a warm hand-off (where adult clinicians have the opportunity to meet the youth prior to transition and where communication between the pediatric and adult team is established prior to transition), medical record transfer, a strong relationship between pediatric clinics and youth-friendly adult clinics, and having the pediatric case manager attend the first adult appointment (17). These factors could potentially improve the transition process and maximize HIV treatment success for youths entering adult care (17).

Transition readiness models

Transition readiness models include benchmarks, checklists, and formal steps to help identify whether or not a young person is ready to transition to adult HIV care.

The HIV Adolescent Readiness for Transition Scale (HARTS) is a developed and validated clinical prediction tool used to identify transition readiness for adolescents transitioning from pediatric to adult HIV care (18). This tool was developed by adapting existing

12. Foster C, Fidler S. Optimizing HIV transition services for young adults. *Current Opinion in Infectious Diseases*. 2018;31(1):33–8.
13. Philbin MM, Tanner AE, Ma A, Chambers BD, Ware S, Kinnard EN, et al. Adolescent and adult HIV providers' definitions of HIV-infected youths' successful transition to adult care in the United States. *AIDS Patient Care & STDs*. 2017;31(10):421–8.
14. Asad H, Collins IJ, Goodall RL, Crichton S, Hill T, Doerholt K, et al. Mortality and AIDS-defining events among young people following transition from paediatric to adult HIV care in the UK. *HIV Medicine*. 2021;22(8):631–40.
15. Halyard AS, Doraivelu K, Camacho-Gonzalez AF, Del Rio C, Hussen SA. Examining healthcare transition experiences among youth living with HIV in Atlanta, Georgia, USA: A longitudinal qualitative study. *Journal of the International AIDS Society*. 2021;24(2):e25676.
16. Chew H, Bonnet K, Schlundt D, Hill N, Pierce L, Ahonkhai A, et al. Mixed methods evaluation of a youth-friendly clinic for young people living with HIV transitioning from pediatric care. *Tropical Medicine & Infectious Disease*. 2024;9(9):28.
17. Momplaisir F, McGlonn K, Grabill M, Moahi K, Nkwihoreze H, Knowles K, et al. Strategies to improve outcomes of youth experiencing healthcare transition from pediatric to adult HIV care in a large U.S. city. *Archives of Public Health*. 2023;81(1):49.

transition readiness scores for other chronic illnesses by conducting focus groups with health care providers and adolescents living with perinatally acquired HIV in South Africa (18). Sixteen questions were developed, focusing on four domains important to HIV transition readiness: disclosure, health navigation, self-advocacy, and health literacy (18). Examples of these questions include (18):

- Do you know why you take your medication?
- Do you know the names of your medications?
- Can you explain your medical history to doctors, nurses, and counsellors?
- Do you travel on your own to your appointment?
- Do you know what illnesses should make you contact the clinic?
- Do you know your last viral load results?

These questions are intended to help identify which adolescents may require additional interventions prior to transitioning to adult HIV care (18). The scale was validated by prospectively administering it to nearly 200 adolescents (aged 15–24) in South Africa before their transition to adult HIV care (18).

In 2022, authors of the above study went a step further and used the HARTS scale plus other scales—including the Youth Risk Behavior Survey for drug and alcohol use, the Adolescent Social Support Scale to determine social support, and the Rosenberg Self-Esteem Scale for self-esteem—to give a score for readiness to transition (6). Scores were then organized into low, intermediate, and high levels of transition readiness (6). Adolescents scoring in the high range would likely to transition to adult HIV care without additional interventions, while those scoring in the intermediate and low range would likely benefit from additional time in pediatric care or targeted interventions prior to transition (6).

One study in the U.S. from a pediatric HIV care clinic adapted the Transition Readiness Assessment Questionnaire (TRAQ), originally developed for youth with special health care needs transitioning to adult care (19), to evaluate factors associated with HIV care transition readiness among adolescents and youth living with HIV (5). The TRAQ model was adapted to meet four “milestones”: HIV Education & Managing Medications 101, Health Management I, Health Management II, and Pre-Transition (5). Responses within each milestone were quantified from 1 (never/no) to 4 (always/yes) and averaged to give a total score for each milestone (5). The overall TRAQ score was then calculated by averaging the scores across all four milestones (5). The study included 103 participants, all of whom identified as Black; the average age was 19, and 50% of the

18. Zandoni BC, Archary M, Sibaya T, Musinguzi N, Kelley ME, McManus S, et al. Development and validation of the HIV adolescent readiness for transition scale (HARTS) in South Africa. *Journal of the International AIDS Society*. 2021;24(7):e25767.
19. Sawicki GS, Lukens-Bull K, Yin X, Demars N, Huang I-C, Livingood W, et al. Measuring the transition readiness of youth with special healthcare needs: Validation of the TRAQ–Transition Readiness Assessment Questionnaire. *Journal of Pediatric Psychology*. 2011;36(2):160–71.
20. Tepper V, Zaner S, Ryscavage P. HIV healthcare transition outcomes among youth in North America and Europe: A review. *Journal of the International AIDS Society*. 2017;20(Suppl 3):21490.
21. Judd A, Sohn AH, Collins IJ. Interventions to improve treatment, retention and survival outcomes for adolescents with perinatal HIV-1 transitioning to adult care: Moving on up. *Current Opinion in HIV & AIDS*. 2016;11(5):477–86.
22. Kennedy VL, Mellor KL, Brophy J, Bitnun A, Alimenti A, Kakkar F, et al. Transition from pediatric to adult HIV care for young women living with HIV. *Journal of the International Association of Providers of AIDS Care*. 2020;19:2325958220903574.

group sample was male (5). Additionally, it should be noted that the study included participants who had acquired HIV perinatally as well as those who acquired HIV horizontally (5). HIV care transition readiness (as measured by TRAQ scores) was significantly affected by patient factors, including age, gender, mode of HIV transmission, viral suppression, and duration of HIV diagnosis (5). Older age, undetectable viral load, and presence of mental health conditions were associated with higher TRAQ scores (5).

Interventions

One review from 2017 found that in North American and Europe, successful health care transition programs shared several characteristics: implementation of a youth-friendly multidisciplinary approach, consistent communication and integration between pediatric and adult care teams, and an individualized approach sensitive to the adolescent's transition readiness (20). A tailored approach, especially for youth living with HIV who have difficulty maintaining consistent engagement in pediatric care, appears to be an important determinant of successful engagement in adult care (11). Another review from 2016 also supports individualized transition planning (21). One U.S. study suggested that interventions should focus on improving patient-provider communication in both pediatric and adult clinics, as well as better preparing youths in pediatric clinics before transitioning to adult care (15). An older Canadian study conducted among women living with HIV (data collected between 2013–2015) also underscores the importance of transition preparedness, especially among those with poor childhood family supports and lower CD4 counts (22).

A 2022 systematic review by Jegede *et al.* reported on transition interventions to improve antiretroviral therapy adherence, retention in care, and viral load suppression among adolescents transitioning to adult HIV care (7). Seven studies were included: two from the United States, two from Thailand, two from Italy, and one from Sweden (7). Authors found evidence that interventions with the following components improved adherence, retention in care, and viral load suppression post-transition over the short- and long-term (7):

- **Individualized care plans:** offer care, support, counselling according to a client's needs;
- **Communication:** emphasize steady flow of communication between pediatric/adolescent clinic staff and adult clinic staff, and give adolescents a voice in the programming;
- **Psychological support:** provide psychological support for individuals transitioning and their families by meeting needs related to disclosure, acceptance, family dynamics, etc.;

23. Griffith D, Jin L, Childs J, Posada R, Jao J, Agwu A. Outcomes of a comprehensive retention strategy for youth with HIV after transfer to adult care in the United States. *Pediatric Infectious Disease Journal*. 2019;38(7):722–6.
24. Griffith D, Snyder J, Dell S, Nolan K, Keruly J, Agwu A. Impact of a youth-focused care model on retention and virologic suppression among young adults with HIV cared for in an adult HIV clinic. *Journal of Acquired Immune Deficiency Syndromes*. 2019;80(2):e41–e7.
25. Ryscavage P, Herbert L, Roberts B, Cain J, Lovelace S, Houck D, et al. Stepping up: Retention in HIV care within an integrated health care transition program. *AIDS Care*. 2022;34(5):554–8.
26. Got Transition. Six Core Elements of Health Care Transition. 2025. Available from: <https://gottransition.org/six-core-elements/>. Accessed: March 7, 2025.
27. Tanner AE, Mertus S, Jibriel MSE, Urquhart R, Phillips K, Dowshen N, et al. Transitioning adolescents to adult HIV care in the United States: Implementation lessons from the iTransition intervention pilot trial. *Tropical Medicine and Infectious Disease*. 2024;9(12):297.

- **Health and sexual education:** delivery of education sessions on HIV infection, transmission routes, prevention measures, and principles of antiretroviral therapy and adherence to each patient;
- **mHealth:** back-and-forth phone calls or text-messages between the peer navigator and patient.

A 2022 synthesis of qualitative studies by Barr *et al.* presented four recommendations that can help develop a strong collaborative connection with a new provider (3):

- **Develop a transition plan:** establish a plan with milestones and goals prior to the health care transition, ensure the plan is individualized, incorporate family into the plan;
- **Prepare the patients and the providers:** begin the education and transition process early, establish healthy expectations around transition, educate the adult care provider, build skills for improved adherence and successful engagement while still in adolescent care, prior to transition;
- **Build and honour trusting relationships:** introduce the adult care provider in the pediatric clinic, transition patients in a group of peers, establish excellent two-way communication between pediatric and adult providers, host a graduation/celebration to mark the years they have been in the care of the pediatric provider and honour the patient-provider relationship;
- **Capacity building to meet the unique needs of adolescents:** establish a stepwise transition model, create a safe clinic space for transitioning adolescents, increase access to ancillary services (e.g. mental health/social workers), assess engagement in care post-transition and if necessary, involve the original pediatric provider again for follow-up and support.

One care model included in the aforementioned Jegede *et al.* systematic review is the Johns Hopkins Accessing Care Early (ACE) clinic in Baltimore for young adults (aged 18–30) living with HIV (23). Young adults are transferred from the pediatric HIV specialty practice to ACE, an HIV care clinic for young adults located **within** the adult HIV clinic (23). To be eligible for ACE, individuals need to have one or more of the following criteria: transfer from pediatric care, mental health diagnosis, substance use, or identified adherence barriers (24).

In the ACE clinic, care is provided by four doctors who have internal medicine and pediatric training, and a dedicated nurse (24). A pediatric social worker and a young adult peer navigator are also part of the care team (24). The team offers a flexible approach in terms of communication (e.g. texting) and clinic visits (e.g. variable appointment times) (24). After transfer to adult care, the pediatric social work team continues to monitor the young adult (23). At multidisciplinary weekly meetings, the individuals in the ACE program are reviewed (24). Individuals who are ineligible for ACE are enrolled into the general adult HIV clinic, where they receive standard of care (SOC) (24).

One study conducted a retrospective cohort analysis comparing individuals aged 18–30 who newly entered care at the ACE clinic (n=61) with those in the same age range enrolling in SOC (n=76) between 2012–2014 (24). Retention in care, virologic suppression, lost to follow up, and clinic service utilization were all examined (24). ACE patients were three times more likely to be retained in care compared to SOC patients; retention in care was associated with features specific to ACE, including more frequent social work visits, nurse phone calls, and peer navigator interactions (24). ACE patients were also less likely to be lost to follow up compared to SOC (16% versus 37%; $p < 0.01$) (24).

Another integrated program in the U.S. is the University of Maryland HIV Structured Transition EmPowerment (STEP) Program, a health care transition program that is embedded within the pediatric/adolescent HIV clinic (25). The STEP program is staffed by an adult HIV provider and health care transition navigator and includes structured collaboration between the pediatric

and adult care team (25). The STEP program is built upon the principles of the GOT Transition program, which has six core elements of transition to care to assist clinicians with youths transitioning to adult care (25, 26):

1. **Policy** (age 12–14): develop, discuss, and share transition care guide
2. **Tracking & monitoring** (age 14–18): track progress using a flow sheet registry
3. **Readiness** (age 14–18): assess self-care skills and offer education on identified needs
4. **Planning** (age 14–18): develop health care transition plan with medical summary
5. **Transfer of care** (age 18–21): transfer to adult-centered care and to an adult practice
6. **Transition completion** (age 18–23): confirm transfer completion and elicit consumer feedback

A retrospective cohort study described health care transition outcomes of the STEP Program for 34 individuals who attempted transition to adult care between 2017 and January 2020 (25). This STEP group was compared to a historical cohort (known as the “pre-STEP cohort”) of individuals transitioning care between 2004 and 2013 (n=50) (25). Authors found that:

- Successful linkage to care occurred in 32 of 34 individuals (94%) in the STEP cohort, though this was not statistically significant compared to the pre-STEP cohort;
- Retention in care at 12 months was significantly higher in the STEP cohort compared to the pre-STEP cohort (95% versus 50%, $p=0.0004$);
- Viral suppression in the STEP cohort did not statistically differ before and after transition periods (66% versus 78%, $p=0.46$) (25).

Authors concluded that while retention in care was high among individuals in the STEP program, long-term data on retention after transition is needed to fully inform optimal health care transition strategies (25).

One study describes implementation lessons from iTransition, an mHealth intervention to facilitate transition to adult HIV care (27). iTransition is a mobile app for youth that includes learning tools, medication reminders, readiness assessments and interactive quizzes; a platform for providers includes a dashboard with educational content, the ability to track youth progress, and an option for two-way chat between the provider and patient (27). A pilot trial of the intervention was conducted between 2020 and 2023 at two sites in the U.S.: a high-volume HIV care centre in Atlanta that has both pediatric/adolescent and adult-oriented clinic space but no formal health care transition protocol, and a children’s hospital in Philadelphia that has two HIV clinics serving adolescents and young adults living with HIV that does have a formal health care transition protocol (27). Four participant groups were included in the trial: a historical control group, a youth intervention group, a provider intervention group, and a “Transition Champion” group, which included staff members from each clinic that supported health care transition (27).

Semi-structured interviews with intervention youth (n=9), providers (n=6), and Transition Champions (n=4) were conducted to examine experiences with iTransition (27). In summation:

- Youth sought support from their pediatric/adolescent provider, which hindered their ability to engage in adult care;
- Youth and providers both agreed that medication adherence, supported by reminders in the app, were beneficial;
- Youth and providers both found the app’s chat feature enabled ongoing communication;
- Youth found that the app made their HIV condition less overwhelming, which

alleviated some of the perceived burden and stigma associated with managing HIV (27).

However, overall usage of app was suboptimal for both youth and provider participants (27). Youth felt overwhelmed with commitments to family, school, and employment, and were not able to use the app regularly (27). Both youth and providers highlighted that access challenges were also an issue, as continuous access to a mobile device and reliable internet was necessary for usage (27). Providers also noted that the app's lack of integration with electronic health records was problematic, as the provider-facing platform felt like an additional task outside their usual workflow (27). Authors concluded that additional efforts are required to develop interventions that ensure continuity of care for young people living with HIV, particularly in non-urban areas, as they transition to adult care. (27).

limited to articles published in English. Reference lists of identified articles were also searched. Google (grey literature) searches using different combinations of these terms were also conducted. The searches yielded 447 references from which 27 were included.

Factors That May Impact Local Applicability

While this review primarily references studies from high-income countries, it also includes some studies and data from low-income countries. Additionally, not all studies were among youth who acquired HIV perinatally; some studies included youth who acquired HIV horizontally (behaviourally). Furthermore, there is no consensus on the appropriate age to begin the health care transition process, nor is there a clear benchmark for defining a “successful” transition to adult care. There is also variation in the support and programs offered at different youth and adult HIV clinics, which may limit their relevance and transferability to local contexts.

What We Did

We searched Medline (including Ovid MEDLINE and Epub Ahead of Print, In-Process, In-Data-Review & Other Non-Indexed Citations) using text terms HIV and (transition* adj5 adult* or transition* adj5 adolescent* or transition* adj5 young* or transition* adj5 youth*). Searches were conducted on October 31, 2024 and results