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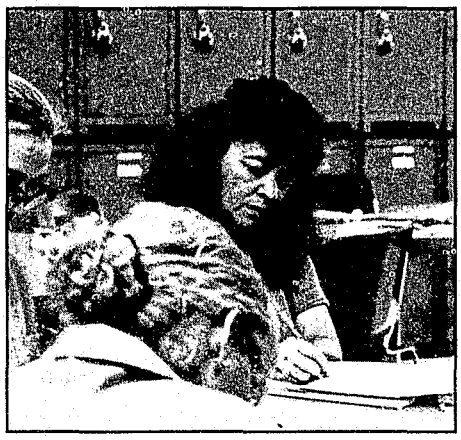

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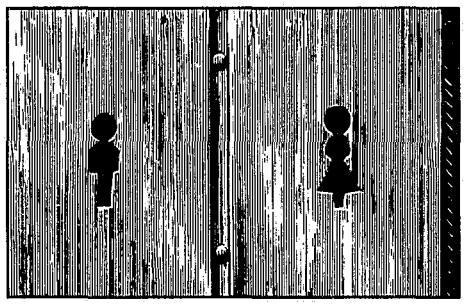

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HIV, AIDS, and the Female Offender

W. Travis Lawson, Jr., and Lena Sue Fawkes

In 1990, the number of reported Acquired Immunodeficiency Syndrome (AIDS) cases among women in the U.S. exceeded 15,000, an increase of 34 percent from 1989 and approximately 9 percent of all adult AIDS cases in the U.S. As the AIDS epidemic approaches its second decade, both the number of new infections with HIV (the Human Immunodeficiency Virus that causes the disease) and the number of full-blown cases of AIDS are expected to continue rising sharply for the next few years in the U.S. and worldwide. At least one drug, AZT, may slow the progression of the HIV infection. In addition, there are medications to treat certain opportunistic diseases to which people with AIDS are susceptible.

Nevertheless, the Centers for Disease Control (CDC) estimates that a million Americans are infected with HIV, most of them with no symptoms and no knowledge that they are carriers. Another 7 to 10 million people around the world are also infected, according to estimates by the World Health Organization (WHO). At the end of 1990, more than 150,000 Americans had been diagnosed with AIDS, two-thirds of whom have since died. The CDC estimates that by the end of 1993, 390,000 to 480,000 Americans will have been diagnosed with AIDS—with between 285,000 and 340,000 deaths.

The disease is no longer primarily the affliction of well-defined risk groups, according to the National Research Council. In particular, heterosexual transmission is on the rise: though it still accounts for a relatively small percentage of U.S. cases, it is the predominant mode of spread in most countries. Among

Fred DeVita

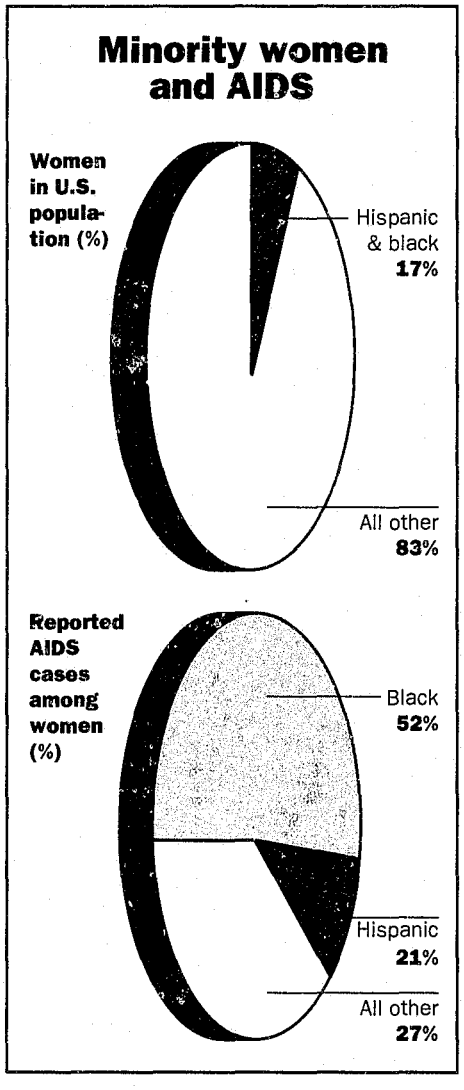
American heterosexuals, sexual partners of IV drug users and people who have multiple partners remain at greatest risk. Some additional facts:

■ By the year 2000, 25 to 40 million people will be infected with HIV internationally, according to projections by the World Health Organization.

■ AIDS is rising sharply among American women, especially poor blacks and Hispanics. The death rate from AIDS among women aged 15 to 44 quadrupled between 1985 and 1988, and undoubtedly will continue to rise. By the year 2000 the number of new cases among women worldwide will begin to equal the number of newly diagnosed men, according to WHO estimates. As of 1990 about 700,000 infected infants had been born worldwide. About 10 million infected infants will have been born by the year 2000, according to WHO data, and there will be millions of uninfected orphans whose parents have died from AIDS. About 6,000 infected American women gave birth in 1989 alone (one-third of babies born to HIV-positive mothers in the United States became infected).

■ AIDS is not just a disease of young people. Those over age 50 account for about 10 percent of all U.S. cases. AIDS-related symptoms are more likely to be misdiagnosed among these older people because doctors may assume that they are not at risk.

■ To identify risk factors for the transmission of HIV from men to women, a European study group analyzed 155 couples recruited from six European countries. Couples were included only if the men were infected first and the women had no risk factors other than an infected partner. Overall, the rate of transmission from men to women was 27 percent. Three independent factors significantly increased the risk of transmission: full-blown AIDS in the men, the practice of anal intercourse, and a history of sexually transmitted disease in the woman. Couples with none of these risk factors had a transmission rate of 7 percent; couples with two or three risk factors had a rate of 67 percent. The authors concluded that the risk of male-to-female transmission of HIV varies considerably and depends on the couple's clinical and behavioral characteristics.



■ Assays of more than 16,000 blood samples collected in health centers at 19 United States universities revealed an HIV seroprevalence rate on campus of 0.2 percent (1 in 500 students)—within the range found in other national surveys. While no HIV infection was found in more than half of the schools, one school had a rate approaching 1 in 100. Seroprevalence increased with age, reaching 1 percent in students over 40, and was 25 times higher in men. Because many students still have misconceptions about the modes of HIV transmission, and because some high-risk behaviors (such as sex with many partners) are common on campus, HIV may spread further in this population.

Epidemiology of HIV infection in women

According to data published by the CDC, as of January 1989, 52 percent of women diagnosed with AIDS in the United States are intravenous drug users, 30 percent were exposed to HIV through heterosexual contact, and 11 percent received HIV-infected blood or blood products. The transmission category for the remaining 7 percent is "undetermined." A significant trend noted between 1982 and 1986, however, is the hundredfold increase in the percentage of female cases classified as heterosexually transmitted, which has increased an additional hundredfold since 1986.

About half of the women with AIDS in the U.S. are aged 30 to 39; 90 percent of adult female cases occur in women aged 20 to 50. CDC data underscore HIV's disproportionate impact on minority populations. Although 17 percent of all women in the U.S. are black or Hispanic, blacks and Hispanics account for 73

percent (52 percent and 21 percent, respectively) of reported AIDS cases among women. This number reflects the prevalence of intravenous drug use in some black and Hispanic communities, particularly on the east coast. Although most States have reported adult female AIDS cases to the CDC, more than half of these cases have been reported from the northeastern States—half in New York alone.

Fifty-nine percent of women with AIDS reported to the CDC have subsequently died, compared to 50 percent of men. AIDS has a significant impact on mortality patterns for women in areas where HIV infection is common; it has now become the leading cause of death for women aged 30 to 34 in New York City.

The virus that causes AIDS may be more common among prison and jail inmates, especially women, than previously thought, according to a study based on testing of nearly 11,000 inmates entering 10 prisons and jails between mid-1988 and mid-1989. The study, conducted by the Johns Hopkins School of Public Health and the Centers for Disease Control, found that rates of HIV infection ranged from 2.1 to 7.6 percent for male inmates, and from 2.5 to 14.7 percent among females.*

*Earlier studies indicated HIV infection rates as high as 17.4 percent among inmates from the New York City area, but far lower rates elsewhere. The names of the prisons and jails in the more recent study were not released, but were said to represent all areas of the country. The findings were reported in the *Journal of the American Medical Association.*

At 9 of the 10 correctional facilities, women had higher rates of HIV infection than men. The difference was greatest among prisoners under age 25, with 5.2 percent of women in that age group testing positive, compared with 2.3 percent of the men. Minority groups also had higher rates of infection: 4.8 percent overall, compared to 2.5 percent of white inmates. No major difference in HIV infection rates was found between prisons and jails.

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In April 1992, 12 percent of HIV-positive inmates in the Federal Bureau of Prisons were women. However, the rate of infection among women was higher—1.52 percent, versus .9 percent for males.

Transmission during pregnancy

The vast majority of adults with HIV infection are in their reproductive years. According to CDC data, the risk factor for about 78 percent of the children who have AIDS in the U.S. is a parent with AIDS or in an AIDS risk group.

It is assumed that these children were born to infected mothers and were infected themselves during the perinatal period. (While the exact methods of perinatal transmission remain unknown, both transplacental and postpartum transmission have been suggested by case reports.) The relative risk of HIV infection to the fetus of an infected woman is not known. In an early study of infected mothers who had previously delivered infants who developed AIDS, 57 percent (6 of 14) of babies born subsequently were also infected. In contrast, no babies born to women impregnated by artificial insemination showed evidence of HIV infection after 1 year of followup. (Because these were small studies, it is important to emphasize that the risk estimates are varied and uncertain.)

At this time, outcomes for the newborn cannot be predicted by the clinical status of the mother during pregnancy. Infected babies have been born to women who are HIV-positive but have not developed symptoms, as well as to mothers with AIDS. A mother with AIDS can also deliver a baby with no evidence of disease. Transmission from an infected woman to older children or to other household members who are not her sexual partners has never been documented.

HIV infection and AIDS in correctional facilities

While the crisis atmosphere surrounding AIDS in prisons and jails seems to have dissipated, the disease remains a serious issue for correctional administrators. Concern has shifted significantly from short-term matters such as fear of casual transmission to "long-haul" issues such as housing, programming, and medical care for prisoners who have HIV infection.

As the population ages, and as determinate sentencing and strict sentencing guidelines continue, inmates will age within our facilities. We will see more and more women of childbearing age who are infected. The historic differences between the Federal offender versus offenders within State, city, or county systems have become blurred by the issue of drug trafficking. These offenders tend to be less well educated, predominantly urban, and from depressed socioeconomic backgrounds. The frequent victimization of female offenders also increases the risk for heterosexual disease transmission.

Although during its first appearance within the correctional setting, AIDS victims were predominantly white homosexual or bisexual males, heterosexuals and minorities are being infected in increasing numbers. In society, the disease currently has a greater impact on the IV drug user population than on the homosexual community. In the Bureau of Prisons, a considerable percentage of present and future inmates will come from backgrounds of IV drug use, or will have had intimate contact with IV drug users.

Although current data suggest a roughly 1-percent seropositive rate of HIV infection (a composite infection rate, slightly less for males and slightly more for females, using current Bureau monitoring standards), this still exceeds the estimated seroprevalence within the at-large population of .005 percent.

Evaluation

Intravenous drug users in treatment programs and those who have the physical signs of IV drug use are at risk for HIV infection. Other women at risk, however, are not so easily identified. A comprehensive patient history will help identify some women at risk. Appropriate questions can be inserted into the social, sexual, and medical portions of the history. These sensitive matters may then be documented in a way that maximizes confidentiality.

Some symptoms of HIV infection are similar to those commonly seen in problem pregnancies—fatigue, anorexia, weight loss, and shortness of breath. Health care workers caring for pregnant women in HIV risk groups must assess these women carefully for signs of HIV infection.

1 "Have you ever been tested for antibodies to AIDS virus? If so, what was the result of your test? When and why were you tested?"

2 "Since the late 1970's, have you ever injected drugs into your body with a needle? If yes, have you shared needles with other people?" If a woman is or has been an IV drug user, a history of the type of drugs used and the extent of drug use and needle sharing should be obtained.

3 "Since 1979, have you ever had sexual relations with a person at risk for AIDS—someone who injects drugs, a gay or bisexual man, a hemophiliac, or a person from Haiti or Central Africa?" If yes, further history should be taken on the clinical status of the person at risk, the type of sexual activity involved, the duration of the relationship, and the use and type of contraception.

4 "Have you had any anonymous sexual partners or partners that you did not know well who may possibly have been in AIDS risk groups?" Many women do not know the risk status of all their sexual partners. The question is most relevant if the patient lives where HIV infection is common.

5 "Have you tried to become pregnant through artificial insemination since the late 1970's? If yes, where?" Again, this question is most relevant if the patient lives where HIV infection is common.

6 "Have you received a transfusion of blood or blood products since 1979?" If yes, ask when, where, and how much blood. The risk is higher if a woman received transfusion before 1985 in an area where HIV was common.

7 When applicable, "are you from Haiti or Central Africa?"

8 "Is there any other reason why you think you might be at risk of exposure to HIV?" This question may lead to the patient's revealing an additional possible risk factor, such as providing health care to people with AIDS or HIV infection. The question also gives the woman a chance to express her fears about AIDS so that the health care worker can evaluate her needs for information.

Even when such histories are taken, not all women at risk will be identified. Many women are unaware of the drug use or unsafe sexual activities of their current or past sexual partners.

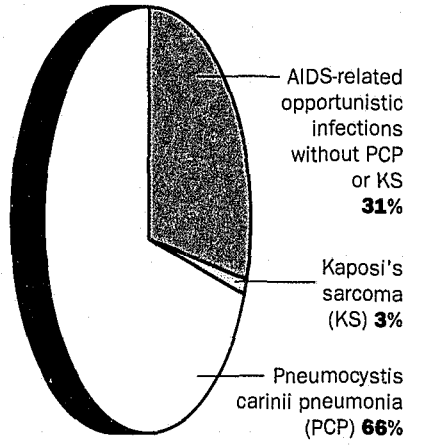
Clinical issues

The signs and symptoms of HIV infection are the same for women as for men, with one notable exception: women rarely develop Kaposi's sarcoma (KS), the most common AIDS-related malignancy. Women with AIDS most frequently develop pneumocystis carinii pneumonia (PCP), the most common AIDS-related opportunistic infection. Sixty-six percent of women diagnosed with AIDS as of October 1988 had PCP as their initial diagnosis; 3 percent had KS as their initial diagnosis. The remaining 31 percent had other AIDS-related opportunistic infections without PCP or KS.

Few studies have been published on aspects of HIV infection that may be unique to women. However, some studies have revealed a high percentage of women with gynecological disorders as well as very high maternal morbidity and mortality rates. Whether these findings were related to HIV infection or to other patient characteristics (such as IV drug abuse and poverty) has not been adequately addressed. Another study reported that women with clinical manifestations of HIV infection had a greater tendency to be inaccurately diagnosed, despite numerous medical evaluations; given the preponderance of infected males, HIV infection in females had simply not been deemed statistically relevant until recently.

HIV infections

Initial diagnoses among women, October 1988



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Pregnancy, which is associated with changes in cellular immunity, may affect both the natural history of HIV infection and the development of AIDS-related disease. One study followed 15 HIV-positive women, asymptomatic at childbirth, for 30 months after their deliveries. During the follow-up period, five of these women developed AIDS, seven developed related symptoms, and only three remained asymptomatic. Still, while there remains a theoretical risk that pregnancy could accelerate progression of HIV disease, controlled studies following both pregnant and non-pregnant seropositive women are needed to answer the question.

A number of case reports discuss women who develop AIDS-related opportunistic infections while pregnant. These women's diseases progressed rapidly; they died within weeks of diagnosis. Some symptoms of HIV infection are similar to those commonly seen in problem pregnancies—fatigue, anorexia, weight loss, and shortness of breath. Health care workers caring for pregnant women in HIV risk groups must assess these women carefully for signs of HIV infection.

Counseling women with HIV infection

Counseling issues differ for women depending on whether they are uninfected but at risk for HIV infection, seropositive but asymptomatic, or have symptomatic HIV infection or AIDS.

■ Women at risk should be counseled on how HIV is transmitted and how to avoid or minimize their exposures. Programs designed to meet the needs of women at risk who are or may become pregnant should make the HIV antibody test understandable and readily available. The CDC recommends antibody testing for women at high risk but emphasizes that many women are unaware of their risks. The most important part of any such program is identifying women at risk and educating them to prevent exposure to (and transmission of) HIV infection. The best way to prevent transmission of HIV to infants is to prevent its transmission to women.

■ The concerns expressed most frequently by seropositive women are fear of becoming ill; fear of transmitting HIV to their sexual partners and children; difficulty in communicating with potential sexual partners and in remaining sexually active; and not being able to bear children for fear they will become infected.

The CDC recommends that seropositive women avoid pregnancy until more is known about HIV transmission during pregnancy. This recommendation is often difficult to accept. Childbearing is a life goal for many women; the potential loss of that option can be devastating. Even more difficult is the situation of a woman who is already pregnant and then learns that she is infected with HIV. Although transmission to the infant is neither inevitable nor predictable, its likelihood is high. Infected women in late pregnancy and those in early pregnancy who do not elect to have an abortion will need extensive counseling and support.

■ The issues that women who have symptomatic HIV infection and AIDS must deal with overlap those of asymptomatic seropositives and women at risk. Fear of transmitting HIV to others is a major concern. Unlike women in the other groups, those who have symptomatic HIV infection and AIDS must deal with grief over the loss of their previous body image, sexual freedom, and potential for childbearing. They must also come to grips with the imminent loss of their own lives. Grief and other emotions triggered by an ARC or AIDS diagnosis can be profound.

Women who have symptomatic HIV infection and AIDS experience a unique social isolation. Although women were among the first persons diagnosed with AIDS, they are still not widely perceived as at risk for AIDS, which is seen as a "man's disease." Moreover, women with AIDS are a diverse group with no parallel community to look to for support, as gay men can. Very few programs have services designed for women with AIDS.

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For some women, being diagnosed with symptomatic HIV disease or AIDS is the first indication that their sexual partners are infected and that these partners are therefore probably IV drug users or bisexuals. The anger and sense of betrayal add to the emotional crisis provoked by the diagnosis.

Because most women with severe HIV disease are in their childbearing years, many already have children. A major concern of such women is care for their children if they become disabled or die. Many infected women are also poor and have had to deal with the problems associated with poverty—inadequate housing, poor nutrition, lack of health care and child care—long before their diagnosis. All of these problems are exacerbated by the diagnosis.

Women who have symptomatic HIV disease and AIDS are often part of households already dealing with the disease: their children and sexual partners may be infected. When AIDS affects an entire family, the psychosocial needs are extensive.

AIDS is a complex, challenging, and tragic issue. It is even more challenging for incarcerated women. The HIV epidemic will continue to influence the custodial and medical missions in correctional facilities for the foreseeable future. This mandates that the correctional system stay abreast of developments in this area. National population projections over the next 10 years notwithstanding, correctional populations will continue to rise. The demographics of those at risk tell us that AIDS will be a significant part of correctional medicine through the coming decade. ■

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