UNLV | University Libraries
University of Nevada, Las Vegas

Community Health Sciences Faculty Publications School of Community Health Sciences

1992

Finding HIV-infected Women - The Clinician's Role

Mary Guinan
University of Nevada, Las Vegas, mary.guinan@unlv.edu

Follow this and additional works at: https://digitalscholarship.unlv.edu/community_health_sciences_fac_articles

Part of the Immune System Diseases Commons, Obstetrics and Gynecology Commons, Virus Diseases Commons, and the Women's Health Commons

Repository Citation
Guinan, M. (1992). Finding HIV-infected Women - The Clinician's Role. *Journal of the American Medical Women's Association, 47* 92-93. Reston, VA:
https://digitalscholarship.unlv.edu/community_health_sciences_fac_articles/71

This Article is brought to you for free and open access by the School of Community Health Sciences at Digital Scholarship@UNLV. It has been accepted for inclusion in Community Health Sciences Faculty Publications by an authorized administrator of Digital Scholarship@UNLV. For more information, please contact digitalscholarship@unlv.edu.

WOMEN'S HEALTH

Finding HIV-infected women — The clinician's role

Mary E. Guinan, MD, PhD

An estimated 100,000 women are currently infected with the human immunodeficiency virus (HIV) in the United States,[1] and a great majority of them are unaware of their condition. Approximately 20,000 HIV-infected women were identified through publicly funded HIV screening programs in 1989 and 1990,[2] and an unknown number through private screening. Because most HIV-infected women are believed to be in the lower socioeconomic strata, it is unlikely that a significant number were identified in the private sector. Therefore, up to 80% of HIV-positive women may not know they are infected.

Finding women with HIV infection is important for two major reasons: 1) early medical treatments, prophylaxis, and a healthy life-style can lengthen life and improve its quality by prolonging disease-free intervals and delaying the onset of AIDS; and 2) patient counseling and education can prevent further transmission of HIV to sex (or drug-sharing) partners and will allow for informed choices about behavior, especially with regard to childbearing. Screening designed to find women with HIV infection must be linked to treatment, counseling, education, prevention, and social services.

Clinicians must become aware that women are at risk for HIV infection and offer HIV testing to appropriate patients. How can we decide who should be screened? First of all, women with known risk factors should be offered testing. All women who 1) are or were injecting-drug users (IDU); 2) have or have had sex partners who are known to be IDU, bisexual, natives of Caribbean or sub-Saharan African countries, or HIV positive; 3) had a transfusion of blood or blood products between 1978 and 1985; or 4) are natives of Caribbean or sub-Saharan African countries.

These criteria alone, however, are insufficient. Of women found through screening to be seropositive, 28% reported none of the above risks.[2] These women either did not know or were unwilling to report their risk and, therefore, would have been missed if only these criteria were used for screening.

Table 1—*States with Highest Cumulative AIDS Incidence in Women and Highest Seroprevalence of HIV in Childbearing Women*

State	AIDS case rate/ 100,000 women	HIV seroprevalence/ 1,000 childbearing women
Puerto Rico	71.3	NA
New Jersey	62.9	4.9
New York	61.0	5.8
District of Columbia	59.8	5.5
Florida	34.7	4.5
Connecticut	24.4	3.0
Maryland	21.0	3.1
Delaware	15.2	2.6
Massachusetts	13.6	2.5
Rhode Island	12.8	1.6
Georgia	11.0	1.6
South Carolina	9.4	1.5

NA = not available

Cumulative incidence rates of cases of AIDS in women through December 31, 1990, and seroprevalence of HIV in childbearing women, 1987 and 1988.[2,3]

Table 2—*Age Groups of Women with AIDS (as of November 30, 1991)*[6]

Age at diagnosis	Number (%)
≤12	1533 (7)
13-19	203 (1)
20-24	1365 (6)
25-29	4030 (18)
30-34	5481 (25)
35-39	4223 (19)
40-44	2196 (10)
45-49	1062 (5)
50-54	669 (3)
55-59	483 (2)
60-64	354 (2)
≥65	673 (3)
Total	22,312 (100)

Another consideration for screening should be the patient's state of residence. The states with the highest incidences of AIDS in women are in the Northeast and along the Atlantic coast.[3] (Puerto Rico and the District of Columbia are considered to be states in these analyses.) The 12 states with the highest incidences were Puerto Rico, New Jersey, New York, the District of Columbia, Florida, Connecticut, Maryland, Delaware, Massachusetts, Rhode Island, Georgia, and South Carolina. In a study of HIV seroprevalence in childbearing women,[4] the highest rates were found in the same 12 states (see Table 1). Likewise, the highest rate of HIV infection in female applicants for military service were found in New Jersey, Puerto Rico, New York, the District of Columbia, and Maryland.[5] Clinicians in these 12 states should be especially aware of the need to screen women for HIV and refer them to appropriate services.

The highest AIDS case rates in women[6] are in the 25 to 44 age group (see Table 2). Assuming that women are infected an average of 10 years

before they are diagnosed, we can best detect early infection by screening appropriate women aged 15 through 44. Since these are the childbearing years, the question of whether all pregnant women should be screened has been raised. After an extensive review, an expert group has advised against mandatory testing of pregnant women,[7] but has advocated a policy of voluntary screening, ie, advising all pregnant women of the HIV epidemic and offering testing.

The presence of a sexually transmitted disease is an indicator of increased risk of HIV infection; therefore, all women with newly diagnosed gonorrhea, syphilis, pelvic inflammatory disease, chancroid, chlamydia, or genital herpes infection should be strongly encouraged to be screened for HIV. In addition, two questions in the sexual history are useful for assessing risk of HIV infection: *How many sex partners have you had in the past year? Did you use condoms with every sexual encounter?* I advise all women who have had more than one sex partner in the past year and who have not used condoms with every encounter to be tested for HIV.

No woman should be tested without her consent. Mandatory testing cannot be justified on public health grounds.[7] Before embarking on a screening program for women, the clinician must ensure that appropriate counseling and testing is available, as well as access to treatment and prevention services. State and local health departments have information on the availability of publicly funded HIV testing. Further information on HIV testing, AIDS services, educational resources, women and HIV, and clinical trials for which women are eligible is available from the Centers for Disease Control's National AIDS Clearinghouse, 800-458-5231.

References

1. *WHO Global Programme on AIDS: Current and Future Dimensions of the HIV/AIDS Pandemic.* WHO/GPA/SFI/90.2, September 1990.
2. CDC: Characteristics of, and HIV infection among women served by publicly funded HIV counseling and testing services—United States, 1989–1990. *MMWR* 1991;40:195–197.
3. Ellerbrock TV, Bush TJ, Chamberland ME, et al: Epidemiology of women with AIDS in the United States, 1981 through 1990. *JAMA* 1991;265: 2971–2975.
4. Gwinn M, Pappaioanou M, George JR, et al: Prevalence of HIV infection in childbearing women in the United States: Surveillance using newborn blood samples. *JAMA* 1991;265: 1704–1708.
5. Department of Defense: *Prevalence of HIV-1 Antibody in Civilian Applicants for Military Service, October 1985–September 1990.* Atlanta, GA, Centers for Disease Control, 1990.
6. CDC: *HIV/AIDS Surveillance Report.* Atlanta, GA, Centers for Disease Control, December 1991, p 12.
7. Working Group on HIV Testing of Pregnant Women and Newborns: HIV infection, pregnant women, and newborns: A policy for information and testing. *JAMA* 1990;264:2416–2420.

PHYSICIAN MOTHERS, *continued*

References

1. Sayres M, Wyshak GF, Denterlein G, et al: Pregnancy during residency. *N Engl J Med* 1986;314:418–423.
2. Feminist Majority Foundation: *Empowering Women in Medicine.* Washington, 1991.
3. *American College of Obstetricians and Gynecologists' Guidelines on Pregnancy, Work, and Disability.* Washington, ACOG, 1982.
4. Harris D, Osborn L, et al: Effects of pregnancy on work performance. *JAMA* 1985;25:1995–1997.
5. Bernstein AE: Maternity and medicine. *Resid Staff Physician* 1991; 37:67–74.
6. Brazelton TB: Issues for working parents. *Am J Orthopsychiatry* 1986; 56:14–25.
7. Sinal S, Weavil P, Conys G: Child care choices of women physicians. *J Am Med Wom Assoc* 1989;44:183–184.
8. Rowe M: Barriers to equality: The power of subtle discrimination to maintain unequal opportunity. *The Employee Responsibilities and Rights Journal* 1990;3:153–163.

TESTIMONY, *continued*

of women in biomedical careers. Our organization has a vital interest in this subject; the following are the top priorities we would like the ORWH to address.

Sexual Harassment. Today's woman physician struggles with subtle discrimination that undermines morale and productivity and decreases opportunities for career advancement. The ORWH could conduct national surveys to document sexual harassment and publicize model policies developed for dealing with it.

Lack of Mentors. Women physicians' lack of access to important mentor relationships early in their careers can handicap them for the rest of their professional lives. The ORWH needs to examine ways not only to increase the number of female role models, but also to review the persistent reluctance of senior male professionals to mentor women physicians.

Dependent Care. The medical structure fails to recognize the parental responsibilities of women in such a profound way that we are at dangerous risk of creating a permanent "mommy track" or underclass of female practitioners. AMWA strongly recommends a minimum of 12 weeks family/medical leave for women in medicine and elsewhere. All hospitals need child care facilities.

Research Credit for Women. Anecdotal reports about the poor treatment of women researchers in biomedicine—plagiarism, stealing women's research, failure to credit women subordinates—should be examined. Mechanisms must be developed to assure proper credit for contributions to research, including a fair hearings appeal process."