Almost 15,000 Kids with HIV…Bacteria and Preterm Births…Sex Balance in U.S. Families…

Welfare: A Family Heritage?
The vast majority of welfare recipients grew up in families that did not receive welfare, but those who grew up receiving welfare are more likely than those who did not to depend on it as adults.1 An analysis of data from more than 13,000 individuals surveyed in 1987 and 1988 as part of the National Survey of Families and Households reveals that among respondents who received welfare in the year preceding the survey, 75% said that their parents were not welfare recipients, while 9% reported that their parents often relied on public assistance. Respondents in the latter group were more likely to have themselves received welfare in the previous year (16%) and in at least one of the last six years (31%) than were those whose parents never received welfare (4% and 7%, respectively). A logistic regression analysis revealed no independent association between respondents’ welfare receipt and parental welfare reliance, but strong, significant associations with negative socioeconomic, household and demographic characteristics. “It is parents’ economic background,” the researchers conclude, “rather than their use of welfare, that largely explains the dynamic of intergenerational welfare use.”

New IUD’s Insertion Problems
The contraceptive efficacy of a new “frameless” IUD known as the CuFix appears to be similar to that of the most effective standard copper IUD, but the rate of insertion failure is much higher.1 The CuFix, a string of six copper beads that is hooked into the upper portion of the uterus, was designed to minimize expulsion and removal for pain or bleeding. In a multicountry study, 53 of 2,155 attempted CuFix insertions failed, compared with one of 2,185 attempted insertions of the standard copper IUD. The cumulative life-table pregnancy rate for the CuFix was significantly higher at one year (1.2 pregnancies per 100 woman-years vs. 0.5 per 100), although not thereafter. The cumulative expulsion rate for the CuFix was 2–3 times that of the standard device.

Rural MDs Shun Abortion
Few obstetrician-gynecologists and virtually no surgeons or family physicians practicing in rural Idaho performed surgical abortions in 1994, according to a recent survey, although one in four expressed interest in performing medical abortions.1 Researchers used a roster of members of the Idaho Medical Association to identify 251 physicians in the three specialties, 212 of whom could be surveyed. Of these, 138 completed the questionnaire. Nearly all were family physicians, and most were male. Although more than one-half offered a variety of contraceptive methods and routine obstetric care, only 4% said they performed first-trimester abortions—three of nine ob-gyns and virtually none of the other physicians. (The researchers note that just four of the 44 rural communities served by the participating physicians had local abortion services available.) However, when asked if they would provide medical abortions should mifepristone (“RU 486”) be approved, 26% said they definitely would and 35% were unsure.

How Many Children with HIV?
Nearly 15,000 U.S. children were born infected with the human immunodeficienc- cy virus (HIV) between 1978 and 1993, according to recent estimates, and by 1994 about one in five of these children had already died of AIDS.1 Investigators with the Centers for Disease Control and Prevention used national survey data, AIDS surveillance data and information from a multicenter pediatric HIV research project to produce the estimates. Their analysis suggests that 14,920 infants have been born infected with HIV since the epidemic began, and that about 12,240 were still alive as of the start of 1994. Thus, about 2,700 infants and children have died of AIDS; a similar number are thought to have progressed to AIDS but have not yet died. The researchers estimate that nearly 40% of those born infected with HIV are now five years of age or older. They also project that if all HIV-infected U.S. women knew they were infected and could be treated with zidovudine, about two-thirds of HIV infections in newborns could be prevented each year.


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had had heterosexual intercourse in the preceding year. Seventy-three percent had used contraceptives in the past 12 months, with 47% reporting they had used condoms. Thirty-one percent of recent users had relied on more than one method. A multivariate analysis showed that condom nonuse over the preceding year was 72% greater among sterilized women than among women who were not sterilized; in addition, this likelihood was 44% greater among oral contraceptive users than among women who had not used the pill. When counseling HIV-infected women, the researchers conclude, health care providers should incorporate information about the different motives for contraceptive use (pregnancy prevention vs. infection prophylaxis), and should “ensure that women understand that different contraceptives may be needed to achieve those different purposes.”


Despite Problems, Implant’s OK

Users of the hormonal implant in Helsinki, Finland, often experience disruptive side effects, yet most women say they are satisfied with the method.1 A total of 262 women who had implants inserted at one of seven clinics in the Helsinki area were sent a questionnaire 1–2 years after getting the implant; 82% responded. One-third of the women were using their second set of implants. Nearly all of those surveyed said they had experienced some side effects, and 72% described at least one such effect as “disruptive.” Ninety-five percent reported a menstrual change, with 59% terming this change disruptive. In addition, one-half of respondents reported feelings of nervousness or irritability, and 44% experienced depression. One-third of first-time users had had their implant removed during the first year, 59% of them because of side effects. Nevertheless, 78% said they were satisfied with the implant, including 90% of those aged 35 and older.


A Drug for Preterm Delivery?

Bacterial vaginal infection (vaginosis) significantly elevates women’s risk of pregnancy loss and premature delivery, but administration of the drug clindamycin reduces the risk of vaginosis-related problems by 50%.1 In a prospective controlled trial involving 1,260 Colorado women, 33% were found to have bacterial vaginosis when they initiated prenatal care. During the first seven months of the study, only women who complained of symptoms were treated. In the second phase, all women were screened for bacterial vaginosis (and for other genital tract infections); women who tested positive were asked to return for treatment. Overall, women with bacterial vaginosis were three times as likely as other women to experience fetal loss. In the first phase of the study, women with vaginosis were nearly twice as likely as others to have a preterm birth. However, from the first phase to the second phase (when treatment was common), the incidence of preterm birth fell by 50%, while premature labor and preterm rupture of the membranes were reduced by 80%.

“Treatment with oral clindamycin,” the investigators observe, “is estimated to have prevented 48% of all potential cases of preterm birth and fully 80% of the potential preterm births” that result from preterm labor of unknown cause.


Sex Balance and Family Building

Women with children of both sexes are more likely to halt childbearing than are those with same-sex families, especially if the women are relatively young or are highly educated.1 Researchers employed a multivariate behavioral model to analyze birth history data from the 1985 Current Population Survey on more than 30,000 second births and nearly 25,000 third births among women aged 25–64. The sex of the first child had no significant effect on either the likelihood of stopping childbearing after the first birth or on the length of time between the first and second births. However, the analysis showed a statistically significant effect on third births: Once a number of demographic characteristics were controlled for, women with two girls or two boys were 20–28% less likely to stop childbearing than were those with a boy and a girl. Moreover, this effect was significantly stronger among women aged 25–44 in 1985 than among older women and stronger among college graduates than among high school graduates and those with some post–high school education.


In Brief

• Although it is legal for physicians to prescribe emergency contraception, advertising the availability of such a service may not be. According to the Food and Drug Administration (FDA), oral contraceptives are not labeled for use as emergency contraception, and promoting them for such a purpose would violate the federal Food, Drug, and Cosmetic Act. Furthermore, in some places there may be state or local laws against such advertising. Giving pill users an extra pill pack for use in an emergency may also constitute a violation, unless the FDA includes emergency contraception in the pill’s labeling. (“What Are Legalities of Promoting ECPs?” Contraceptive Technology Update, 16:137–140, 1995.)

• As part of a state-mandated counseling requirement, all abortion providers in Louisiana must now inform patients that there may be a link between induced abortion and breast cancer. Although nine states have counseling laws that mandate the types of information to be given to patients, Louisiana’s law, which went into effect on September 25, is the first to specify inclusion of the abortion—breast cancer information. (D. M. Gianelli, “Law Requires Disclosure of Possible Abortion/Cancer Link,” American Medical News, Vol. 38, No. 37, Oct. 2, 1995 p. 9.)

• Several Montana laws intended to limit women’s access to induced abortion services have been blocked by the courts recently. On September 27, a federal district court judge struck down a one-parent notification requirement because its judicial bypass language was more strict than U.S. Supreme Court precedents allow. Several days later, another district court judge ruled that two of three restrictions enacted in 1995 could not be enforced. One required that all second-trimester abortions be performed in a hospital; the second banned any advertising of abortion services. However, the judge allowed a measure to stand that prevents nonphysicians from performing abortions. (“In the Federal Courts: Federal Court Strikes Down Montana’s New Parental Notification Requirement,” Reproductive Freedom News, Vol. IV, No. 17, Sept. 29, 1995 p. 2; and “In the Federal Courts: District Court Allows Montanta to Enforce One of Three Challenged Abortion Restirctions,” Reproductive Freedom News, Vol. IV, No. 18, Oct. 13, 1995, p. 3.)