Letters to the Editor

Community-Level HIV Intervention Work for Women Means Restructuring Society and Culture

We strongly agree with Kelly[1] that individual-level interventions are but a limited part of reducing HIV risk. However, we would extend his argument, using the example of HIV and women.

Kelly does not specifically cite women in discussing potential beneficiaries of community interventions. But solving the problem of women and HIV means working on a macro level first. Numerous authors have found popular behavior models to be of limited relevance for women.[2–5] HIV risk for women, in the United States and worldwide, is rooted in their being second-class citizens much more than in individual behavior traits.[6–8] Entrenched sexism and oppressive gender roles have been adopted as societal and cultural values; it is their rooting out, and the ensuing transformation of policy, practice, and norms, that is necessary for women to break out of the logjam of risk—for HIV infection, other sexually transmitted diseases, unplanned pregnancies, poverty, drug use, and more. Vulnerable populations, such as women—especially poor and minority women—have internalized their less empowered status and adapted. Depending on men economically and emotionally, women rightly perceive the *benefits* of unsafe sex far more than the risks.[9] Across cultures and risk subgroups (e.g., injection drug users and nonusers), women show remarkable consistency in risk behaviors with an intimate partner. They practice behaviors that will not threaten the only kind of security and future that society has given them hope for—a male partner as protector and provider.

The very notion of a "women's community" does not fit the isolated reality of many women at highest risk of HIV infection. By raising women's opportunity levels through education, job training, affirmative action in hiring, free and accessible child care, and so forth (all of these belong on Kelly's list of HIV risk reduction policies as well), we help create such a community, a base for promoting prevention activities. In addition, targeting these core issues will bring payoffs far beyond a reduction in HIV/AIDS and will ensure maintenance of risk reduction in a way that individual approaches—cosmetic at best—simply cannot.

The bulk of HIV prevention work to date reflects this country's emphasis on the individual and not the community; it fails to recognize that influencing society, policy, and culture *is* the essential business of reducing HIV risk.[10] Internationally, there is far greater appreciation of the community's primary role,[8,11,12] and available examples should be studied. Stepping outside the US model also means that our search for grounding theories should extend far beyond the behavioral and into the political and economic. Family planning—a more seasoned public health field—teaches us that improving women's societal status and political and economic autonomy increases women's empowerment, boosts women's health, and improves the welfare of the community (e.g., by increasing use of contraception).[13] Similarly, reducing HIV risk for women means changing society and culture to align women's perceived power with actual power so that avoiding HIV infection really has only benefits and no costs. □

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References

1. Kelly JA. Community-level interventions are needed to prevent new HIV infections. *Am J Public Health.* 1999;89:299–301.
2. Beeker C, Guenther-Grey C, Raj A. Community empowerment paradigm drift and the primary prevention of HIV/AIDS. *Soc Sci Med.* 1998;46:831–842.
3. Amaro H. Love, sex and power: considering women's realities in HIV prevention. *Am Psychol.* 1995;50:437–447.
4. Gillespie CC. Women's HIV risk reduction efforts and traditional models of health behavior: a review and critique. *Womens Health.* 1997;3:1–30.
5. St. Lawrence JS, Eldridge GD, Shelby MC, Little CE, Brasfield TL, O'Bannon RE. HIV risk reduction for incarcerated women: a comparison of brief interventions based on two theoretical models. *J Consult Clin Psychol.* 1997;65:504–509.

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6. Heise LL, Elias C. Transforming AIDS prevention to meet women's needs: a focus on developing countries. *Soc Sci Med.* 1995;40:931–943.
7. Zierler S, Krieger N. Reframing women's risk: social inequalities and HIV infection. *Annu Rev Public Health.* 1997;18:401–436.
8. Gupta GR, Weiss E. Women's lives and sex: implications for AIDS prevention. *Cult Med Psychiatry.* 1993;17:399–412.
9. Sobo EJ. Inner-city women and AIDS: the psycho-social benefits of unsafe sex. *Cult Med Psychiatry.* 1993;17:455–485.
10. Sweat MD, Denison JA. Reducing HIV incidence in developing countries with structural and environmental interventions. *AIDS.* 1995; 9(suppl A):S251–S257.
11. de Bruyn M. Women and AIDS in developing countries. *Soc Sci Med.* 1992;34:249–262.
12. Ickovics JR, Yoshikawa H. Preventive interventions to reduce heterosexual HIV risk for women: current perspectives, future directions. *AIDS.* 1998;12(suppl):S197–S208.
13. Rogow D. Where hope floats: the Manuela Ramos movement. *Qualité/Quality/Calidad.* The Population Council. In press.

The Legalization of Abortion: A Major Public Health Issue

Levine et al. analyzed the effect of abortion legalization on fertility in the United States by comparing fertility rates over time between states where abortion was legalized at different dates.[1] The authors concluded that "a complete recriminalization of abortion nationwide could result in 440 000 additional births per year."[1(p199)]

Most countries that have legalized abortion have done so for public health purposes, namely, to reduce (with great success) maternal mortality and morbidity resulting from illegal abortions. This objective was indeed endorsed by the American Public Health Association as early as 1968.[2] Levine et al. analyzed trends in fertility rates; these are not by themselves indicators of public health.

Any discussion on this topic must take into account a number of results now well established.[3–7] Analyses of international data suggest that legal status makes little difference in overall numbers of abortions (except immediately after the legalization, partly because of the shift from unreported illegal abortion to reported legal abortion).[3] Fertility levels are determined by a wealth of socioeconomic factors extending well beyond the legal context,[4,7] as acknowledged by Levine et al. A rather straightforward methodology such as the one used by Levine et al. cannot account for this complexity.

Furthermore, although comparative studies have shown the consistentcy of short-range effects on fertility rates as a result of a sudden change in abortion legislation, the longer-term effects are much more debatable.[3,4] Finally, decreases in fertility rates after the legalization of abortion by no means infer that a subsequent recriminalization will produce exactly symmetrical effects.[4]

Above all, however, the issue of abortion cannot be examined without taking into consideration social and health consequences. It has been shown all over the world that any legalization of abortion leads to a substantial drop in abortion-related mortality and morbidity; conversely, more restrictive access to abortion services leads to a significant increase in maternal mortality and morbidity.[5,6] In countries where abortion is severely restricted, women often attempt to have abortions by unauthorized means. This practice results in approximately 600 000 deaths per year in the worldwide,[8] not to mention damage to women's health and the effects on the psychological and social welfare of both women and men.[2] □

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References

1. Levine PB, Staiger D, Kane TJ, Zimmerman DJ. *Roe v Wade* and American fertility. *Am J Public Health.* 1999;89:199–203.
2. Susser M. Induced abortion and health as a value [editorial]. *Am J Public Health.* 1992;82: 1323–1324.
3. *Sharing Responsibility: Women, Society and Abortion Worldwide.* New York, NY: Alan Guttmacher Institute; 1999.
4. Frejka T. Induced abortion and fertility: a quarter century of experience in Eastern Europe. *Popul Dev Rev.* 1983;9:494–520.
5. Royston E, Armstrong S, eds. *Preventing Maternal Deaths.* Geneva, Switzerland: World Health Organization; 1989.
6. Stephenson P, Wagner M, Badea M, Serbanescu F. The public health consequences of restricted induced abortion—lessons from Romania. *Am J Public Health.* 1992;82:1328–1331.
7. Leridon H. Overview. In: Höhn C, Mackensen R, eds. *Determinants of Fertility Trends: Theories Re-examined.* Liège, Belgium: Ordina; 1982:297–306.
8. Division of Reproductive Health. *Unsafe Abortion: Global and Regional Estimates of Incidence and Mortality due to Abortion.* Geneva, Switzerland: World Health Organization; 1998.

Breast Implant Verdicts Resulted From Corporate Misconduct and Legitimate Science

The Journal published a series of articles on breast implant litigation in the Public Health Policy Forum of the April 1999 issue. Ostensibly, the aim of this forum was to shed light on the use of epidemiologic science in toxic tort claims and to explain how this evidence was unable to halt the "widespread error" in court decisions that eventually caused the bankruptcy of a major corporation, Dow Corning. The forum authors see the litigation's outcome as yet another example of the failure of tort laws, caused, in part, by jurors' compassion for breast implant victims and jurors' misinterpretation of the "cold, hard" scientific facts. In fact, the editor's note prefacing the forum concludes that "in the end, the needs of the most vulnerable [breast implant plaintiffs] will not be advanced or protected if the voice of reason and science is subverted in the name of compassion."[1]

The course taken by the litigation, however, was not due to jurors' overwrought sympathies for breast implant victims; it was an expression of outrage and faultfinding against breast implant manufacturers for engaging in a pattern of systematic misconduct. Juries across the country affirmed that these manufacturers had disregarded, downplayed, and concealed their knowledge of potential heath hazards associated with breast implant use. Manufacturers conducted private studies demonstrating multiple risks associated with breast implant use, and they responded by terminating studies and misrepresenting the risks to users, physicians, and regulatory agencies. Because of the very real controversy about the health effects of breast implants that existed at the time of the litigation,[2] the conduct of these manufacturers proved to be compelling evidence for juries deciding whose story to believe. Contrary to Marcia Angell's assertions that this litigation demonstrates how being a liberal feminist can put you at odds with sound scientific thinking (not many liberal feminists were selected for the breast implant juries, however), the lesson is that juries refused to separate corporate misconduct from the ultimate issue of what caused a plaintiff's disease.

Dr. Angell, a trained pathologist, laments that the damages handed down by these juries were an injustice that ran contrary to the strength of the epidemiologic evidence.[2] Although the weight given to epidemiologic studies by Dr. Angell, Ruth Macklin,[3] and others in the breast implant litigation has elevated epidemiology to the final arbiter of