Letters to the Editor

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A Pilot Study of HIV-Infected Immigrants

We conducted a pilot study to (1) determine the areas in which additional human immunodeficiency virus (HIV) education is needed by the undocumented and recently immigrated HIV-infected population and (2) obtain preliminary information on this community's access to medical treatment for HIV. We obtained information regarding health status, immigration status, and the use of medical services from all HIV-seropositive undocumented and recently immigrated individuals who sought HIV-related services from a San Diego nonprofit agency between July 1, 1990, and December 31, 1990. (Because of confidentiality concerns, the agency has requested that its name be withheld.)

A total of 54 such individuals requested services during this period. Individuals had been referred to the agency by organizations providing services to HIV-infected persons, clinics, private medical personnel, churches, and gay and lesbian support groups. Each individual requesting services—or each individual's family unit if the person was part of a unit—earned not more than 125% of the federal poverty income guideline for the size of that family unit and owned assets worth less than $5000.

Forty two of the 54 individuals (77.8%) reported Mexico as their place of origin. Fifty percent of the individuals had been living in the United States for 7 or more years. Fifty individuals were males. The majority of the men reported unprotected homosexual activity as the risk factor for their HIV infection. Only two of the individuals reported previous intravenous drug use.

Six individuals who had reported unprotected sexual activity as the primary risk factor also reported that they had shared needles for vitamin B-12 injections. Seven other individuals, who also reported sexual behavior as the most likely route of their HIV infection, reported the intrafamilial sharing of injection equipment for the administration of antibiotics. All 13 individuals were originally from Mexico. All reported that either the injection equipment was not cleaned between uses or they did not remember if it had been cleaned. Only one of these 13 individuals reported the availability of private medical insurance. The other 12 were able to obtain coverage only for emergency medical services, through MediCal. (Ryan White funds have since become available.)

The practice of sharing equipment for the injection of medications and vitamins has been reported among Hispanic participants in other studies.[1,2] It is unclear to what extent this self-medicating practice derives from a cultural belief in healing by nonmedical persons. Research is needed to determine the risk of HIV infection resulting from these parenteral injections and the underlying reasons for the shared use of equipment for these injections. □

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The HIV Rates of Injection Drug Users in Less-Populated Areas

In the April 1992 issue of the Journal, Allen and colleagues[1] discussed human immunodeficiency virus (HIV) seroprevalence rates in injection drug users entering drug treatment in selected US metropolitan areas. Their data show that the highest seroprevalence rates are in metropolitan areas in the Northeast, and their findings are useful in targeting HIV prevention and treatment to accessible populations of injection drug users. Other

TABLE 1—Number of AIDS Cases[a] and Percentage of Cases Diagnosed in Injection Drug Users,[b] United States, 1989 through 1991

US Geographic Region	Non-MSA		Small MSA		Large MSA	
	Total No. of AIDS Cases	% IDU	Total No. of AIDS Cases	% IDU	Total No. of AIDS Cases	% IDU
Northeast	1078	45.2	2093	53.2	35 170	46.5
North Central	1092	16.8	1908	19.8	9 977	18.3
South	4340	24.3	6154	24.0	33 218	24.5
West	942	21.7	2357	19.8	27 008	14.9

Note. The table data excludes unknown MSAs. MSA = metropolitan statistical area; IDU = injection drug user.
Source. Data are from Centers for Disease Control, Atlanta, Ga.
[a]Adjusted for reporting delays.
[b]Includes men who have sex with men and inject drugs, heterosexual men who inject drugs, and women who inject drugs.

studies have described seroprevalence patterns in similar populations[2,3] and in out-of-treatment injection drug users in urban settings.[4] However, because injection drug users are largely a hidden population in our society, it is difficult both to estimate their total numbers and to identify their locations for sampling.[5] Therefore, it is difficult to estimate HIV seroprevalence rates in injection drug users outside of treatment settings, in rural areas, or in small towns and cities.

Acquired immunodeficiency syndrome (AIDS) case reports provide another measure of the magnitude of HIV disease attributable to injection drug use in smaller metropolitan statistical areas and nonmetropolitan areas. Based on AIDS surveillance data reported to the Centers for Disease Control, the highest proportions of AIDS cases in injection drug users are in the Northeast, regardless of the size of the metropolitan statistical area (Table 1). However, the proportions of AIDS cases attributable to injection drug use in nonmetropolitan areas (<50 000 people) and in small (50 000 to 499 999 people) and large (≥500 000 people) metropolitan statistical areas are comparable across each US geographic region.

Though nonmetropolitan areas account for just 5.9% and small metropolitan statistical areas for 10.0% of US AIDS cases diagnosed from 1989 through 1991, a clear need exists for research attention to injection drug use as a risk factor for HIV disease in small cities and nonmetropolitan areas. To formulate effective HIV prevention strategies in these areas, systematic studies about the nature and extent of risk behaviors of injection drug users in less-populated areas are called for. □

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Maternal Age and Cesarean Delivery Rate in Shanghai

In China, the rate of newborn delivery by cesarean section has been increasing dramatically in the past 2 decades. It has been reported that the rate in the 1980s was about five times higher than that in the 1960s.[1] In Shanghai in the early 1980s, 17.5% of newborn infants were delivered by cesarean section,[2] a rate close to that of the United States.[3] Gordon et al. demonstrated that advanced maternal age alone is a sufficient indication for cesarean delivery.[4] The data from Shanghai that I will present here show similar results.

For two previous studies,[5,6] 1058 live births in 1981 in Shanghai and 2227 in 1983 were selected; the combined data from these two studies have been detailed in another previous report.[2] After the exclusion of 68 multiple births, 555 (17.3%) of 3217 women delivered their first child by cesarean section. Table 1 shows that mothers aged 30 years and older had a significantly higher cesarean delivery rate (23.0%) than those younger than 30 (15.4%) ($\chi^2 = 23.855$, $P < 0.001$). In addition, mothers delivering infants with birthweights ranging from 2500 g to 2999 g had the lowest risk of cesarean section. Small and large values of birthweight were associated with higher risk of cesarean section. After adjustment for study area, birthweight, and parental educational levels, the odds ratio of cesarean section for women aged 30 years and older was 1.64 (95% confidential limit = 1.37, 2.06), compared with those aged less than 30 years.

Older women may have more of the complications of pregnancy, labor, and delivery that are the indications of cesarean section. However, Gordon et al. found that the relationship between maternal age and cesarean section were not found to be confounded by the complications but modified by some of them.[4] Chinese physicians may be similar to their American counterparts who "treat older women more aggressively."[4] □

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