Women with HIV presenting at three London clinics between 1985-1992


Abstract
Objective—To determine the changing patterns of HIV infection in women in three units in London.

Subjects—Three hundred and fifty-seven HIV seropositive women who have attended outpatient clinics between 1984 and 1992.

Methods—A retrospective review of data obtained from a computerised database and supplemented by direct inspection of the notes.

Results—The number of newly identified women with HIV has risen steadily over the period of study with a significant shift towards a heterosexual mode of transmission. This is a reflection of increasing numbers of women from Sub-Saharan Africa rather than a rise in the incidence of HIV in women born in the UK.

Conclusions—The increase in women infected by HIV remains predominantly restricted to women in “high risk” groups. Although encouraging, our data should be interpreted with caution since it suffers from the inherent bias of selective testing. Safer sex education and epidemiological surveillance should continue despite the apparent low risk to women born in the UK.

Introduction
The spread of HIV infection in the UK has been the subject of diverse opinions, with estimates in most cases, significantly exceeding the actual number of cases, causing some to doubt whether there is a heterosexual epidemic in the UK.1,2 By December 1992 there were 19,065 reports of HIV infection in the UK, 12.4% of these were women.3 Nationally, the incidence of newly identified individuals has remained stable with 1800–3000 cases a year since 1985.4 There has, however, been a change in the relative importance of different exposure categories. The only group that has shown a year on year rise in the incidence of HIV has been men and women acquiring HIV heterosexually.5 Earlier reports from our own and other departments in London4–6 have suggested this is predominantly “imported” from Sub-Saharan Africa. To determine whether this remains the case, data from our three clinics (1985–1992) was analysed. By the end of 1992, 357 HIV seropositive women had been seen in three outpatient clinics in London.

Methods
The data were obtained from the computerised database in the three units and supplemented by direct inspection of the case notes. The parameters investigated included year in which seropositivity was diagnosed, mode of transmission, country of birth and year of entry to the UK where possible. For women born in the UK who had acquired the infection heterosexually any additional risk factors were also determined.

Results
The number of new cases of women seen with HIV in our units has risen steadily since 1984 with an apparent stabilisation after 1990, whilst the number of new cases of women infected as a result of injecting drug use has fallen after a peak in 1987 (fig 1). There has been a significant shift towards a heterosexual mode of transmission (fig 1) and the major component of this increase is a result of women born in sub-Saharan Africa (fig 2). In women from sub-Saharan Africa, data regarding entry to the UK were available in 52% of cases and 86% of these women had entered the UK in the previous year. The annual incidence of new cases of HIV reported among women born in the UK has remained stable over the period of study and totals 50 (fig 2). Of these women, 30 had a recognised risk factor, eight had a partner who was an intravenous drug user, five women had a bisexual partner, nine had a
partner from sub-Saharan Africa and eight
had a partner known to be seropositive.
Twenty women had no apparent risk factors.

Discussion
Although national data published by the
Communicable Disease Surveillance Centre
(CDSC) provide more detailed information
about the epidemiology of HIV infection in
women and recognise the fact that increasing
numbers of women are reporting exposure to
partners from endemic areas, it does not dis-
tinguish between immigrants and UK born
individuals who have travelled abroad. The
main aim of this study was to address this
issue. A potential bias was the possibility of
patient selection of which clinic to attend for
their HIV infection giving a distorted view of
the nature of the HIV epidemic in London.
However, the effect is likely to have been
small since few clinics offer specialist HIV
care in the region and our three centres are
geographically close and would have allowed
for adequate patient choice.

Analysis of our data reveals that the
increase in new cases of HIV infection seen
thus far is primarily restricted to women born
in endemic areas. Most of these women are

recent immigrants and the acquisition of HIV
is likely to have occurred before entry to the
UK. Whilst this may suggest that the risk to
the local “low risk” population can be virtu-
ally discounted, the bias inherent in named
testing should be recognised. Individuals who
are “at risk” are more likely to be offered test-
ing and this may underestimate the extent of
infection in heterosexuals assumed to be “low
risk”. Only anonymous seroprevalence stud-
ies which include assessment of risk factors
can confirm or deny the true spread of HIV
in the “low risk” heterosexual population.
Furthermore as the cumulative number of
both men and women infected heterosexual-
ly increases, the risks of acquiring HIV in the
UK will also increase. It has become clear
that predictions of the spread of HIV infec-
tion are fraught with difficulties and that the
debate regarding the risks of a heterosexual
epidemic in the UK will continue. It is there-
fore important that safer sexual practices
should continue to be encouraged and con-
tinuing epidemiological surveillance main-
tained both anonymous and selective.

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1 Anonymous. Heterosexual AIDS: pessimism, pandemics,
2 Stewart GT. Errors in the predictions of the incidence and
distribution of AIDS. Lancet 1993;341:898.
3 PHLS AIDS centre. Communicable Disease Surveillance
Centre & Communicable Disease (Scotland) Unit.
Trends in exposure category distribution of HIV 1
infected persons England, Scotland, Wales and N
Ireland reported to 31 Dec 1992.
4 Murphy S, Breuer J, Chinn R, Goldmeier D, Harris JRW.
HIV infection among Sub-Saharan African patients in
the UK. Lancet 1989;i:1225.
5 Mitchell S, Rand B, Bradbeer C, Barlow D. Imported
heterosexual HIV infection in London. Lancet 1991;
337:1614-5.
6 Nandwani R, Hawkins D, Barton S. Imported hetro-