FIMR

Making Healthy Communities Happen

A PUBLICATION OF THE NATIONAL FETAL AND INFANT MORTALITY REVIEW PROGRAM

Summer 2009

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NFIMR

New Role for FIMR: Addressing Missed Perinatal HIV Prevention Opportunities

Interventions exist to eliminate perinatal HIV transmission in the United States, but many infants still become HIV positive due to missed prevention opportunities. (See Perinatal HIV Prevention Cascade, p 4–5) The Fetal and Infant Mortality Review (FIMR) methodology is an effective continuous quality improvement model used to improve perinatal systems to reduce infant mortality in more than 200 U.S. communities. Like infant mortality, perinatal HIV transmission is a sentinel event warranting investigation and action. Highly effective service systems, robust community resources and comprehensive interventions must be put in place to prevent perinatal HIV transmission.

Like infant mortality, perinatal HIV transmission is a sentinel event warranting investigation and action.

CDC creates a new opportunity. In 2005, the Division of HIV/AIDS Prevention at the Centers for Disease Control and Prevention (CDC) convened a meeting with several national organizations: CityMatCH, the National Fetal and Infant Mortality Review (NFIMR) Program, the American College of Obstetricians and Gynecologists (ACOG), and the Maternal and Child Health Bureau (MCHB) at the Health Resources and Services Administration. CDC asked each of these groups to partner with them to adapt the FIMR methodology to identify and address missed opportunities for HIV prevention and local systems failures associated with perinatal HIV exposure and transmission.

The partners agreed on four core objectives of this adapted FIMR-HIV case review and community action process:

- Examine and identify the significant social, economic, cultural, safety, MCH health systems and HIV service system factors that are associated

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VISIT THE NFIMR WEBPAGE http://www.nfimr.org

FIMR Faces Now in every issue!

Margaret Lampe, RN, MPH
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When I first learned about the Fetal and Infant Mortality Review Program, I was particularly interested in learning more about how it honed in on local systems issues and affected community change. As a former practicing perinatal nurse, each fetal death or perinatal HIV infection often left me feeling as if more could have been done *at a systems level* and that each case had a story from which we, as health care providers, could benefit.

I have worked in the field of Perinatal HIV Prevention since the early 1990's and have been fortunate to witness and participate in the development and testing of interventions to reduce the risk of perinatal HIV transmission. We now have the interventions to reduce the risk of perinatal transmission to 1% or less and perhaps to even *eliminate* perinatal HIV in the U.S. However, we continue to see ongoing infections, often because of local systems issues.

CDC has partnered with CityMatCH, NFIMR, ACOG and 3 communities (Jacksonville, FL, Detroit, MI, and Baton Rouge, LA) to pilot a modified FIMR-HIV methodology to investigate and address missed opportunities for perinatal HIV prevention. The lessons learned have been invaluable and we are incorporating the lessons learned from the pilot into a FIMR-HIV Methodology, which will be widely available this Summer.

Despite working at the federal level for over 11 years, I have not lost perspective that each case has a unique and telling story. The FIMR-HIV Pilot Project, using the maternal interview, allows some of those important stories to be told and to affect change. This methodology, I believe, will be one of the key strategies for the U.S. to get to zero cases of perinatal HIV…a goal that is achievable.

FIMR Faces is an editorial addition to *FIMR: Making Healthy Communities Happen*. To submit your articles on the challenges and joys of working with FIMR, please send your 500-word document to:

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NFIMR
Making Healthy Communities Happen

NFIMR is a collaborative effort between the American College of Obstetricians and Gynecologists and the federal Maternal and Child Health Bureau. Supported by Project #U 08MC00136 from the Maternal and Child Health Bureau (Title V, Social Security Act), Health Resources and Services Administration, Department of Health and Human Services.

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New Role for FIMR: Addressing Missed Perinatal HIV Prevention Opportunities.
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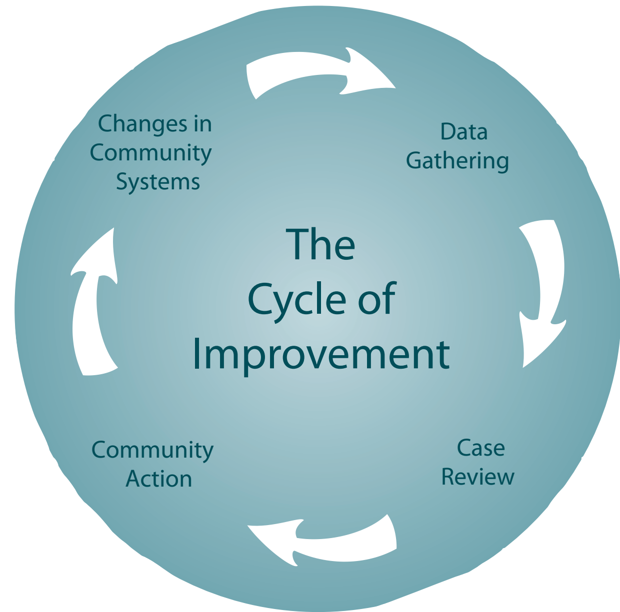
with care of HIV positive women and their infants through review of individual cases;

- Plan a series of interventions and policies that address these factors to improve the service system and community resources;
- Participate in the implementation of community-based interventions and policies; and
- Assess the progress of the interventions.

Some of the key characteristics of the FIMR process that the partners carried over into the FIMR-HIV review process include the following:

1. **Confidentiality is key.** FIMR cases are de-identified so that the names of families, providers and institutions are confidential—the FIMR focus is on improving service systems not assigning blame.
2. **FIMR focuses on systems.** Each FIMR case review provides an opportunity to improve communication among medical, public health and human service providers and develop strategies to improve local service systems and resources for women, children and families.
3. **FIMR includes a family perspective.** The FIMR process includes a home interview and the mother's story is conveyed to the FIMR team members.
4. **FIMR promotes broad community participation.** FIMR convenes two tiered community teams that can represent all ethnic and cultural community views and become models of respect and understanding.
5. **FIMR is action-oriented.** FIMR's two-tiered teams make recommendations to improve service systems and implement multiple creative community improvements in resources and service systems for women, infants and families.

As a prelude to implementing the FIMR-HIV program, the national partners developed HIV specific tools to aid in the process including: a priority assessment system for selecting which cases to review, detailed medical record abstraction and maternal interview forms, a case review team meeting guide and a community action team meeting guide. The medical data abstraction forms utilized Enhanced Perinatal



Surveillance and FIMR items when possible to support data sharing.

In 2005, through a competitive application process, the partners chose three communities with existing FIMR programs (Baton Rouge, LA, Detroit, MI and Jacksonville, FL) to receive funding to conduct the FIMR-HIV pilot for a period of two years. Each site was to gather information on 25 mother-infant pairs per year, choosing cases most likely to elicit information on gaps in perinatal and HIV health systems. The sites convened multidisciplinary, expert case-review teams (CRTs) to identify key missed opportunities and make specific recommendations for change. In addition, they called upon community leaders to join them in community action teams (CATs) and implement the recommended changes.

Findings. Each of the three local pilots was successful in adapting the FIMR process to examine cases of HIV exposure and/or transmission. As cases were reviewed, the CRTs asked:

- Did the HIV positive pregnant woman and her infant receive the services or community resources they needed?
- Are there gaps in the system?
- Are there specific missed opportunities for HIV prevention, treatment or follow-up?

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The Perinatal HIV Prevention Cascade*

Perinatal HIV Prevention

Reduction of mother to child transmission of HIV has been one of the major public health successes in the fight against HIV/AIDS in the United States. Without intervention, 20-30% of pregnant women who are HIV positive transmit the virus to their infants during pregnancy or delivery. With appropriate use of antiretroviral medications and cesarean delivery, the rate of transmission can be reduced to less than 2%. The timely initiation of such interventions depends upon a cascade of events beginning with the woman's preconception care and identification of her HIV status.

Every case of mother to child transmission of HIV is a sentinel health event. A breakdown in any of the steps in the prevention process described below may create a breach where transmission might occur. Highly effective service systems, robust community resources and comprehensive interventions must be put in place at each step to maximally prevent perinatal HIV transmission.

Chain of Events in Prevention of Perinatal HIV Transmission

- **Early diagnosis:** HIV screening should be a routine component of preconception care for all women. Women who become pregnant without knowing their HIV status represent important missed opportunities for prevention.
- **Prevention of unplanned pregnancies and planning of desired pregnancies:** Nearly half of all pregnancies in the United States each year are unplanned. Many cases of mother to child HIV transmission could be averted if women who are HIV positive and who do not desire pregnancy could access reliable family planning methods and avoid unplanned pregnancy. For other women who are HIV-positive and planning pregnancy, preconception care must focus on optimizing maternal health including maximally suppressing HIV viral load, improving immune status and prescribing a therapeutic drug regimen.Effective and appropriate contraception can then be employed until the optimal maternal health status for pregnancy is achieved. Preconception education should include information about perinatal transmission risks and all the prevention strategies that will be employed to prevent transmission. Exploring the mother's expectations for the child's future health and development is also important.

- **Acceptable prenatal care and ongoing HIV testing:** Approximately 10% of pregnant women who are HIV positive in the United States do not receive prenatal care. Some of these women cited the potential for discrimination and discomfort as reasons for avoiding prenatal care. Prenatal care providers should be mindful of these potential barriers to care. They should make every effort to provide accessible and acceptable care for all women to avoid missed opportunities for HIV detection and prevention. It is recommended that all pregnant women be screened for HIV infection as early as possible during each pregnancy following opt-out prenatal screening where legally possible. Pregnant women should be notified that they will receive an HIV test as part of the routine panel of prenatal tests unless they decline testing. (Providers should be aware of and follow their states' perinatal HIV testing requirements.) In some areas, transmissions have been reported among women who

**Adapted from a draft document titled* The Perinatal HIV Prevention Cascade *prepared by Margaret Lampe, RN, MPH and Allan Taylor, MD, MPH with the Division of HIV/AIDS Prevention at the Centers for Disease Control and Prevention.*

were diagnosed as HIV positive at term, following a negative first trimester HIV test result. Therefore, repeat testing in the third trimester is recommended for women in areas with elevated HIV prevalence, women known to be at high risk for acquiring HIV infection, and women who declined testing earlier in pregnancy.

- **Antenatal antiretroviral (ARV) initiation and regular prenatal care for women:** All pregnant women who are HIV positive should receive routine prenatal care. In addition, specific tests to monitor HIV status and a specific HIV drug regimen should be ongoing. In this way, the woman's health can be optimized, and the HIV virus maximally suppressed to decrease the risk of mother to child transmission. Consultation and ongoing communication between the obstetric provider and a health care provider well versed in HIV medicine is recommended.
- **Scheduled cesarean delivery:** Cesarean delivery performed before the onset of labor and before rupture of membranes effectively reduces the risk of mother to child transmission of HIV infection when a viral load of less than 1,000 copies per milliliter is not achieved. Discussion of the option of scheduled cesarean delivery should begin as early as possible during pregnancy to give women with HIV an adequate opportunity to consider the choice and plan for the procedure. Cesarean delivery is recommended for women with a viral load of greater than 1,000 copies per milliliter and there is no evidence that a Cesarean delivery reduces risk of transmission when the woman's viral load is less than 1,000 copies per milliliter. Cesarean delivery at 38 completed weeks of gestation is recommended to reduce the likelihood of the onset of labor or rupture of membranes occurring prior to delivery. There are, however, some potential barriers to making this intervention available, including late or no prenatal care, late identification of HIV status during pregnancy, or preterm delivery.
- **Intrapartum ARV medications:** ARVs should be administered to the mother who is HIV positive during labor. Even if a woman is identified as HIV positive only shortly before delivery, ARV prophylaxis can still significantly reduce the risk of transmission. All women who present in labor with unknown or undocumented HIV status should be tested for HIV infection using a rapid HIV test to obtain results as soon as possible. A negative rapid test result is definitive. A positive rapid test result is not definitive and must be confirmed with a supplemental test. However, antiretroviral treatment should be initiated, with the mother's consent, without waiting for the results of the confirmatory test in order to further reduce possible transmission to the infant.
- **Neonatal ARVs, diagnosis and prophylaxis:** Any infant born to a woman with undocumented HIV status should be tested for HIV as soon as possible after delivery using a rapid HIV test. Also, every infant whose mother is HIV positive and thus, is exposed to HIV should receive ARVs for the first six weeks of life. Other medications to prevent opportunistic infection may be prescribed as well. In addition, the diagnosis of HIV in an infant often requires multiple tests over at least a two to four month period. Appropriate infant diagnosis and prophylaxis begins with the recognition of possible exposure by the delivery staff, documentation of HIV status, tests and medications in the maternal and neonatal medical records, and communication among the infant's medical providers. Education and public health home follow-up should be made available to the infant's mother or other caretaker to help ensure compliance with the complicated medication regimen and the multiple medical visits and tests schedules.
- **Avoidance of breastfeeding:** Mother to child HIV transmission through breast milk adds an estimated 15-20 percent risk of perinatal transmission. All mothers who are HIV positive in the United States should be counseled to avoid breastfeeding. They should also receive postpartum education about simple measures to relieve breast engorgement discomfort and techniques to bottle feed their infants with an appropriate breastmilk substitute.
- **Postpartum linkage to care for mother and infant:** Postpartum, HIV positive women and their infants should be linked with appropriate obstetric, pediatric and HIV treatment providers as well as other community resources necessary for their continued health and wellbeing. The mother should have full access to family planning services as an integral part of her health care. Public health home follow-up is highly recommended to ensure that women and infants access these services and that other urgent needs are identified and addressed, as necessary.

Resources

From Centers for Disease Control and Prevention:

CDC's perinatal HIV web site is at http://www.cdc.gov/hiv/topics/perinatal/

CDC has many culturally diverse publications/pamphlets available for the public at http://wwwn.cdc.gov/pubs/hiv.aspx

CDC's National Prevention Information Network (NPIN) is the reference, referral, and distribution service for information on HIV/AIDS, viral hepatitis, sexually transmitted diseases (STDs), and tuberculosis (TB) in the United States. NPIN produces, collects, catalogs, processes, stocks, and disseminates materials and information on HIV/AIDS, Viral Hepatitis, STDs, and TB to organizations and people working in all these disease fields in international, national, state, and local settings. For more information, go to http://www.cdcnpin.org/scripts/index.asp

One Test. Two Lives. (OTTL) is a health communications program developed by the Centers for Disease Control and Prevention (CDC) to help obstetricians, nurse-midwives and other obstetric providers ensure that all of their patients have the opportunity to learn their HIV status as a routine part of prenatal care and to protect their newborns from HIV infection. This campaign builds on the strategies that led to significant progress in reducing mother-to-child HIV transmission, and gives providers new tools to further reduce the number of infants born with HIV. The campaign offers a variety of tools for providers, including patient education materials. For more information, visit the ***One Test. Two Lives*** website at http://www.cdc.gov/1test2lives.

Also review Branson BM, Handsfield HH, Lampe MA, Janssen RS, Taylor AW, Lyss SB, et al. Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings. MMWR Recomm Rep 2006;55(RR-14):1–17; quiz CE1-4 at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm

From Health Resources and Services Administration:

AIDS*info* is a U.S. Department of Health and Human Services (DHHS) general web site about HIV/AIDS sponsored by the following U.S. Federal government agencies: National Institutes of Health (NIH), Office of AIDS Research, National Institute of Allergy and Infectious Diseases (NIAID), National Library of Medicine (NLM), Centers for Medicare and Medicaid Services (CMS), Health Resources and Services Administration (HRSA) and the Centers for Disease Control and Prevention (CDC) View this site at http://www.aidsinfo.nih.gov/

Learn more about the Ryan White HIV/AIDS programs, which serve children and their families, and Part D programs which specifically focus on this population. Services include perinatal and pediatric specialty care, support services, and linkages to research and clinical trials. To read the fact sheet about Ryan White, go to ftp://ftp.hrsa.gov/hab/Pediatric.pdf

From American College of Obstetricians and Gynecologists (ACOG):

Visit ACOG's Perinatal HIV Resources Web site at www.acog.org/goto/HIV and download ACOG's Perinatal HIV Toolkit *Reducing HIV/AIDS in Babies and Improving the Health of Pregnant Women with HIV/AIDS*, now available as a free PDF file . The toolkit is an information packet for state legislators, state health lobbyists, maternal/child health and HIV/AIDS advocates, and anyone else interested in understanding the issues surrounding prenatal/perinatal HIV testing. It contains information about current national testing guidance and includes suggested legislative language developed from and consistent with current ACOG and CDC recommendations. Other documents on this ACOG web site are available by emailing rcarlson@acog.org

From CityMatCH:

Access *Profiles of Perinatal HIV Prevention*, a publication which documents the success of 11 cities working with CityMatCH to advance perinatal HIV prevention in their communities at http://www.citymatch.org/hiv_intro.php

From the March of Dimes:

New Nursing Module! *Sexually Transmitted Infections, Including HIV: Impact on Women's Reproductive Health*

Resources

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(2008) This module provides clinical information about sexually transmitted infections (STIs), including information on the scope of the problem, pathogens, epidemiology, risk factors, transmission, and complications. The module identifies nursing interventions for women's sexual health, safer sex guidelines, screening, and counseling and addresses treatment guidelines from the Centers for Disease Control and Prevention (CDC). Access the module at http://www.marchofdimes.com/gyponline/index.bm2?cid=00000003&spid=ne_s2_1&tpid=ne_s2_1_2

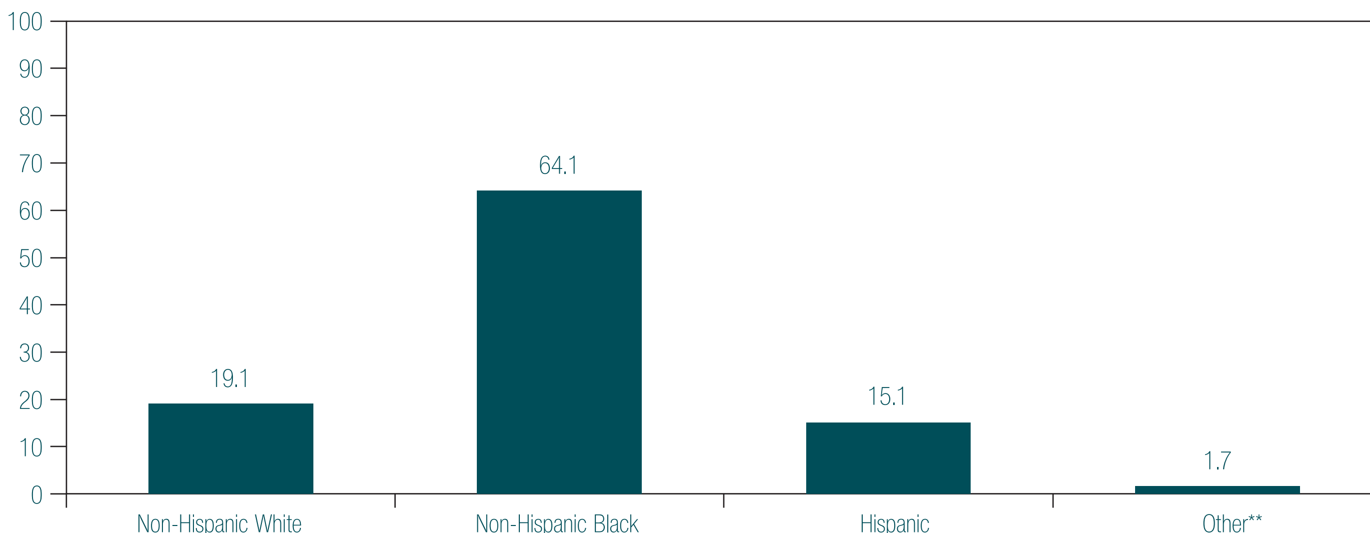
From Other Sources:

The Women, Children, and HIV Web site is the result of a collaboration between the François-Xavier Bagnoud (FXB) Center at the University of Medicine and Dentistry of New Jersey (UMDNJ) and the Center for HIV Information (CHI) at the University of California San Francisco. The goals of this web site are to: 1) Disseminate state-of-the-art clinical information and training resources on mother-to-child transmission of HIV (MTCT) and related topics; 2) Communicate the best practices in preventing mother-to-child transmission of HIV (PMTCT) and caring for infected children; 3) Disseminate PMTCT program resource materials; 4) Disseminate state-of-the-art clinical information and training resources on perinatally acquired pediatric HIV infection and 5) Implement services responsive to the needs of the CDC Global AIDS Program (CDC/GAP). To learn more, go to http://www.womenchildrenhiv.org/

Fast Stats

Adolescent and Adult Females Living with HIV/AIDS,*

by Race/Ethnicity, 2005



** Includes persons with a diagnosis of HIV infection (not AIDS), a diagnosis of HIV infection and a later diagnosis of AIDS, or concurrent diagnoses of HIV infection and AIDS; estimates are based on 33 States with confidential name-based HIV reporting. **Asian/Pacific Islanders, American Indian/Alaska Natives, persons of more than one race, and unknown.*

From U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. Women's Health USA 2007. Rockville, Maryland: U.S. Department of Health and Human Services, 2006.

Note: HIV/AIDS disproportionately affects minorities: in 2005, 64.1 percent of adolescent and adult females living with HIV/AIDS were non-Hispanic Black. In 2004, HIV/AIDS was the leading cause of death among non-Hispanic Black women aged 25–34.[1]

[4]Centers for Disease Control and Prevention. HIV/AIDS Fact Sheet, HIV/AIDS among Women. Rev ed. June 2007. Available from: http://www.cdc.gov.

Gable L, Gostin LO and Hodge JG. HIV/AIDS, reproductive health and the law. AJPH. 2008. Volume 98, No.10 pp 1779–1786

The authors point out that the law is a frequently overlooked tool for addressing the complex practical and ethical issues that arise from the HIV/AIDS pandemic. The law intersects with reproductive and sexual health issues and HIV/AIDS in many ways. They suggest that well-written and rigorously applied laws could benefit persons living with (or at risk of contracting) HIV/AIDS, particularly concerning their reproductive and sexual health.

The authors conclude that:

- Access to reproductive health services should be a legal right, and discrimination based on HIV status, which undermines access, should be prohibited.
- Laws against sexual violence and exploitation, which perpetuate the spread of HIV and its negative effects, should be enforced.
- A human rights framework should inform the drafting of laws to more effectively protect health.

Gray AD, Carlson R, Morgan MA, Hawkes D and Schulkin J. Obstetrician–Gynecologists' Knowledge and Practice Regarding Human Immunodeficiency Virus Screening ***Obstetrics & Gynecology*** **2007:Vol 110, pp 1019–1026**

The authors examined information regarding the prenatal human immunodeficiency virus (HIV) testing patterns of obstetrician–gynecologists. They sent survey questionnaires to 1,032 American College of Obstetricians and Gynecologists (ACOG) Fellows and Junior Fellows in practice. Questionnaires included inquiries about obstetrician–gynecologist characteristics, testing practices, and knowledge regarding HIV screening.

A total of 582 surveys (56%) were returned. They found that 1) most (97%) obstetrician–gynecologists reported recommending HIV testing to all of their pregnant patients, 2) almost half (48%) of the physicians reported using the opt-out approach to prenatal HIV testing, and 3) respondents were sometimes unaware of their state requirements regarding HIV testing during pregnancy.

The authors conclude that the finding that some obstetrician–gynecologists are unaware of their state regulations regarding prenatal HIV testing suggests that they would benefit from an increased awareness of state laws and regulations and having timely access to these requirements. The finding that most obstetrician–gynecologists offer HIV testing to all of their pregnant patients is consistent with the literature regarding prenatal HIV screening and with federal and national recommendations. However, the authors say that the study results also suggest that obstetrician–gynecologists may benefit from additional information to increase knowledge and strengthen perinatal HIV testing practice patterns.

Abatemarco DJ, Catov JM, Cross H, Delnevo C, Hausman A. Factors associated with the zidovudine receipt and prenatal care among HIV infected pregnant women in New Jersey. J Health Care Poor Underserved. 2008 Aug, Vol 19, No 3, pp 814–28

Despite reductions in perinatal HIV transmission, cases continue to occur. To determine factors associated with zidovudine (ZDV) receipt among HIV-infected pregnant women, the authors merged three data sets for women in New Jersey in 1995-1997, identifying 395 HIV-infected pregnant women. Half received ZDV prophylaxis. Attendance at five or more prenatal visits was the strongest independent factor related to ZDV receipt. Half (49.0%) had limited prenatal care. AIDS diagnosis, race/ethnicity, and drug use were also independently related to little or no ZDV receipt.

Further analysis also revealed that being unmarried, Black, multiparous, having no insurance, and illegal drug use were associated with limited prenatal care. Although the U.S. has seen reductions in HIV perinatal transmission, the authors conclude

that HIV- positive women who did not get prenatal care were less likely to receive ZDV prophylaxis. They suggest that a wide public health net that brings all women into care is necessary to reduce perinatal transmission further.

Cohen MH, Olszewski Y, Webber MP, Blaney N, Garcia P, Maupin R, Nesheim S, Agniel D, Danner SP, Lampe MA, Bulterys M. Women Identified with HIV at labor and delivery: testing , disclosing and linking to care challenges Matern Child Health J. 2008 Sep, Vol 12, No 5 pp 568–76

The authors set out to determine if women with undocumented HIV status in late pregnancy or at labor and delivery who are rapidly tested and identified as HIV infected have high-risk behaviors and psychosocial obstacles hindering postpartum follow-up. The authors interviewed and rapid tested consenting participants (women with undocumented HIV status and >/=24 weeks gestational age (GA) or imminent delivery or >/=34 weeks GA) in 6 cities. HIV- positive women were offered follow-up. From 2001-2005, the authors identified 54 HIV positive women: median age 26 years; 91% African American; 11 (20%) lost custody of their infants; 30 (56%) knew they or their partner were HIV-infected, but had no antenatal HIV care; 25 met criteria for starting antiretroviral therapy.

Comparison between 48 HIV- positive and 130 HIV- negative women, tested and interviewed at the same hospitals, showed HIV- positive women more likely to be African American and report no prenatal care, use street drugs, have unstable residency, not live with the father of their infant, and have children in foster care. Sixteen women (30%) and 17 (31%) infants did not remain in follow-up study due to relocation, child protective custody, and psychosocial issues including frequent substance use.

The authors conclude that over half of HIV- positive women knew they or their partner had HIV, but did not initially disclose their status. They strongly encourage that increased support services and substance abuse treatment are critical to facilitate better continuity of care for these socially marginalized women.

Burr CK, Lampe MA, Corle S, Margolin FS, Abresh C, Clark J. An end to perinatal HIV: success in the US requires ongoing and innovative efforts that should expand globally. J Public Health Policy. 2007 Jul,Vol 28, No 2 pp 249–60

The authors report that routine HIV screening during pregnancy followed by appropriate therapy has been extremely effective. This paper puts forth three strategies needed to maintain these gains and reach the goal of eliminating perinatal HIV:

- Standardize medical interventions and policy changes that support perinatal HIV reduction;
- Institute HIV screening in routine preconception care to identify HIV infection in women before pregnancy; and
- Critically focus attention and resources on primary prevention of HIV infection in women.

The authors also recommend that healthcare providers should incorporate HIV prevention education and routine screening into women's primary health care. They say that public health leaders should support and fund prevention strategies directed at young women. Successful approaches that have nearly eliminated perinatal HIV transmission in the United States offer valuable lessons that should also be applied to countries around the world.

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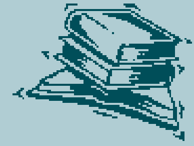

In The Literature

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Peters VB, Kai-Lih L, Robinson LG, Dominguez KL, Gill BS, Thomas PA. Trends in Perinatal HIV Prevention in New York City, 1994–2003 October 2008. AJPH. Vol 98, No.10 pp 1857–1864

The authors set out to examine trends in perinatal HIV prevention interventions in New York City implemented during 1994 to 2003 to ascertain the success of the interventions in reducing perinatal transmission. They used data obtained from infant records at 22 hospitals. They analyzed data for 4729 perinatally HIV exposed singleton births.

The authors found that 92% had prenatal care. The overall proportion of those who received prenatal care and were diagnosed with HIV before delivery was 86% in 1994 to 1996 and 90% in 1997 to 2003. Use of prenatal antiretrovirals among mothers who received prenatal care was 63% in 1994 to 1996 and 82% in 1997 to 2003. From 1994 to 2003, cesarean births among the entire sample increased from 15% to 55%. During 1997 to 2003, the perinatal HIV transmission rate among the entire sample was 7%; 45% of mothers of infected infants had missed opportunities for perinatal HIV prevention. During 1997 to 2003, maternal illicit drug use was significantly associated with lack of prenatal care. Lack of prenatal, intrapartum, and neonatal antiretrovirals; maternal illicit drug use; and low birthweight were significantly associated with perinatal HIV transmission.

The authors conclude that interventions for perinatal HIV prevention can successfully decrease HIV transmission rates. They suggest ongoing perinatal HIV surveillance for monitoring the implementation of guidelines to prevent mother to child transmission of HIV and determining factors that may contribute to perinatal HIV transmission.

New Role for FIMR: Addressing Missed Perinatal HIV Prevention Opportunities.

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- What can the case tell us about how women who are HIV positive are using the existing local resources?

The three pilot projects reviewed a total of 135 cases. These CRT reviews resulted in several important recommendations for systems change. In fact, all three projects recommended improved access to family planning and preconception care services. Other examples of recommendations include: 1) enhance mental health services for pregnant women who are HIV positive, 2) ensure timely transfer of records from provider to provider and 3) improve rates of prenatal HIV testing.

The pilot CATs have taken several actions to improve service systems. For example, the Jacksonville CAT developed a reproductive health needs assessment for women who are HIV positive. Ryan White Part A case managers in Jacksonville now use this assessment. The city of Detroit has enhanced mental health services for pregnant women who are HIV positive in the one hospital that serves this population. Also, the Baton Rouge CAT has tailored CDC's *One Test. Two Lives* social marketing campaign to include local resources. They disseminated it throughout key areas in the community to promote HIV prevention and testing during pregnancy.

Future Activities. All pilot site staff indicated that increased technical assistance would be helpful for all new projects. To that end, CityMatCH is working with the other national partners to create a replication guide and toolkit for new projects. CDC is funding CityMatCH and ACOG/NFIMR to assist additional sites with funding to conduct the FIMR-HIV project in 2009–2010. Existing FIMR sites, perinatal HIV prevention grantees and other interested parties are encouraged to apply. CityMatCH and NFIMR will also provide extensive technical assistance to these newly selected FIMR-HIV projects and others opting to implement the FIMR-HIV process.

For more information about this new FIMR-HIV process or to look for updates on the 2009–2010 grant application process, go to www.citymatch.org or www.nfimr.org

ACOG *Statement of Policy*

As issued by the ACOG Executive Board

This document was developed jointly by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists.

JOINT STATEMENT OF ACOG/AAP ON HUMAN IMMUNODEFICIENCY VIRUS SCREENING

The problem of perinatal transmission of HIV infection was first appreciated in 1982**.** In 1991, the Institute of Medicine (IOM) recommended a policy of routine counseling and offering testing (with specific informed consent) for HIV infection to all pregnant women. Since 1991, there have been major advances in the treatment of HIV infection, including demonstration in 1994 of the efficacy of zidovudine to reduce perinatal transmission. The U.S. Public Health Service subsequently issued guidelines for use of zidovudine to reduce perinatal transmission and for counseling and voluntary testing for pregnant women. Dramatic declines in reported pediatric AIDS cases have been observed as a consequence of implementation of these guidelines. However, for a variety of reasons, screening pregnant women in the United States has been far from universal and infected babies continue to be born to undiagnosed infected women. Further reduction in the rate of perinatal HIV infection will require wider application of both screening to identify infected women, and treatments, which have demonstrated efficacy in reducing vertical transmission.

The IOM recently completed a study of interventions that would be helpful to further reduce the rate of perinatal HIV infection in the United States (Reducing the Odds). They have recommended that “the United States should adopt a national policy of universal HIV testing, with patient notification, as a routine component of prenatal care”. Early diagnosis of HIV infection in pregnant women allows them to institute effective antiretroviral therapy for their own health and to reduce the risk of HIV transmission to their infants. The use of “patient notification” provides women the opportunity to decline to be tested but eliminates the obligation to provide extensive pretest counseling, which has been a barrier to testing in many settings. Care providers would be charged with responsibility for the details of how the notification would take place. The IOM has recommended universal testing for two reasons. First, attempts to identify those “at risk” for infection inevitably fail to identify some infected individuals. Second, universal testing of all pregnant women avoids stereotyping and stigmatizing any social or ethnic group. The IOM recognizes in its report that many states now have laws requiring a formal, and in many cases written informed consent process prior to testing. They recommend that the Federal government adopt policies that will encourage these states to change their laws.

The AAP and the ACOG strongly support efforts to further reduce the rate of perinatal transmission of HIV in the United States. We therefore support the recommendation of the IOM for universal HIV testing with patient notification as a routine component of prenatal care. If a patient declines testing, this should be noted in the medical record. We recognize that current laws in some states may prevent implementation of this recommendation at this time. We encourage our members and Fellows to include counseling as a routine part of care, but not as a prerequisite for, and barrier to, prenatal HIV testing.

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