HIV IN PREGNANCY FACT SHEET

The rate of HIV infection is increasing in women, particularly women of childbearing age. Since 2005, the Public Health Service has recommended universal prenatal HIV counseling and HIV testing without consent (OPT OUT) for all pregnant women in the U.S.

With appropriate HIV treatment in pregnancy, the risk of transmission from the mother to the baby can be drastically reduced. In a US study since 1990, transmission was observed in 20% of women with HIV infection who received no antiretroviral treatment during pregnancy; 10.4% who received zidovudine (AZT) alone; 3.8% who received combination therapy without protease inhibitors; and 1.2% who received combination therapy with protease inhibitors.

Each individual birth of an HIV infected infant is a sentinel event representing missed opportunities and barriers to prevention. Important obstacles of prenatal transmission in the State of Alabama include the continued increase of HIV infection among women of childbearing age; absent or delayed prenatal care, particularly in women using illicit drugs; acute (primary) infection in late pregnancy; poor adherence to prescribed ARV regimens and lack of full implementation of routine, universal HIV counseling and testing.

Offering routine HIV testing during pregnancy is especially important in Alabama due to our rising incidence of HIV in women of childbearing years. Remember you can’t tell who has HIV by looking at them. Many people (about 1 out of 3) who are HIV positive do not know that they or their partner(s) have HIV.

Recent reports support that HIV spread through heterosexual sex is the fastest rising type of transmission in women, including in Alabama. In some parts of the South (Alabama), African American women comprise over 30% of the HIV positive population. In some rural, southern counties, this figure is closer to 50%. The figure is higher than in the United States as a whole. This is attributed in a large part to unprotected sexual relations with HIV infected men.

Domestic violence frequently begins or intensifies during pregnancy, and there is a strong association between domestic violence and risk for HIV in women. The Statewide hotline number for domestic violence Programs is: 1-800-650-6522. The number of new AIDS cases is increasing faster in the South than in any other part of the country.
HIV EPIDEMIOLOGY IN ALABAMA

Reference: HIV/AIDS IN ALABAMA

An Update from the Alabama Department of Public Health - There has been a cumulative total of 17,674 people infected with HIV/AIDS in the state. The number of new HIV infections and AIDS cases are increasing among women in Alabama. Of all the HIV positive women, 41% reported they were exposed through heterosexual contact.

Unequal economic and social power between genders may make women more vulnerable to unsafe sexual practices and sexual exploitation. There is a strong association between domestic violence and the risk of HIV infection in women. The statewide domestic violence hotline number in Alabama is 1-800-650-6522.

Since 1982 there have been a cumulative total of 156 pediatric cases infected with HIV/AIDS in Alabama. By ADPH estimates, since 1999 there have been 300 infants born to HIV positive mothers in Alabama. Ten of these infants have been HIV infected. In the past 10 years there has been at least one infected infant a year in Alabama. There have been more HIV infected infants born recently, although these numbers are not yet available in the ADPH reports.

SUMMARY OF HIV GUIDELINES IN PREGNANCY


Recommendations for the Use of Antiretroviral Drugs in Pregnant Women Infected with HIV-1 for Maternal Health and for Reducing Perinatal HIV-1 Transmission in the United States (September 14, 2011 update)

Recommendations change quickly:
See the Website: http://aidsinfo.nih.gov for updates and further information principles:

All pregnant women should be routinely offered HIV testing in order to determine if they are infected with HIV.

CDC now recommends:
1. Routine testing (OPT OUT) for all pregnant women
2. Simplification of the testing progress
3. Flexibility in obtaining consent
4. Exploration of reason for refusal
5. Opt-out testing for all Pregnant Women, in which each woman is notified that an HIV test will be included in the standard battery of prenatal tests and that she may refuse the HIV test.
6. A pregnant woman is diagnosed with HIV when she has two HIV Elisa that are reactive and Western Blot that are positive from 2 different blood samples.
7. All HIV positive pregnant women should be referred to HIV medical provider
**CDC website: www.cdc.gov/hiv/PROJECTS/perinatal/op_1.pdf**

All HIV-infected pregnant women who require HIV therapy for their own health should receive a combination antepartum antiretroviral (ARV) drug regimen containing at least three drugs for treatment, which will also reduce the risk of perinatal transmission. The known benefits and potential risk of ARV drug regimen during pregnancy should be discussed with all women. Adherence to the ARV regimen should also be emphasized.

Combination antepartum drug regimens are also recommend for prevention for perinatal transmission in women who do not yet require therapy for their own health.

ARV prophylaxis is more effective when patients are given a longer duration than a shorter time. Consideration can be given to delaying initiation of prophylaxis until the 2\textsuperscript{nd} trimester in women who are receiving ARV solely for prevention of perinatal transmission, but earlier initiation of therapy may be more effective in reducing in utero transmission.

In the absence of antepartum administration of ARV drugs, ARV drugs should be administered intrapartum in combination with infant ARV prophylaxis to reduce the risk of perinatal transmission. If antepartum and intrapartum ARV drugs are not given, infant ARV prophylaxis should be provided.

This recommendation is based on the consistent findings that the risk of perinatal transmission increases with increasing maternal HIV RNA levels, that transmission rates are below 2\% among women receiving highly active ART, and that the use of multiple agents minimizes the potential for the development of resistance.

All HIV positive pregnant women are best served in consultation with experienced HIV practitioners. Evolving new therapies of HIV infection in pregnancy require expertise in managing the antiretroviral medications, the metabolic toxicities that may arise during treatment, and antiretroviral resistance. These linkages with experienced HIV providers are crucial during pregnancy.

All hospitals in Alabama with emergency departments and delivery suites where women may present in active labor should have intravenous ZDV (zidovudine, AZT, Retrovir) available for prophylaxis against perinatal HIV transmission. (See the full text on the website or consult with an HIV specialist for alternative intrapartum and postpartum regimens in the case of women with no HIV care during pregnancy).

All hospitals with newborn nurseries should have pediatric ZDV suspension on hand for administration to infants of HIV positive mothers beginning at 8-12 hours after birth.
Rapid HIV antibody tests are now available to clinical laboratories and hospitals. HIV antibodies can be detected within 20 minutes. Rapid testing is to be done at the bedside as a stat test and stat reporting of the test results. This can allow for the possibility providing AZT Prophylaxis to be given to the mother during labor. This is a valuable tool for optimizing management of pregnant women whose HIV status is not known.

CDC Website: www.cdc.gov/hiv/rapid_testing/rt-labor&delivery.htm

Failure to provide appropriate medication during delivery to pregnant women with known HIV infection and their exposed infants is a medical legal risk.

All HIV-infected pregnant women should be counseled about and administered antiretroviral (ARV) drugs during pregnancy for prevention of perinatal transmission, regardless of their HIV RNA levels.

Highly effective antiretroviral treatment should be offered to all pregnant women at 2nd trimester of pregnancy to decrease the transmission risk. Most practitioners would include ZDV as one of these medications. Treatment recommendations change quickly, so see the above website for further discussion and updates.

Consultation with an experienced HIV treating physician is critical.

Because the long-term impact of combination ART on fetus/infant is unknown, children who are exposed to ART need follow-up through the 1st 2 years of life for late potential toxicities.

For women known to be at high risk for acquiring HIV during pregnancy, consideration should be given to offering repeat testing in the third trimester with ELISA, Western Blot and HIV RNA/DNA PCR, preferably before 36 weeks of gestation. Also, women who develop a “mononucleosis-like syndrome” or other symptoms that could be associated with HIV seroconversion syndrome, or develop other sexually transmitted diseases during pregnancy should be considered for retesting.

Any woman presenting in labor with no documentation of HIV testing, should have a Rapid HIV test administered when she presents to the Labor and Delivery.

Infants of these women should be followed for possible HIV infection extremely closely after birth; even if their mother’s HIV test results in pregnancy are negative. The infant should be referred to HIV specialist. (There have been infants in Alabama whose mother tested HIV negative early in pregnancy, the mother became infected later in pregnancy and was not retested, and the infants became infected.)
HIV positive women and their infants should be provided information about participation in HIV clinical trials through the Adult or Pediatric AIDS Clinical Trials Group funded by NIH.

Goals of therapy of HIV infected pregnant women:
_ To effectively treat the woman’s HIV infection
_ To reduce the risk of perinatal HIV transmission
_ To provide the necessary social support services and adherence education for successful treatment
_ To link the mother and her family into a health care system for long term care

Initial assessment of HIV positive pregnant women includes:
_ Confirmation of HIV infection by documenting a second positive HIV antibody confirmatory test on a second blood specimen drawn at a separate time.
_ Co-management by an experienced HIV provider and the obstetric personnel
_ History of symptoms, duration of HIV infection, hospitalizations for therapy, Immunizations, immune status
_ Documentation of prior and current antiretroviral therapy
_ Supportive care to enhance adherence to a complex medical regimen
_ Risk for disease progression as determined by the level of plasma HIV RNA (viral load), and evaluation of the degree of existing immunodeficiency determined by the CD4 count
_ Baseline CBC with differential, renal and liver function tests
_ Determination of maternal status of gonorrhea, syphilis, chlamydia, hepatitis B and C, and TB
_ Counseling: effect of pregnancy on HIV; effect of HIV on pregnancy – perinatal transmission, therapy, mode of delivery

Recommendations for Antiretroviral Chemoprophylaxis to Reduce Perinatal HIV Transmission, for Use in Consultation with an Experienced HIV Provider:
_ Highly active antiretroviral treatment (HAART) should be discussed and offered to all HIV infected pregnant women to reduce the risk of perinatal transmission to maximally suppress HIV replication, and to minimize the risk of resistant virus.

Many experienced HIV practitioners would include ZDV as one of the components of HAART treatment. Women not on ZDV should still receive the intrapartum component, and their infants should receive the postpartum component of the ZDV protocol.

For HIV-infected women in labor who have had no prior therapy, several effective regimens are available. See the full Website text for further discussion.

To reduce the potential for emergence of resistance, if therapy requires temporary discontinuation for any reason during pregnancy, all drugs should be
stopped and reintroduced simultaneously.

The following drugs or combinations are not recommended in pregnancy:
1) monotherapy with ZDV due to suboptimal antiretroviral activity;
2) combination treatment with ddl (Videx)/d4T (Zerit) due to mitochondrial toxicity including lactic acidosis;
3) ZDV(Retrovir)/d4T (Zerit) due to antiretroviral activity antagonism; and
4) any regimen containing efavirenz (Sustiva) due to teratogenicity.

HIV medications have potential side effects requiring monitoring. Pregnant patients on protease inhibitors should have glucose levels closely monitored. Pregnant patients receiving nucleoside analogue drugs should have hepatic enzymes and electrolytes assessed more frequently during the last trimester of pregnancy. See the full text on the website for further discussion.

HIV RNA levels should be monitored at least every three to four months or approximately once each trimester. In addition, HIV RNA levels should be evaluated at 34-36 weeks of gestation to allow discussion of options for mode of delivery based on HIV RNA results.

Resistance testing should be done for the same indications as in non pregnant persons. In addition, The International AIDS Society-USA Panel and Euro Guidelines Group for HIV Resistance recommend that all pregnant women with detectable HIV RNA levels have resistance testing performed, even if they are antiretroviral naïve, to try and maximize the response to antiretroviral in pregnancy.

All pregnant women receiving antenatal ARV drugs who have suboptimal viral suppression or persistent viral rebound to detectable levels after prior viral suppression on an ARV regimen should have resistance testing.

Resistance testing should be done in consultation with an experienced HIV provider.

Note: Discussion of treatment options and recommendations should be noncoercive and the final decision regarding the use of antiretroviral drugs is the responsibility of the woman. A decision to not accept treatment with ZDV or other drugs should not result in punitive action or denial of care. Use of ZDV should not be denied to a woman who wishes to minimize exposure of the fetus to other antiretroviral drugs and who therefore chooses to receive only ZDV during pregnancy to reduce the risk for perinatal transmission.

Mode of delivery:
HIV positive pregnant women with viral load > 1000/mm3 (determined at 34-36 weeks) will receive counseling regarding the potential risks and benefits of
elective cesarean delivery at 38 weeks EGA. Prophylactic intravenous ZDV should begin 3 hours prior to cesarean delivery. All current oral antiviral therapy should be continued prior to and following delivery.

Obstetrical management should avoid invasive monitoring, avoid the use of instruments to assist delivery, and avoid a prolonged interval between rupture of membranes and delivery.

**For all HIV infected women in labor:**
At first sign of active labor, administer IV ZDV with a loading dose of 2mg/kg over 1 hour, followed by 1mg/kg/hr until cord is clamped.

All current oral antiviral therapy should be continued during labor and postpartum.

For HIV-infected women in labor who have had no prior therapy, several effective regimens are available.

*See the full Website text for further discussion.*

**Post-delivery recommendations:**
Coordinate visits of both mother and infant with HIV specialty providers within 2 weeks of birth.

Assess the need for changes in therapy. Ensure that arrangements have been made for ongoing HIV care with an experienced provider. Needed support services should be identified and provided if at all possible.

**INFANT CARE**
Because this field is changing so rapidly, referral/consultation with a specialist in the care of HIV-exposed or infected infants is essential for optimal management of infected or exposed infants. **Referral of infected infants is crucial.**

**Follow-up Care for Infants Born to Mothers with HIV Infection:**
- The Public Health Service recommends that documentation of *in utero* exposure to anti-HIV drugs become part of the permanent medical record of each affected child because of the yet unknown potential late toxicities of this preventive therapy.
- Because of reports of possible toxicities in infants born to HIV infected women who received ART including mitochondrial disorders, and theoretical concerns of carcinogenicity, it is recommended that these infants be referred for long-term follow-up continuing into adulthood, with yearly physicals. Most experts would include gynecologic exams with PAP smears for adolescent females, especially once they are sexually active.

**No breastfeeding**

**Infant Antiretroviral Prophylaxis (Updated September 14, 2011)**
The mother should leave the hospital with the full amount of ZDV needed for 6 weeks of therapy if possible as well as Nevirapine if needed.

Infants of mothers with advanced disease, or other significant risk factors for perinatal transmission, makes consultation essential with a pediatric HIV disease specialist as soon as possible.

**Panel’s Recommendations:**

- The 6-week neonatal component of the zidovudine chemoprophylaxis regimen is recommended for all HIV-exposed neonates to reduce perinatal transmission of HIV (AI).
- Zidovudine should be initiated as close to the time of birth as possible, preferably within 6–12 hours of delivery (AII).
- The 6-week zidovudine prophylaxis regimen is recommended at gestational age-appropriate doses; zidovudine should be dosed differently for premature infants less than 35 weeks than for infants at least 35 weeks of age (see Zidovudine Dosing and Table 8) (AII).
- In the United States, the use of antiretroviral (ARV) drugs other than zidovudine cannot be recommended in premature infants because of lack of dosing and safety data (BIII).
- The use of intrapartum/neonatal zidovudine is recommended regardless of maternal history of zidovudine resistance (BIII).
- Infants born to HIV-infected women who have not received antepartum ARV drugs should receive prophylaxis with a combination ARV drug regimen, begun as soon after birth as possible (AI). A randomized, controlled trial has shown that a 2 drug regimen of zidovudine given for 6 weeks combined with three doses of nevirapine in the first week of life (at birth, 48 hours later, and 96 hours after the second dose) is as effective as but less toxic than a 3 drug regimen of zidovudine, nelfinavir and lamivudine. The 2-drug regimen is preferred due to lower toxicity and because nelfinavir powder is no longer available in the United States. (see General Considerations for Choice of Infant Prophylaxis and Table 9) (AI).
- In other scenarios, the decision to combine other drugs with the 6-week zidovudine regimen should be made in consultation with a pediatric HIV specialist, preferably before delivery, and should be accompanied by counseling of the mother on the potential risks and benefits of this approach (BIII).
- The National Perinatal HIV Hotline (1-888-448-8765) provides free clinical consultation on all aspects of perinatal HIV, including infant care.

**Zidovudine Dosing**

All HIV-exposed infants should receive postpartum ARV drugs to reduce perinatal transmission of HIV. The 6-week neonatal zidovudine chemoprophylaxis regimen is recommended for all HIV-exposed infants [1-2]. Table 8 shows zidovudine dosing
intrapartum, which is a continuous intravenous infusion during labor, and neonatal dosing. Table 9 shows intrapartum and neonatal dosing for other drugs to be considered in certain situations as delineated below.

**Recommended Intrapartum Maternal and Neonatal Zidovudine Dosing for Prevention of Mother to Child Transmission of HIV**

<table>
<thead>
<tr>
<th>Maternal Intrapartum</th>
<th>Dosing</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zidovudine (ZDV)</td>
<td>2 mg per kg body weight intravenously over 1 hour, followed by continuous infusion of 1 mg per kg body weight per hour</td>
<td>Onset of labor until delivery of infant</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Neonatal</th>
<th>Dosing</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zidovudine (ZDV)</td>
<td>≥35 weeks gestation: 4 mg per kg body weight per dose given orally twice daily, started as soon after birth as possible and preferably within 6-12 hours of delivery (or, if unable to tolerate oral agents, 1.5 mg per kg body weight per dose intravenously, beginning within 6–12 hours of delivery, then every 6 hours)</td>
<td>Birth through 6 weeks</td>
</tr>
<tr>
<td></td>
<td>&lt;35 to ≥30 weeks gestation: 2 mg per kg body weight per dose given orally (or 1.5 mg per kg body weight per dose intravenously), started as soon after birth as possible and preferably within 6-12 hours of delivery, then every 12 hours, advanced to every 8 hours at age 2 weeks</td>
<td>Birth through 6 weeks</td>
</tr>
<tr>
<td></td>
<td>&lt;30 weeks gestation: 2 mg per kg body weight per dose given orally (or 1.5 mg/kg/dose intravenously) started as soon after birth as possible and preferably within 6-12 hours of delivery, then every 12 hours, advanced to every 8 hours at 4 weeks of age</td>
<td>Birth through 6 weeks</td>
</tr>
</tbody>
</table>

**Intrapartum Maternal and Neonatal Dosing for Additional Antiretroviral Drugs in Special Circumstances Based on NICHD-HPTN 040/PACTG 1043 Regimen**

(See Special Considerations Regarding the Use of Antiretroviral Drugs by HIV-Infected Pregnant Women and their Infants for further discussion.)

<table>
<thead>
<tr>
<th>Maternal Intrapartum/Postpartum</th>
<th>Dosing</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antiretroviral (ARV) Drug</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ZDV</td>
<td>2 mg per kg body weight intravenously over 1 hour, followed by continuous</td>
<td>Onset of labor until delivery of infant</td>
</tr>
</tbody>
</table>
Neonatal (initiated as soon after delivery as possible)

<table>
<thead>
<tr>
<th>Antiretroviral (ARV) Drug</th>
<th>Dosing</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-drug regimen: ZDV + NVP</td>
<td>• ZDV: 4 mg/kg given orally twice daily&lt;sup&gt;a,b&lt;/sup&gt;</td>
<td>Birth through 6 weeks</td>
</tr>
<tr>
<td></td>
<td>• NVP: <em>Birth weight 1.5–2 kg</em>: 8 mg per dose given orally</td>
<td>3 doses in the first week of life</td>
</tr>
<tr>
<td></td>
<td><em>Birth weight &gt;2 kg</em>: 12 mg per dose given orally</td>
<td>• 1st dose within 48 hrs of birth (birth–48 hrs)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 2nd dose 48 hrs after 1st</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 3rd dose 96 hrs after 2nd</td>
</tr>
</tbody>
</table>

Key to Abbreviations: 3TC = lamivudine; NFV = nelfinavir; NVP = nevirapine; ZDV = zidovudine

The zidovudine dosing requirements differ for premature infants and term infants. Zidovudine is primarily cleared through hepatic glucuronidation to an inactive metabolite; this metabolic pathway is immature in neonates, leading to prolonged zidovudine half-life and clearance compared with older infants. Clearance is further prolonged in premature infants because their hepatic metabolic function is even less mature than in term infants<sup>16-17</sup>. The recommended zidovudine dosage for infants less than 35 weeks gestation is 2 mg/kg body weight per dose orally every 12 hours (or 1.5 mg/kg body weight intravenously per dose every 12 hours), increasing to 2 mg/kg body weight per dose every 8 hours at age 2 weeks for infants born at 30 weeks gestation or more or at age 4 weeks in those born at less than 30 weeks gestation. For infants born at 35 weeks gestation or greater who are unable to tolerate oral zidovudine, the drug can be given intravenously at a dose of 1.5 mg/kg body weight every 6 hours.

**Zidovudine Dosing**

The recommended dose of zidovudine for post-exposure prophylaxis in full term neonates is 4mg/kg body weight orally twice daily for the first 6 weeks of life, beginning as soon after birth as possible preferably with-in 6–12 hours of delivery.

Within 48 hours after birth, obtain the following labs: HIV DNA PCR on peripheral blood, CBC with differential, ALT and glucose. A negative or undetectable RNA PCR is not sufficient to rule out HIV infection but an HIV RNA PCR can be

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<sup>1</sup>Dosing for the 3-drug regimen is not shown because nelfinavir powder is no longer commercially available in the United States, and the 2-drug regimen is preferred.

<sup>a</sup>NICHD-HPTN 040/PACTG 1043 used ZDV 12 mg given orally twice daily if the birth weight was >2 kg and 8 mg given orally twice daily if the birth weight was 1.5–2.0 kg.

<sup>b</sup>ZDV dosing regimen is for infants >=35 weeks’ gestation. See Table 8 for recommended doses for premature infants.
useful in making an early diagnosis of infection in some high risk situations. Consult with an HIV pediatric specialist).

To prevent Pneumocystis Pneumonia (PCP) TMP-SMX should be started at 6 weeks of age for all infants exposed to HIV, unless there is adequate test information to presumptively exclude HIV infection and continued until HIV infection is reasonably excluded.

Preferred dosage regimen: 150mg TMP/m2/day divided doses every 12 hours for 3 consecutive days per week.
Refer the infant for follow-up care to an HIV specialist within 2 weeks or less.
Determination of HIV-infection status with testing at 1-2 days, 2 weeks, 6-8 weeks, and 4-6 months of age.

The National Perinatal HIV HOTLINE(1-888-448-8765)provides free clinical consultation on all aspects of perinatal HIV, including infant care.

Additional Considerations in Management of Infants Born to Mothers Who Have Received No Antiretroviral Therapy During Pregnancy or Intrapartum:

The ZDV chemoprophylaxis regimen (see above) should be started as soon as possible after delivery-preferably within 6-12 hours of birth if possible, or immediately upon recognition that exposure occurred.
Chemoprophylaxis is more likely to be effective the sooner it is started.

The recommendations are changing quickly; consultation with an expert in pediatric HIV infection is crucial.

Follow-up care for Infants Born to Mothers at Increased Risk of Acquiring HIV Infection during Pregnancy:
For infants born to a mother who is at increased risk of acquiring HIV infection during pregnancy the following labs should be performed in the nursery after birth, at 2 weeks, 6 weeks of age and 4 months: Elisa, Western Blot, and HIV RNA and DNA PCR. These infants should be referred for care by a pediatrician with expertise in the diagnosis and treatment of HIV infection in infants. Mothers at high risk for acquisition of HIV infection should be advised not to breastfeed their infants.

Preconceptual Care for HIV Infected Women of Childbearing Age
_ Selection of effective and appropriate contraceptive methods to reduce the likelihood of unintended pregnancy.
_ Education and counseling about perinatal transmission risks and strategies to reduce those risks and potential effects of HIV or treatment on pregnancy course and outcomes.
_ Initiation or modification of antiretroviral therapy prior to conception in order to:
avoid agents with reproductive toxicity for the developing fetus, choose agents effective in reducing the risk of perinatal HIV transmission, attain a stable and maximally suppressed viral load, and evaluate and control for therapy associated side effects.

- Evaluation of opportunistic infections and initiation of appropriate prophylaxis and immunizations.
- Optimization of maternal nutritional status.
- Institution of standard recommendations for preconception evaluation and management.
- Screening for maternal psychological disorders, substance abuse disorders, and/or domestic violence.
- Planning for perinatal OB and HIV consultation if desired or indicated.

**FURTHER RESOURCES FOR HIV CARE IN PREGNANCY**

UAB Family Clinic
Barbara Corley, CRNP
Birmingham, AL
(205) 939-9400

**For obstetrical care questions:**

UAB Department of OB/GYN Division of Maternal-Fetal Medicine
Birmingham, AL

Alice Goepfert, MD or Maternal Fetal Medicine Physician on call
(205) 934-MIST

Alan Tita, MD
UAB Obstetrical Complications Clinic
(205) 934-MIST
(205) 934-2565

Gail Williams, RN
(205) 934-2170
UAB Obstetrical Complications Clinic

**UAB Family Clinic**
Birmingham, AL

Barbara Corley, CRNP
(205) 939-9400

Marsha Sturdevant, MD, Director
(205) 939-9400

**The University of South Alabama Family Specialty Clinic**
Mobile, AL
Theresa Miller, PA
(251) 434-3890

For HIV exposed or infected infants:

UAB Family Clinic
Birmingham, AL

Cecelia Hutto, MD or Pediatric Infectious Diseases Physician call
(205) 934-2441
(205) 934-MIST

Barbara Corley, CRNP
1-888-441-3767

University of South Alabama Family Specialty Clinic
Mobile, Alabama
Theresa Miller, PA
(251) 434-3890

Perinatal and Pediatric AIDS Clinical Trials Group Protocols:

UAB, Pediatric AIDS Clinical Trials Unit
Birmingham, AL

Marilyn Crain, MD
(205) 934-2441

USA Pediatric AIDS Clinical Trials Unit
Mobile, Al

Theresa Miller, PA
(251) 434-3980

HIV Clinics in Alabama, for treatment of adult or adolescent patients, including
For HIV treatment questions for pregnant patients:

UAB Family Clinic
Birmingham, AL
Marsha Sturdevant, MD, Director
(205) 939-9400
1-888-441-3767
(334) 284-5211 (Montgomery)
HIV Clinics in Alabama, for treatment of adult or adolescent patients, including
For HIV treatment questions for pregnant patients:

Health Services Center
Anniston, AL
Barbara J. Hanna, MD, Clinical Director
(256) 832-0100

Davis Clinic, AIDS Action Coalition
Mary Elizabeth Marr, Executive Director
Huntsville, AL
(256) 536-4700

HOPE Clinic
Tuscaloosa, AL
(205) 349-3250

Franklin Memorial Primary Health Center Part C Clinic
Mobile, AL
(251) 690-8158

Mobile County Health Department Part C Clinic
Mobile, AL
(251) 690-8158

Montgomery AIDS Outreach
Montgomery, AL with rural clinics in Clayton, Georgiana, Troy, Tuskegee, Pineapple, Selma and a full-time clinic in Dothan
Dr. Laurie Dill
(334) 280-3349 Montgomery (Copeland Care Clinic)
(334) 673-0494 MAO-Dothan
1-800-510-4704

St. George’s Clinic
Cooper Green Hospital
Birmingham, AL
Dr. Jane Mobley
(205) 930-3284

Montgomery Internal Medicine Residency Program
UAB School of Medicine
Montgomery, AL
Wick Many, MD
1-888-467-0765
UAB 1917 Outpatient Clinic
Birmingham, AL
Dr. Jim Raper or Truss Delfos-Broner
(205) 934-6684

USA Family Specialty Clinic
Mobile, AL
Theresa Miller, PA
(251) 434-3890

On-line and Print Resources
Standards of Care are rapidly changing, and up-to-date recommendations are available on the web:


Alabama Department of Public Health Website periodically updates summaries of recommendations and statewide resources. It also has links to many other HIV treatments and care resources. www.adph.org

American College of Obstetricians and Gynecologists www.acog.org

Helpline Numbers in Alabama for HIV
State Health Department Helpline: 1-800-228-0469
AIDS Alabama Helpline: 1-800-592-2437
Center for Disease Control and Prevention Helpline: 1-800-342-2437

Other Resources
Domestic Violence Statewide Hotline Number: 1-800-650-6522
Alabama Coalition Against Domestic Violence: (334) 832-4842

Recent review article:

The Governor of Alabama’s HIV Commission for Children, Youth, and Adults
Representative: Laura Hall, Chair

9/20/2011 bc