HHS Updates Perinatal and Pediatric HIV Guidelines

Revised guidance include a discussion of mixed feeding of breast milk and formula.

July 3, 2026 By Liz Highleyman

On June 25, the Department of Health and Human Services (HHS) updated its Recommendations for the Use of Antiretroviral Drugs During Pregnancy and Interventions to Reduce Perinatal HIV Transmission in the United States and Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection. When revising recommendations, the guidelines panels review new data and publications released since the prior update.

The guidelines recognize that women who consistently use antiretroviral therapy and maintain viral suppression have a very low risk of transmitting HIV during pregnancy, delivery or breastfeeding. The concept of "undetectable equals untransmittable," or U=U, is well established for sexual transmission of HIV, but adoption has been slower for perinatal transmission.

Infant Feeding

In light of U=U, women living with HIV have advocated for more autonomy in decisions about infant feeding, citing benefits of breastfeeding, such as better infant nutrition, lower cost, reduced stigma and mother-child bonding.

Older DHHS guidelines advised HIV-positive mothers not to breastfeed if safe formula and clean water are available. But the January 2023 update, for the first time, recommended "evidence-based, patient-centered counseling" to support shared decision-making about infant feeding, starting prior to conception or as early as possible in pregnancy.

If antiretroviral therapy is taken consistently and viral load is maintained at a level below 50 copies for at least three months prior to delivery, the current guidelines recommend counseling about the options of formula feeding, use of banked donor milk or breastfeeding, and state that providers should support the mother's decision. Under these circumstances, the risk of transmission via breastfeeding is "less than 1%, but not zero."

The guidelines urge providers to support exclusive breastfeeding while acknowledging that there may be scenarios where formula supplementation is needed. Older guidelines cited prior research

showing that infants who were exclusively breastfed had a lower risk of HIV acquisition than those who received mixed feeding that also included formula, other liquids or solid food. But there is “no evidence that formula supplementation increases the risk of HIV acquisition in the breastfed infant in the context of parental antiretroviral therapy and viral suppression.”

Antiretroviral Prophylaxis and Treatment

The guidelines state that all newborns exposed to HIV during gestation or delivery should receive one or more antiretrovirals as soon as possible after birth, preferably within six hours. Infants at low risk for HIV acquisition—defined as being born to a mother with a viral load below 50 from 20 weeks of gestation through delivery—should receive zidovudine (AZT; Retrovir) alone for a two weeks. For infants at high risk, presumptive treatment now consists of a three-drug regimen of dolutegravir (Tivicay) or nevirapine (Viramune) plus zidovudine and lamivudine (3TC; Epivir).

Extended antiretroviral prophylaxis during breastfeeding, when used, should continue until either four weeks after the last exposure to breast milk or four weeks after concerns about maternal viral suppression have been resolved. If maternal viral load rises to 200 or higher during breastfeeding or lack of viral suppression is suspected (for example, due to nonadherence), the guidelines recommend cessation of breastfeeding. If the infant was not already receiving antiretroviral prophylaxis, a three-drug regimen should be given for four weeks. If the infant was already on prophylaxis with one drug, the decision about whether to continue or switch to a three-drug regimen should be based on maternal viral load and other factors.

The latest guidelines revise the timing of virological diagnostic testing for infants with perinatal HIV exposure who are being breastfed. The last test should be performed three months after cessation of breastfeeding and at least two weeks after completion of infant antiretroviral prophylaxis.

For infants known to have HIV, the preferred regimen for initial treatment is dolutegravir plus zidovudine and either lamivudine or emtricitabine (Emtriva). The guidelines support the use of a dispersible dolutegravir tablet that is dissolved in water (Tivicay PD) for newborns, although this dosing strategy is not currently approved by the Food and Drug Administration. The panel noted that the recent FDA approval of Idvynso (doravirine/islatravir) will be addressed in the next update.

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