



HIV and Pregnancy

Women living with HIV can have healthy HIV-free babies, but this takes planning.

February 12, 2024 By [Liz Highleyman](#)

Thanks to highly effective antiretroviral treatment, many people with HIV are living healthy lives and pursuing long-term goals, such as starting a family. Women with HIV—as well as some transgender men and nonbinary people—can have problem-free pregnancies and give birth to healthy babies, but this requires planning before conception, during pregnancy and after delivery.

One concern for serodiscordant heterosexual couples is how to prevent HIV transmission during condomless sex. Fortunately, antiretroviral treatment and pre-exposure prophylaxis (PrEP) dramatically lower the risk, making natural conception very safe. People who consistently take antiretrovirals and maintain viral suppression do not transmit the virus during sex, and PrEP further protects HIV-negative partners.

Women on modern antiretroviral therapy with well-controlled HIV do not appear to be at greater risk for complications during pregnancy, premature delivery or having infants with birth defects, and pregnancy does not seem to worsen HIV disease progression.

To maximize the chances of a healthy pregnancy, all pregnant people should receive prenatal care. But some women with HIV have poor access to health care. They may not be aware of their HIV status until after they learn they are pregnant—or even until delivery. Lack of HIV testing before and during pregnancy and lack of prenatal care are major barriers to the elimination of mother-to-child HIV transmission.

Perinatal, or vertical, transmission can occur during gestation, during delivery or after birth via breastfeeding. Without treatment, an HIV-positive woman has about a 25% chance of passing HIV on to her baby. But for a woman on antiretroviral therapy with an undetectable viral load, the risk falls to 1% or less.

People who test positive for HIV during pregnancy should start antiretrovirals as soon as possible. Those who are already on a suppressive regimen when they become pregnant can often keep using the same drugs. Treatment should continue throughout pregnancy and during delivery. Pregnant people should not delay treatment or stop taking antiretrovirals due to concerns about fetal exposure, according to the federal government's HIV treatment guidelines.

The guidelines designate several antiretrovirals as preferred, meaning they have good efficacy,

acceptable side effects, no known risk of pregnancy complications or birth defects, are easy to use and have pregnancy-specific pharmacokinetic data available to guide dosing. Various alternative regimens are also acceptable options. However, the newest antiretrovirals have insufficient data on pharmacokinetics and safety for the mother and baby.

Pregnant women with HIV used to routinely receive intravenous AZT during labor and delivery, and cesarean section was recommended to prevent the baby from coming into contact with the mother's blood during vaginal delivery. These interventions are no longer necessary if the mother maintains good treatment adherence and has a viral load below 50 around the time of delivery, but they are still recommended if viral load is above 1,000 or unknown.

Whether to breastfeed can be a difficult decision for mothers living with HIV. Earlier in the epidemic, HIV-positive women were advised not to breastfeed if clean water and safe formula were readily available. Today, antiretroviral therapy that leads to full viral suppression lowers the risk of transmission via breastfeeding to less than 1%. Whether they choose to breastfeed or opt for formula feeding, mothers with HIV should be supported in their choices.

Beyond reducing the risk of perinatal transmission, staying on antiretroviral treatment after pregnancy is important for the mother's own health. Some women may have trouble maintaining good treatment adherence and finding time for health care appointments amid the whirlwind of caring for a newborn. Just remember—your health matters too!