



Updated Perinatal and Pediatric HIV Guidelines

Revised guidance include a discussion of what to do if viral rebound happens while breastfeeding.

February 21, 2025 By [Liz Highleyman](#)

On December 19, the Department of Health and Human Services (DHHS) 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](#). To revise the recommendations, the guidelines panels reviewed new data and publications released since the last updates. The same changes were made to both sets of guidelines.

The guidelines acknowledge that some individuals who give birth are transgender or gender-diverse and may prefer the term “chestfeeding” rather than “breastfeeding.” So far, DHHS HIV guidelines appear to have escaped the purge of gender-related language following President Donald Trump’s January 20 executive order on “gender ideology.”

The revised guidelines recognize that people on effective antiretroviral treatment with adequate viral suppression have a very low risk of transmitting HIV during pregnancy, delivery or breastfeeding, as is the case for sexual transmission—a concept known as [“undetectable equals untransmittable,” or U=U](#). The viral load threshold for reducing perinatal HIV transmission is thought to be around 50.

Infant Feeding

In light of U=U, HIV-positive women in the United States and other high-income countries have advocated for more autonomy in decisions about infant feeding, citing the benefits of breastfeeding, such as better infant nutrition, improved health, lower cost, reduced stigma and mother-child bonding.

Older DHHS guidelines advised mothers living with HIV 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.” Maintaining viral suppression during pregnancy and postpartum decreases breastfeeding transmission risk to less than 1%, and the guidelines state that, “Individuals with HIV who are on

[antiretroviral therapy] with a sustained undetectable viral load and who choose to breastfeed should be supported in this decision”—as should those who choose formula feeding.

The latest revision includes a discussion about what to do if viral load becomes detectable during breastfeeding. The panels recommend that breastfeeding should be stopped temporarily or discontinued and replaced with formula or donor milk while viral load is rechecked, causes of viral rebound are assessed and the importance of adherence is reinforced.

Depending on the level and persistence of viremia, the next steps may include starting or modifying antiretroviral prophylaxis for the infant, permanently stopping breastfeeding and considering the need for additional infant HIV testing. Most experts recommend permanent discontinuation of breastfeeding if viral load rises above 200. If the parent’s viral load goes back to undetectable on repeated tests, a joint decision can be made with providers about whether breastfeeding may safely resume.

Infant Diagnosis

In the section on “Diagnosis of HIV Infection in Infants and Children,” the authors recommend virologic diagnostic testing at birth using an HIV nucleic acid test. Such testing should generally be performed for all infants exposed to HIV during gestation or around the time of birth, but this is not necessary for babies at low risk because they were born to a person with a viral load below 50 from 20 weeks of pregnancy through delivery. However, birth testing should still be done for infants at low risk if the mother plans to breastfeed or there are concerns about loss to follow-up.

Antiretroviral Treatment for Exposed Infants

The section on “Antiretroviral Management of Infants With In Utero, Intrapartum or Breastfeeding Exposure or HIV Infection” has been extensively revised.

The authors added a new table on [Transmission Risk Assessment by HIV RNA Levels and Antenatal Time Period](#), which summarizes the risk of HIV transmission during three time periods: less than 20 weeks gestation, more than 20 weeks through four weeks prior to delivery, and within four week before delivery. Robust data are not available to define exact risk thresholds, so they selected time points that balance available data with implications for clinical management, such as antiretroviral prophylaxis and presumptive HIV treatment for exposed infants.

The authors recommend that infants at high risk for HIV acquisition from in utero or intrapartum exposure—defined as being born to a mother with a viral load of 50 or higher during the four weeks before delivery—should receive a three-drug antiretroviral regimen starting at birth and continuing for two to six weeks, which will serve as either enhanced prophylaxis or presumptive treatment. If the three-drug regimen is stopped before six weeks, AZT (zidovudine or Retrovir) should be continued alone to complete a total of six weeks of prophylaxis.

Infants at low risk of in utero and intrapartum HIV acquisition—defined as being born to a pregnant person with a viral load below 50 from 20 weeks of gestation through delivery—should receive AZT

alone for two weeks. For infants who do not meet either the high or low risk criteria, antiretroviral regimens and durations should be decided on case-by-case basis taking into account on the level and timing of viremia during pregnancy.

The section includes updated recommendations and expanded content about antiretroviral prophylaxis for infants who are breastfed by a parent with HIV. Infants are considered to be at low risk for HIV acquisition if the breastfeeding parent is on antiretroviral treatment with sustained viral suppression (below 50) for at least three months prior to delivery and the parent and provider are confident about good adherence during breastfeeding. Some experts do not recommend extended antiretroviral prophylaxis for infants at low risk, while others favor extended use of either nevirapine (Viramune) or lamivudine (3TC or Epivir), so the guidelines panels did not reach a consensus.

Bulleted recommendations, a table and associated content in this section have been added to provide guidance about infant antiretroviral prophylaxis or presumptive treatment when the breastfeeding parent experiences viral rebound (described above) or is newly diagnosed with HIV while breastfeeding.

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