PREGNANCY AND POSTPARTUM HIV TESTING AND IDENTIFICATION OF PERINATAL AND POSTNATAL HIV EXPOSURE

Updated: May 19, 2025
Reviewed: May 19, 2025

Panel's Recommendations

- HIV testing is recommended for all sexually active people and should be a routine component of pre-pregnancy care **(AII).**
- For all pregnancies, opt-out HIV testing should be done as early as possible during each pregnancy (see Laboratory Testing for the Diagnosis of HIV Infection: Updated Recommendations and 2018 Quick Reference Guide: Recommended Laboratory HIV Testing Algorithm for Serum or Plasma Specimens from the Centers for Disease Control and Prevention [CDC]) **(AII).**
- For all pregnancies, partners should be referred for HIV testing when their status is unknown **(AIII).**
- Repeat HIV testing in the third trimester is recommended during pregnancies in which there are negative initial HIV tests and increased risk of acquiring HIV, including pregnancies in which the care is received in facilities that have an HIV incidence of ≥1 case per 1,000 patients experiencing pregnancy per year, those who reside in jurisdictions (states or counties) with elevated HIV incidence among females aged 15 to 45 years (>17 per 100,000 females aged 15–45 years), or those who reside in states or territories that require third-trimester testing **(AII).** Annual state and county-level HIV diagnosis rates are available at CDC's National Center for HIV, Viral Hepatitis, Sexually Transmitted Diseases, and Tuberculosis Prevention AtlasPlus webpage.
- Repeat HIV testing is recommended when there is a sexually transmitted infection during pregnancy, when there are signs and symptoms of acute HIV infection, or when there is ongoing exposure to HIV **(AIII).** Initiation of pre-exposure prophylaxis (PrEP) is recommended if HIV testing is negative **(AIII).** See Pre-exposure Prophylaxis (PrEP) to Prevent HIV During Periconception, Antepartum, and Postpartum Periods for more information.
- Expedited[a] HIV testing should be performed during labor or after delivery when HIV status is undocumented as well as when HIV tests were negative early in pregnancy but there is increased risk of HIV infection and there was no retest in the third trimester **(AII).** HIV antigen/antibody testing should be available 24 hours a day, and results should be available within 1 hour. If results of expedited[a] HIV testing are positive, intrapartum intravenous zidovudine prophylaxis should be initiated immediately **(AI);** see Intrapartum HIV Care.
- When acute HIV infection is suspected during pregnancy or the intrapartum period or while breastfeeding, a plasma HIV RNA assay should be performed in conjunction with an antigen/antibody immunoassay **(AIII).**
- When there is a positive HIV test result during labor and delivery or postpartum, a maternal HIV-1/HIV-2 antibody differentiation assay and an HIV RNA assay should be performed **(AI).** In these situations, an HIV nucleic acid test (NAT) should be performed on the infant, with immediate initiation of presumptive HIV therapy appropriate for an infant at high risk of perinatal HIV transmission **(AI);** see Diagnosis of HIV Infection in Infants and Children for additional information.
- If maternal HIV test results are unavailable at birth, the newborn should be tested using an expedited[a] antibody test to identify perinatal HIV exposure **(AI).** If positive, an HIV NAT should be performed on the infant, and standard maternal HIV diagnostic testing should be offered as soon as possible **(AI).**
  - In this situation, presumptive HIV therapy appropriate for infants who are at high risk of perinatal HIV transmission should be initiated immediately **(AI).** See Antiretroviral Management of Infants With *In Utero*, Intrapartum, or Breastfeeding Exposure to HIV for guidance.

- When there is an initial positive HIV test during labor or delivery or immediately postpartum and there are plans to breastfeed, the Panel on Treatment of HIV During Pregnancy and Prevention of Perinatal Transmission recommends against breastfeeding. Breast milk should be expressed and stored appropriately until all supplemental HIV tests are reviewed and are negative **(AI).**

- When there is increased risk of HIV acquisition postpartum, HIV testing and PrEP should be offered. If breastfeeding is occurring, consult an HIV specialist regarding frequency of HIV testing for the breastfeeding dyad **(AIII).**
- Maternal HIV test results should be documented in the newborn's medical record and communicated to the newborn's primary care provider **(AIII).**
- To identify perinatal HIV exposure and possible HIV infection, HIV testing is recommended for infants and children in foster care and adoptees for whom maternal HIV status is unknown **(AIII)** (see Diagnosis of HIV Infection in Infants and Children).

[a] The term "expedited" is used to designate HIV testing performed in situations when a very short turnaround time is optimal. Expedited testing is dependent on the available HIV tests in each facility and may include antigen/antibody immunoassays or antibody-only assays; see Approved HIV Tests in the text below.

Rating of Recommendations: *A = Strong; B = Moderate; C = Optional*

Rating of Evidence: *I = One or more randomized trials in children[†] with clinical outcomes and/or validated endpoints; I* = One or more randomized trials in adults with clinical outcomes and/or validated laboratory endpoints with accompanying data in children[†] from one or more well-designed, nonrandomized trials or observational cohort studies with long-term clinical outcomes; II = One or more well-designed, nonrandomized trials or observational cohort studies in children[†] with long-term outcomes; II* = One or more well-designed, nonrandomized trials or observational studies in adults with long-term clinical outcomes with accompanying data in children[†] from one or more similar nonrandomized trials or cohort studies with clinical outcome data; III = Expert opinion*

[†]Studies that include children or children and adolescents, but not studies limited to postpubertal adolescents

Incident HIV infection during pregnancy, postpartum, or breastfeeding represents a period of high viremia and significantly increased risk of infant HIV acquisition. Similarly, entering pregnancy without knowledge of HIV infection also presents a high risk of perinatal transmission. This section addresses HIV testing in pregnancy, during labor and delivery, and postpartum. The section also addresses HIV testing to identify HIV perinatal and postnatal exposure in infants. For guidance on diagnosis of HIV in infants and children, see Diagnosis of HIV in Infants and Children.

Approved HIV Tests and Recommended HIV Testing Algorithm

There are multiple U.S. Food and Drug Administration (FDA)–approved tests available for the diagnosis of HIV infection. Clinicians should familiarize themselves with the testing available at their facilities, including the turnaround time for receiving results and test performance characteristics (e.g. sensitivity, specificity). For the purposes of this section, three types of testing are discussed: antigen/antibody immunoassays; antibody-only immunoassays; and HIV nucleic acid tests (NATs).

- Antigen/antibody immunoassays: Most routine laboratory testing for HIV currently uses antigen/antibody tests. Because these tests also detect HIV p24 antigen, they can detect acute HIV infection as early as 1 to 2 weeks after appearance of HIV RNA and before appearance of HIV antibody. These tests also detect HIV-2 infection. Laboratory-based tests require trained laboratory staff, and results can be available within 1 hour, but in some hospitals the test may not be readily available 24 hours a day. One FDA-approved antigen/antibody test can be performed at the point of care (POC), provides results after 20 minutes, and must be read before 30 minutes. Using timed seroconversion panels, this POC antigen/antibody test has been shown to detect HIV infection just 1 day later than laboratory-based antigen/antibody tests. However, it

has lower specificity than laboratory-based antigen/antibody tests; therefore, false positive results are more likely than with laboratory-based tests.[1]

- Antibody-only immunoassays: Many antibody-only immunoassays in current use can be performed using blood from a finger stick or oral fluid and provide results within 30 minutes. Because of this very short turnaround time, they are often referred to as rapid tests. Many of these tests are also approved by the FDA for POC usage. Because these tests detect only antibody, acute HIV infection may be missed.
- HIV NAT: HIV-1 NAT detects HIV viral nucleic acid in blood. Depending on the type of HIV NAT, it may detect acute HIV infection, help diagnose HIV infection, and assess response to HIV therapy. Different laboratories may have varying turnaround times for HIV NAT; some require several days before results are available.
- In this section, the term expedited is used to designate testing performed in situations when a very short turnaround time is optimal, such as when HIV status is undocumented during labor. Expedited testing should be available in all delivery units 24 hours a day, and results should be available within 1 hour. Expedited testing is dependent on the available HIV tests in each facility and may include any of the three test types. In a setting with low HIV prevalence and/or frequent testing, false positive initial test results will be common. Expedited and/or concurrent NAT can be helpful in managing an initial positive HIV test result. An HIV-1/HIV-2 antibody differentiation assay may be helpful if an antibody response has been mounted.

The Panel on Antiretroviral Therapy and Medical Management of Children Living with HIV and the Panel on Treatment of HIV During Pregnancy and Interventions to Reduce Perinatal HIV Transmission (the Panels) **recommend that clinicians initiate HIV testing with an immunoassay that can detect HIV-1 antibodies, HIV-2 antibodies, and HIV-1 p24 antigen (referred to as an HIV antigen/antibody immunoassay).** The Panels' recommendations for HIV testing are based on the Centers for Disease Control and Prevention's (CDC's) 2014 Laboratory Testing for the Diagnosis of HIV Infection: Updated Recommendations.[2]

Individuals with a reactive antigen/antibody immunoassay should be tested further with an **HIV-1/HIV-2 antibody differentiation assay (referred to as supplemental testing).** Individuals with a reactive antigen/antibody immunoassay and a nonreactive differentiation test should be tested with an FDA-approved plasma HIV RNA assay to assess for acute HIV infection (see the CDC's 2018 Quick Reference Guide: Recommended Laboratory HIV Testing Algorithm for Serum or Plasma Specimens).

In some clinical settings, initial testing may be conducted with a **rapid HIV test,** which may detect a combination of antigen and antibodies or only HIV antibodies. Positive results on POC rapid tests should be followed first by a laboratory-based antigen/antibody assay using serum or plasma and when reactive, followed by a differentiation assay.[3]

Clinicians should assess risk of acute HIV infection during pregnancy, particularly late in pregnancy, because there may be a negative result for HIV immunoassays during the window period (the time between infection and when the infection can be detected by a specific laboratory test). The antigen/antibody immunoassay may detect infection as early as 18 days after infection; antibody-only assays may not detect infection until as long as 45 days post-infection. However, during this period, the person with acute HIV will be viremic,[4] with a high risk of perinatal transmission. The HIV RNA assay can detect the presence of HIV as early as 10 days post-infection. **When acute HIV infection is suspected** during pregnancy, during the intrapartum period, or while breastfeeding, **a plasma HIV RNA assay should be performed in conjunction with an antigen/antibody immunoassay.** See Early (Acute and Recent) HIV Infection for more information.

Discordant or False Positive HIV Test Results

Discordant HIV testing results can occur, requiring careful evaluation and often repeat tests. Early in HIV infection, before HIV seroconversion, the test combination of a positive antigen/antibody screen, negative HIV-1/HIV-2 antibody differentiation assay, and positive HIV RNA assay may be seen. This combination of results can occur because the immunoglobulin G–based antibody differentiation assay is positive later in infection than the antigen capture or the immunoglobulin M result in the antigen/antibody screen.

False positive results do occur with HIV testing. The frequency of false positive HIV testing is dependent both on the specificity of the assay and the prevalence of HIV in the population, so frequency may vary considerably. In a large urban hospital in Dallas, 21,163 women were screened using a combination antigen/antibody immunoassay. Reactive initial screens were followed by supplemental testing recommended by the CDC algorithm. Of the 190 who tested positive, 28 were determined to have a false positive HIV test, yielding a positive predictive value of 83% (95% confidence interval [CI], 77% to 88%) and a false positive rate of 0.16% (95% CI, 0.11% to 0.22%), using the ARCHITECT HIV Ag/Ab assay.[5] For women screened a second time in pregnancy, the rate of false positive results relative to true positive results may be higher, as it depends on the community risk of HIV acquisition over a short time period (i.e., the 6 months between first- and third-trimester testing).

For any positive HIV screen late in pregnancy, during labor, or immediately postpartum, an HIV RNA assay should be done at the same time as the supplemental HIV-1/HIV-2 antibody differentiation assay. The HIV RNA assay will be needed to resolve questions raised by discordant results between the antigen/antibody screen and the antibody differentiation assay.

The combination of a positive HIV antigen/antibody screen with a negative supplemental HIV-1/HIV-2 antibody differentiation assay and a negative HIV RNA assay is seen when there is a false positive antigen/antibody screen.

Timing and Benefits of HIV Testing Prior to Conception or During Pregnancy

HIV infection should be identified before pregnancy (see Prepregnancy Counseling and Care) or as early as possible in pregnancy. In the United States, approximately 20% to 34% of infants with perinatal HIV exposure were born to mothers whose HIV diagnosis was not known before pregnancy.[6] Early diagnosis provides the best opportunity to improve maternal health and pregnancy outcomes and to prevent infant acquisition of HIV. Universal voluntary HIV testing is recommended as the standard of care during all pregnancies in the United States by the Panels, CDC, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, and U.S. Preventive Services Task Force.[7-11] HIV testing should be performed during pregnancy wherever care is provided (including emergency departments and prenatal clinics) to avoid missed opportunities to identify HIV infection. Repeat HIV testing should be performed in the third trimester when there is increased risk of acquiring HIV or when living in areas of high HIV incidence. Repeat testing is also recommended when a sexually transmitted infection (STI) is diagnosed during pregnancy, or when symptoms and signs of acute HIV infection are present. When HIV status is unknown or undocumented during labor, providers should test for HIV before delivery or as soon as possible after delivery.[12-15] Because women are more susceptible to HIV acquisition during pregnancy and the postpartum period, HIV testing provides an opportunity for clinicians to initiate a discussion about preventive interventions, including educating and counseling about pre-exposure prophylaxis (PrEP) when there is risk for acquiring HIV during pregnancy. See Pre-exposure Prophylaxis (PrEP) to Prevent HIV During Periconception, Antepartum, and Postpartum Periods and guidance available on CDC's Pre-exposure Prophylaxis (PrEP) webpage for more information.

Determining HIV status before pregnancy or during the antenatal period enables:

- Provision of appropriate antiretroviral therapy (ART) and prophylaxis against opportunistic infections;
- Initiation of treatment to maintain and improve health and to decrease risk of perinatal HIV transmission and transmission to partners[7,17,18];
- Referral of partners for testing, providing an opportunity for treatment initiation by partners testing positive, PrEP initiation by serodifferent partners testing negative, and counseling on other preventive measures (see Pre-exposure Prophylaxis (PrEP) to Prevent HIV During Periconception, Antepartum, and Postpartum Periods);
- Counseling during pregnancy and HIV care about recommended modes of delivery based on individualized risks of perinatal transmission of HIV[19-21];
- Provision of an appropriate antiretroviral (ARV) prophylaxis regimen to the newborn to reduce risk of infant HIV acquisition (see Antiretroviral Management of Infants With *In Utero*, Intrapartum, or Breastfeeding Exposure to HIV);
- Shared decision-making on infant feeding choice, specifically breastfeeding or use of replacement feeding (see Preventing HIV Transmission During Infant Feeding); *and*
- Early diagnostic evaluation of infants exposed to HIV, as well as testing of other children, to permit prompt initiation of ART and any indicated prophylaxis measures (see Diagnosis of HIV Infection in Infants and Children, Antiretroviral Management of Infants With *In Utero*, Intrapartum, or Breastfeeding Exposure to HIV, and Table 6. What to Start: Initial Antiretroviral Regimens During Pregnancy When Antiretroviral Therapy Has Never Been Received).[8,22,23]

Finally, all HIV testing should be performed in a manner that is consistent with state and local regulations. The CDC recommends the “opt-out” approach, which is allowed in many jurisdictions and involves notification that HIV testing will be performed as part of routine pregnancy care unless the choice is made not to be tested.[7] The “opt-in” approach involves obtaining specific consent before testing, and this approach has been associated with lower testing rates.[24,25] Despite the guidelines for universal HIV screening during pregnancy, recent studies indicate that fewer than 80% of women report having been tested for HIV during pregnancy.[26,27] The mandatory newborn HIV testing approach, which has been adopted by several states, involves testing newborns with or without parental consent. In some areas, this applies to all newborns; in others, it applies only when prenatal or intrapartum maternal testing has been declined.

Repeat HIV Testing in the Third Trimester

Repeat HIV testing during the third trimester, before 36 weeks of gestation, is recommended when there were negative results on the initial HIV tests during pregnancy and:

- There is high risk of acquiring HIV (i.e., injection drug use or sex with people who inject drugs, exchange of sex for money or drugs, sex partner with HIV who has a detectable or unknown HIV viral load, new sex partner or more than one sex partner during the current pregnancy,[7] suspected or diagnosed STI during pregnancy,[10] recent immigration from a high-burden HIV setting, partner who either recently immigrated from a high-burden HIV setting or recently traveled to such a setting); *or*
- Health care is being provided by facilities where prenatal screening identifies one or more HIV cases per 1,000 patients experiencing pregnancy screened or the jurisdiction of residence (state or county) has an elevated incidence rate of HIV in females aged 15 to 45 years. An annual HIV diagnosis rate ≥17 per 100,000 females aged 15 to 45 years can be used as a proxy for elevated HIV incidence. Annual state- and county-level HIV diagnosis rates by age are available at the

CDC's National Center for HIV, Viral Hepatitis, Sexually Transmitted Diseases, and Tuberculosis Prevention AtlasPlus webpage[7,10]; *or*

- The states or territories of residence have statutes or regulations that require third-trimester HIV testing. In a 2020 article, these included Arizona, Connecticut, Delaware, Florida, Georgia, Illinois, Louisiana, Maryland, Nevada, New Jersey, North Carolina, Tennessee, Texas, Virginia, and West Virginia.[28] State-level clinical guidelines may also recommend third-trimester HIV testing (e.g., New York). Clinicians should check current requirements and recommendations in their jurisdictions; *or*
- There are signs or symptoms of acute HIV (e.g., fever, lymphadenopathy, skin rash, myalgia, headaches, oral ulcers, leukopenia, thrombocytopenia, elevated transaminase levels).[7,10,29,30]
- There is self-perception as being at increased risk for HIV infection (regardless of whether or not any of the above criteria apply). When testing is declined earlier in pregnancy, providers should offer testing again during the third trimester.

An antigen/antibody immunoassay should be used for third-trimester testing because these tests have a higher sensitivity in the setting of acute HIV infection than older antibody tests.[2,31] If acute HIV infection is suspected, a plasma HIV RNA assay should be performed in conjunction with an antigen/antibody immunoassay. See Early (Acute and Recent) HIV Infection for more information.

Providers should be proactive in assessing HIV acquisition risk during pregnancy and implementing third-trimester HIV retesting when indicated. A study in Baltimore found that only 28% of women were retested for HIV despite the high incidence of HIV in Maryland and a high frequency of clinical risk factors.[15] A study of data from 2007 to 2014 on children in Florida with perinatal HIV exposure found that perinatal HIV transmission was associated with poor or late prenatal care, diagnosis of HIV during labor and delivery or after birth, and, in some cases, acute maternal infection (as indicated by negative results for initial tests).[32]

When determining the timing of repeat HIV testing in the third trimester, some clinicians conduct testing at or around 28 weeks of gestation in conjunction with the recommended timing of syphilis testing. This approach limits the number of blood draws and allows adequate time for syphilis treatment and congenital syphilis prophylaxis. Some clinicians also conduct a third test for HIV at the time of delivery hospitalization admission.

HIV Testing During Labor When HIV Status Is Unknown

When HIV status is undocumented during labor or HIV testing was negative early in pregnancy but there is an increased risk of HIV infection and there was no retesting in the third trimester, expedited HIV testing should be performed.[7-9,22,33,34]

- Perform an expedited HIV test—either an antigen/antibody immunoassay that can provide results within 1 hour or the most sensitive rapid test (includes rapid POC tests) available during labor. An HIV RNA assay should also be performed when there is suspected acute HIV infection. In a setting with low prevalence and/or frequent testing, false positive initial test results will be common. Expedited and/or concurrent NATs can be helpful in managing an initial positive HIV test result.[35]
- If the initial HIV test result is negative (nonreactive), no further testing is required unless acute HIV infection is suspected (see Acute HIV Infection During Pregnancy or Breastfeeding below).[2]
- A positive antigen/antibody immunoassay or rapid HIV test result must be immediately followed by a supplemental HIV-1/HIV-2 antibody differentiation assay, as well as a maternal HIV RNA assay and an HIV NAT for the infant.[2] If possible, contact the laboratory to prioritize results.

- For delivery units, every effort should be made to have the ability to run a confirmatory supplemental test (HIV-1/HIV-2 antibody differentiation assay) 7 days a week. If possible, results of HIV RNA assays should be available in 24 hours or less.
- When there is a positive HIV test result or suspected acute HIV infection during labor, provide counseling about HIV test results and implications for care.
    - Initiate intravenous zidovudine during labor (see Intrapartum HIV Care).
    - Immediately initiate presumptive HIV therapy appropriate for infants who are at high risk of perinatal HIV transmission (see Antiretroviral Management of Infants With *In Utero*, Intrapartum, or Breastfeeding Exposure to HIV or contact the National Clinician Consultation Center Perinatal HIV/AIDS hotline).
    - When there are plans to breastfeed, the Panel on Treatment of HIV During Pregnancy and Prevention of Perinatal Transmission strongly advises against initiating breastfeeding given the high risk of perinatal transmission. Breast milk should be expressed and stored appropriately; it should not be used for infant feeding unless all supplemental HIV test results are reviewed and determined to be negative (see Preventing HIV Transmission During Infant Feeding).

HIV Testing During the Postpartum Period

When there has been no testing for HIV during pregnancy or labor, expedited testing during the immediate postpartum period should be offered. Postpartum HIV testing should be done using the antigen/antibody immunoassay to screen for established and acute HIV; results should be obtained in <1 hour. If acute HIV infection is a possibility, then a plasma HIV RNA test should be sent as well.

When HIV testing is requested postpartum or there is increased risk of HIV acquisition (e.g., injection drug use or sex with people who inject drugs, exchange of sex for money or drugs, sex partner with HIV who has a detectable or unknown HIV viral load, new sex partner or more than one sex partner during the current pregnancy,[7] suspected or diagnosed STI during pregnancy,[10] recent immigration from a high-burden HIV setting, partner that either recently immigrated from a high-burden HIV setting or recently traveled to such a setting) HIV testing and PrEP should be offered. See Pre-exposure Prophylaxis (PrEP) to Prevent HIV During Periconception, Antepartum, and Postpartum Periods for more information. If breastfeeding is occurring, consult an HIV specialist regarding frequency of HIV testing in the breastfeeding dyad.

When an initial maternal or infant HIV test is positive or there is high suspicion of acute HIV infection, it is strongly recommended that clinicians initiate presumptive HIV therapy appropriate for infants who are at high risk of perinatal HIV transmission, ideally ≤6 hours after birth (see Antiretroviral Management of Infants With *In Utero*, Intrapartum, or Breastfeeding Exposure to HIV). Providers should counsel against breastfeeding pending the results of supplemental testing, which should include a plasma HIV RNA assay. Breast milk can be expressed while HIV diagnostic testing is being completed, but it should not be given to the infant until HIV negative maternal testing is confirmed. If supplemental test results are negative and acute HIV is excluded, infant ARV drugs can be discontinued. In the absence of ongoing HIV exposure, breastfeeding can be initiated. Consultation with a pediatric HIV specialist is strongly recommended if questions remain about the potential for acute infection while lactating or ongoing infant risk of HIV exposure.

Infant HIV Testing When Maternal HIV Test Results Are Unavailable

When maternal HIV test results are unavailable (e.g., testing declined during pregnancy, infant or child is in foster care) or their accuracy cannot be evaluated (e.g., for internationally adopted infants and children), HIV testing of these infants or children is indicated to identify HIV exposure and

possible infection.[8] If maternal HIV test results are unavailable, the infant should be tested using an expedited antibody test to identify perinatal HIV exposure. If positive, an HIV NAT should be performed on the infant, presumptive HIV therapy appropriate for infants at high risk for perinatal HIV transmission should be initiated immediately (see Antiretroviral Management of Infants With *In Utero*, Intrapartum, or Breastfeeding Exposure to HIV for guidance), and standard maternal HIV diagnostic testing should be offered as soon as possible. For older infants and children, the choice of test will vary based on the age of the child (see Diagnosis of HIV Infection in Infants and Children).

Acute HIV Infection During Pregnancy or Breastfeeding

Pregnancy and the early postpartum period are times of increased risk for HIV infection.[36] Risk of HIV exposure should be assessed when considering becoming pregnant, during all pregnancies and postpartum periods when there have been previous negative HIV tests, and when breastfeeding. When there are risk factors for HIV acquisition before, during, and after pregnancy, prevention counseling and appropriate interventions should be provided, including PrEP if indicated[36,37] (see Prepregnancy Counseling and Care and Pre-exposure Prophylaxis [PrEP] to Prevent HIV During Periconception, Antepartum, and Postpartum Periods for more information). When there is acute HIV during pregnancy or lactation, there is an increased risk of perinatal transmission; acute HIV also increase risk for sexual transmission of HIV (see Early [Acute and Recent] HIV Infection). The antigen/antibody immunoassay will detect acute HIV infection earlier than other immunoassays—within approximately 18 days of acquisition. When acute HIV infection is suspected, a plasma HIV RNA test should be sent as well as the antigen/antibody test, because virologic tests can detect the presence of HIV approximately 5 days earlier than the antigen/antibody immunoassay. When acute HIV infection is possible and breastfeeding is ongoing, counsel about the Panel's recommendation to cease breastfeeding immediately until HIV infection is confirmed or excluded.[38] Breast milk can be expressed and stored appropriately while HIV diagnostic testing is completed. Expressed breast milk should not be used for infant feeding until all supplemental HIV test results are reviewed and determined to be negative. Breastfeeding can resume if HIV infection is excluded and there is no ongoing risk. Care during pregnancy or breastfeeding for the breastfeeding dyad when there is acute or early HIV should follow the recommendations in the Perinatal Guidelines (see Early [Acute and Recent] HIV Infection, Antiretroviral Management of Infants With *In Utero*, Intrapartum, or Breastfeeding Exposure to HIV, and Preventing HIV Transmission During Infant Feeding).

Other Issues

Clinicians should be aware of public health surveillance systems and regulations that may exist in their jurisdictions for reporting infants who have been exposed to HIV; this is in addition to mandatory reporting of confirmed HIV, including infants with confirmed HIV. Reporting infants who have been exposed to HIV allows the appropriate public health functions to be accomplished.

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