

WHAT'S NEW IN THE GUIDELINES

June 25, 2026

The U.S. Department of Health and Human Services Panel on Treatment of HIV During Pregnancy and Prevention of Perinatal Transmission (the Panel) has reviewed and updated three sections of the guidelines developed in collaboration with the Panel on Antiretroviral Therapy and Medical Management of Children Living With HIV. Key updates are summarized below. Revisions are highlighted in yellow in the [PDF](#) version of the guidelines.

Preventing HIV Transmission During Infant Feeding

- If antiretroviral therapy (ART) is taken consistently and the viral load is maintained at a level of <50 copies/mL (i.e., undetectable viral load) for at least 3 months prior to delivery, the Panels recommend counseling about the options of formula feeding, use of banked donor milk, or breastfeeding.
- The Panel notes there is no evidence that formula supplementation increases the risk of HIV acquisition in the breastfed infant in the context of parental ART and viral suppression.
- The Panel recommends that women with HIV with mastitis or other unilateral breast pathology stop breastfeeding on the affected breast and feed on the contralateral (or unaffected) breast; when symptoms resolve, women can again feed from both breasts.

Antiretroviral Management of Infants With *In Utero*, Intrapartum, or Breastfeeding Exposure to HIV

- Three-drug presumptive treatment for infants with high risk of HIV acquisition now consists of ZDV/3TC plus nevirapine (NVP) or DTG.
- The Panel recommends performing a birth HIV nucleic acid test in all scenarios except for those in which infants are at low risk for HIV acquisition.
- The Panel recommends that extended antiretroviral (ARV) prophylaxis during breastfeeding, when used, be continued until either 4 weeks after the last exposure to breast milk or 4 weeks after concerns about maternal virologic suppression have resolved (**BIII**). If extended prophylaxis with NVP is planned, it should ideally be initiated from birth, replacing ZDV as the initial prophylaxis; alternatively, extended prophylaxis with 3TC should be initiated after the completion of initial ZDV prophylaxis.
- If a maternal HIV RNA level of ≥ 200 copies/mL (viremia) develops or there is presumed viremia (e.g., reports of nonadherence to ARVs) during breastfeeding, the Panels recommend cessation of breastfeeding. If the infant had not been receiving ARV prophylaxis, a three-drug ARV regimen should be given for 4 weeks. If the infant had been receiving ARV prophylaxis with 3TC or NVP, the decision to either continue the single-drug prophylaxis or initiate treatment with a three-drug regimen should be based on maternal RNA level and other factors (**AII**).

Diagnosis of HIV Infection in Infants and Children

- Non-subtype B HIV-1 is no longer a diagnostic concern. All recommendations and text referencing non-subtype B HIV-1 have been removed.

- The Panels revised the recommended timing of virologic diagnostic testing for infants with perinatal HIV exposure who are being breastfed. The last test should be performed 3 months after cessation of breastfeeding and at least 2 weeks after completion of infant ARV prophylaxis.
- The HIV RNA Assays subsection has been updated to include a sensitive HIV-1/HIV-2 RNA assay that can be used for infant diagnosis.
- [Table 13. Recommended Virologic Testing Schedules for Infants With Perinatal and Breastfeeding Exposure to HIV](#) has been simplified and restructured.

March 31, 2026

Pre-exposure Prophylaxis (PrEP) to Prevent HIV During Periconception, Antepartum, and Postpartum Periods

- There are now several U.S. Food and Drug Administration (FDA)–approved oral and long-acting injectable pre-exposure prophylaxis (PrEP) options for preventing HIV transmission from receptive vaginal sex, including during pregnancy and breastfeeding. Health care professionals should discuss potential options with patients and engage in shared decision-making to assist in choosing the best HIV prevention option for the individual patient.

Initial Use of Antiretroviral Therapy During Pregnancy

- Dolutegravir (DTG)/lamivudine (3TC) is now classified as an *Alternative* antiretroviral therapy (ART) regimen for use in pregnancy when used in individuals without prior long-acting cabotegravir (CAB-LA) PrEP exposure, with HIV RNA $\leq 500,000$ copies/mL, with no evidence of hepatitis B virus (HBV) coinfection, and with confirmed 3TC susceptibility on HIV resistance testing.
- [Table 6. What to Start: Initial Antiretroviral Regimens During Pregnancy](#) has been revised to reflect updated Panel recommendations for initial use of ART during pregnancy.

Table 7. Situation-Specific Recommendations for Use of Antiretroviral Drugs During Pregnancy and When Trying to Conceive

- DTG/3TC is now classified as an *Alternative* ART regimen for use when initiating ART in pregnancy when antiretroviral (ARV) drugs have never been previously used, starting or restarting ART during pregnancy when ARV drugs have been used in the past, starting ART when trying to conceive as long as HIV RNA is $\leq 500,000$ copies/mL, there is no evidence of HBV coinfection, and there is confirmed 3TC susceptibility on current or historical HIV resistance testing.

Hepatitis B Virus/HIV Coinfection

- The Panel recommends that everyone should be tested for hepatitis B surface antigen (HBsAg) in every pregnancy. Triple panel (HBsAg, hepatitis B core antibody [HBcAb], and hepatitis B surface antibody [HBsAb]) screening is recommended for pregnant women who do not have a documented triple screen after age 18 years that indicates vaccine-induced immunity (HBsAb ≥ 10 mIU/mL with negative HBsAg and HBcAb) or presence of HBV infection (i.e., HBsAg positive).

- In people with HBV/HIV coinfection, the Panel emphasized that using 3TC or emtricitabine (FTC) as the only drug with HBV activity in a regimen **is not recommended** because HBV resistance to these drugs can emerge. Everyone with HBV/HIV coinfection should be counseled and encouraged to continue ARV regimens that also include drugs with anti-HBV activity before, during, and after pregnancy.
- Increased guidance was added to the Isolated Detection of Hepatitis B Core Antibody subsection to help in the management of pregnancy with HIV and isolated hepatitis B core antibody. The Panel advises that providers consider HBV DNA testing when HIV and isolated hepatitis B core antibody are present, because the result may influence management during pregnancy and at delivery. If HBV DNA testing is negative, then HBV vaccination is recommended, as further explained in the bullet below. If HBV DNA testing is positive (suggesting occult HBV infection), the ART regimen should be adjusted to include two drugs that are active against HBV, and monitoring of HBV DNA during pregnancy should be considered. Despite low likelihood of perinatal HBV infection, many experts would manage infants as potentially exposed to HBV and administer both the HBV vaccine and hepatitis B immune globulin within 12 hours of birth.
- The Panel advises that people with HIV and isolated hepatitis B core antibody due to remote infection may have lost immunity to HBV and should be vaccinated with one standard dose of HepB vaccine (one dose of Heplisav-B, or Engerix-B, or Recombivax HB); HBsAb titers should be checked 1 to 2 months after vaccination. If the anti-HBs titer is >100 mIU/mL, no further vaccination is needed and the person is considered HBV immune; if the titer is ≤100 mIU/mL, a complete series of the same HepB vaccine should be completed and followed by HBsAb testing.
- Maternal HBV infection is not a contraindication to breastfeeding. Infant feeding recommendations for those with HBV/HIV do not differ from recommendations for those with HIV but without HBV, as long as the infant receives immunoprophylaxis at birth.

Hepatitis C Virus/HIV Coinfection

- Updated information about ongoing studies of direct-acting antivirals in pregnancy has been included.
- The Panel emphasizes that recommendations for infant feeding and infant hepatitis C virus (HCV) diagnostic testing do not differ for infants exposed to HCV/HIV compared to infants exposed to HIV without HCV.

Appendix B: Safety and Toxicity of Individual Antiretroviral Agents in Pregnancy

- [Table 14. Antiretroviral Drug Use in Pregnancy: Pharmacokinetic and Toxicity Data in Human Pregnancy and Recommendations for Use in Pregnancy](#) and the individual drug sections have been reviewed and updated where indicated. The drug sections have been revised to include standardized language about the Antiretroviral Pregnancy Registry with a link to updated data provided through an [interim report](#) released twice a year. Significant changes are summarized below:
 - o [Lenacapavir](#) is now FDA approved for HIV PrEP in addition to treatment for heavily treatment-experienced adults with multidrug-resistant HIV-1 infection whose current ARV regimen is failing due to resistance, intolerance, or safety considerations. Pharmacokinetic and safety data are available in pregnancy and lactation and detailed in the [Lenacapavir](#) drug section.

June 12, 2025

Pregnancy and Postpartum HIV Testing and Identification of Perinatal and Postnatal HIV Exposure

- When determining the timing of repeat HIV testing in the third trimester of pregnancy, 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.

Prepregnancy Counseling and Care

- The Panel has added a bulleted recommendation about care for partners in the setting of childbearing potential with HIV. Providers should assess knowledge about partner HIV status and the need to screen partner(s) for HIV and sexually transmitted infections and provide testing or refer for services as needed. They should also discuss whether HIV status has been disclosed to sexual partner(s) and discuss options for PrEP when indicated.

Initial Use of Antiretroviral Therapy During Pregnancy

- Bictegravir (BIC) plus tenofovir alafenamide (TAF) plus FTC (available as the fixed-dose combination [FDC] BIC/TAF/FTC) is now recommended as a *Preferred* ART regimen for HIV during pregnancy. BIC/TAF/FTC is also now recommended as a *Preferred* regimen when trying to conceive if ART and CAB-LA as PrEP have never been previously used. BIC/TAF/FTC was previously recommended as an *Alternative* ART regimen.
- [Table 6. What to Start: Initial Antiretroviral Regimens During Pregnancy When Antiretroviral Therapy Has Never Been Received](#) has been revised to reflect updated Panel recommendations for people who are ARV naive and list the advantages and disadvantages of ARV combinations and regimens.

Table 7. Situation-Specific Recommendations for Use of Antiretroviral Drugs During Pregnancy and When Trying to Conceive

- BIC, which is available in the FDC BIC/TAF/FTC, is now recommended as a *Preferred* ARV for use in pregnancy and when trying to conceive, based on available data that suggest sufficient pharmacokinetics, efficacy, and safety in pregnancy.
- Abacavir (ABC) is now recommended as an *Alternative* rather than a *Preferred* ARV for use in pregnancy and when trying to conceive due to the need for HLA-B*5701 testing prior to initiating therapy and concerns over cardiac safety with ABC.
- [Appendix C: Antiretroviral Counseling Guide for Health Care Providers](#) has been updated to incorporate changes in the tables and text sections that address recommendations regarding the use of specific ARV drugs in pregnancy.

Antiretroviral Drug Regimens and Pregnancy Outcomes

- The Panel has updated bulleted recommendations and revised the section text to streamline content and focus on recent, relevant data.
- The Panel recommends that ART should not be avoided or withheld before conception or in early pregnancy for the purpose of preventing preterm birth.
- ART should not be avoided or withheld to prevent hypertensive disorders of pregnancy (HDP) or stopped if HDP develops.
- Enhanced antenatal surveillance of fetal growth in the third trimester may be considered, especially if ART with boosted protease inhibitors is prescribed during pregnancy, due to the increased risk for low-birth-weight or small-for-gestational-age infants.

HIV-2 and Pregnancy

- The Panel has added new bulleted recommendations about HIV-2- during pregnancy that align with the [Adult and Adolescent Antiretroviral Guidelines](#) to address monitoring response to treatment, lack of validated HIV-2 genotypic or phenotypic resistance assays for clinical use, and ART regimens for use with virologic and immunologic failure. Monitoring HIV-2 plasma viral loads and receiving the results in a timely manner can be difficult because plasma samples must be sent to the [University of Washington](#) or the [New York State Department of Health](#).
- The Panel now recommends that ARV management of infants with potential *in utero* or intrapartum exposure to HIV-2 mono-infection or HIV-1/HIV-2 coinfection should follow recommendations for infants perinatally exposed to HIV-1 infection using drugs that are active against HIV-2—see the subsection Care of Infants With *In Utero*, Intrapartum, and Breastfeeding Exposure to HIV-2 in the section text. Nevirapine should not be used because it lacks activity against HIV-2. Additional information is available in [Antiretroviral Management of Infants With *In Utero*, Intrapartum, or Breastfeeding Exposure to HIV](#); [Table 11](#); [Table 12](#); and [Table 12.1](#).
- If HIV-2 infection is suspected or confirmed during pregnancy or at delivery, infant diagnostic testing for HIV-2 can follow the same schedule as for infants with potential *in utero* or intrapartum exposure to HIV-1 using virologic assays to diagnose HIV-2 infection. See [Diagnosis of HIV Infection in Infants and Children](#) and [Table 13. Recommended Virologic Testing Schedules for Infants With Perinatal and Breastfeeding Exposure to HIV](#) for guidance about infant testing.

Early (Acute and Recent) HIV Infection

- The Panel has revised bulleted recommendations about ARV resistance testing and ART for early (acute or recent) HIV to reflect updated Panel recommendations about *Preferred* ART in pregnancy and to align with the [Early \(Acute and Recent\) HIV Infection](#) section of the [Adult and Adolescent Antiretroviral Guidelines](#).
- *Preferred* ART regimens recommended for treating early (acute or recent) HIV infection when ART and CAB-LA as PrEP have not previously been used now include BIC plus TAF plus FTC or DTG plus (TAF or tenofovir disoproxil fumarate [TDF]) plus (FTC or 3TC).
- For instances of early (acute and recent) HIV infection and a history of CAB-LA use as PrEP, a regimen of ritonavir-boosted darunavir with (TAF or TDF) plus (FTC or 3TC) is recommended for initial ART.

- o Use of an empiric integrase strand transfer inhibitor (INSTI)–containing regimen is **not recommended** unless genotype testing shows no evidence of INSTI resistance. This is because INSTI resistance may be present in those who acquire HIV during and possibly after the use of CAB-LA as PrEP.
- o If baseline drug-resistance tests show no evidence of INSTI resistance, a switch to one of the *Preferred* INSTI-based regimens with DTG or BIC (listed above) should be considered.
- When early HIV infection is diagnosed during the postpartum period, decisions on HIV drug-resistance testing and ARV regimens should be guided by recommendations outlined in the [Early \(Acute and Recent\) HIV Infection](#) section of the [Adult and Adolescent Antiretroviral Guidelines](#).

Intrapartum HIV Care

- When HIV RNA is >1,000 copies/mL or is unknown near the time of birth, scheduled cesarean birth at 38 weeks of gestation is recommended to minimize perinatal HIV transmission. However, given the potential for rapid decreases in viral load with current ART options, individualized birth plans to extend these pregnancies beyond 38 weeks to avoid the need for a cesarean birth can be considered with expert consultation and shared decision-making. Expert guidance from the [National Perinatal HIV/AIDS Clinical Consultation Center](#) (1-888-448-8765) may be helpful when choosing to develop an individualized birth plan.
- Fetal scalp electrodes should be avoided when virologic suppression is achieved during pregnancy and should not be used when virologic suppression (≥ 50 copies/mL) is not achieved during pregnancy.

Initial Postnatal Management of the Neonate Exposed to HIV

- The Panel has updated recommendations and content about infant safety monitoring. Longitudinal laboratory monitoring for adverse events is not needed in otherwise healthy infants receiving currently recommended ARV drugs for prophylaxis in the first 6 weeks of life (see the subsection Safety of Antiretroviral Drugs Used for Infant Prophylaxis in [Antiretroviral Management of Infants With In Utero, Intrapartum, or Breastfeeding Exposure to HIV](#)).
- New bulleted Panel recommendations have been added to include information about infant testing for viral coinfections: screening for congenital cytomegalovirus, testing for infants perinatally exposed to HBV, and testing for infants with perinatal exposure to HCV. Additional information is available in the [Pediatric Opportunistic Infection Guidelines](#) (see [Cytomegalovirus](#), [Hepatitis B Virus/HIV Coinfection](#), [Hepatitis C Virus/HIV Coinfection](#)).

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