



1-800-439-4079

INTRAPARTUM AND POSTPARTUM CARE FOR PREGNANT PEOPLE WITH HIV, PEOPLE WITH A PRELIMINARILY POSITIVE RAPID HIV TEST, AND NEWBORNS WITH HIV EXPOSURE

PURPOSE

- To establish best practices for the delivery and postpartum care of people with HIV (PWH), including those with a preliminary positive rapid HIV test at L&D and newborns with HIV exposure.
- To establish guidelines for the determination of risk status and antiretroviral prophylaxis for infants with perinatal exposure to HIV, including management for breastfeeding infants.

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I. Considerations for LABOR and DELIVERY

- A.** All pregnant people in Illinois should receive HIV counseling and opt-out testing two times during pregnancy (as early in pregnancy as possible and again in the third trimester). The third trimester test should be done between the 27th week of pregnancy and delivery, preferably before 36 weeks of pregnancy to optimize confirmatory testing and initiation of interventions.
- B.** Any pregnant person who does not have documentation of a negative HIV test result from after 27 weeks of the current pregnancy must be offered a rapid HIV test upon admission, ideally a combination HIV-1/2 antigen/antibody test. A rapid HIV test is a screening test that produces an expedited result. These tests can be rapid point-of-care tests or instrumented, laboratory-based tests, but they must result within 60 minutes. A rapid/expedited HIV test that is positive/reactive is considered “preliminarily positive” because supplemental tests are needed to confirm an HIV diagnosis.
- ***Per Illinois law, the Illinois Perinatal HIV Hotline must be called within 12 hours, but no later than 24 hours, of the test result for all pregnant people and exposed newborns found to be preliminarily positive with rapid HIV testing.***
 - ***It is recommended that the Hotline be called as soon as the positive rapid test is resulted. The Hotline can provide care recommendations, advise on supplemental HIV tests to confirm HIV status, and link people to case management services.***
- C.** When a pregnant PWH **arrives** in L&D (or at the time of a positive rapid HIV test result), notify an obstetrician with expertise in HIV perinatology or an infectious disease specialist. The **24/7 Illinois Perinatal HIV Hotline (1-800-439-4079)** is available to provide consultation if no hospital-based specialist experienced in perinatal HIV is available.
- D.** The Hotline recommends that for all pregnant PWH, regardless of HIV RNA level (viral load), intravenous (IV) zidovudine (ZDV, also known as AZT) be started as soon as possible after the person presents in labor. Similarly, if a scheduled cesarean delivery is planned, the Hotline recommends that people receive IV ZDV for at least 3 hours prior to surgery regardless of viral load. The IV ZDV



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infusion provides the infant with pre-exposure ZDV prophylaxis that will continue as post-exposure prophylaxis after birth while the infant receives oral prophylaxis.

- The Hotline views the use of intrapartum IV ZDV regardless of viral load to be consistent with and complementary to the recommendation for postnatal ZDV. The Hotline acknowledges these recommendations differ from but are not inconsistent with the Department of Health and Human Services (DHHS) [Perinatal Guidelines](#). These guidelines state the following: “IV ZDV is **not** required for individuals who meet **ALL** of the following three criteria: (1) are receiving ART (antiretroviral therapy), (2) have HIV RNA <50 copies/mL within 4 weeks of delivery, and (3) are adherent to their ARV regimen. However, a study showing that 6 percent of women with suppressed HIV RNA levels during pregnancy had viral load rebound near delivery highlights the importance of using clinical judgement when making the decision to use intrapartum IV ZDV, regardless of the patient’s viral load. The additional benefit of IV ZDV in women who are receiving ART and are virally suppressed (HIV RNA <50 copies/mL) has not been evaluated in randomized clinical trials.”
- The Hotline recommends use of intrapartum IV ZDV due to 1) methodological limitations of the current evidence that led to the policy change, 2) the complementary benefit of both pre- and post-exposure prophylaxis for individuals at risk of HIV acquisition, and 3) the public health benefit of simple and consistent messaging across hospital systems that ensures consistent access to ZDV for intrapartum prophylaxis.
- ZDV dosage is based on the person’s weight. People admitted in preterm labor with a significant chance of delivery should be started on IV ZDV immediately.
 - IV ZDV dosing is as follows: 2 mg/kg loading dose over 1 hour followed by 1 mg/kg/hour maintenance infusion until the cord is clamped.
 - **ZDV is not compatible with all medications.** Please check with pharmacy before running ZDV in the same line with other medications.
 - In situations where IV ZDV is not available, the 24/7 Illinois Perinatal HIV Hotline should be consulted as soon as possible.
- E. Invasive procedures should be avoided if possible (fetal scalp electrodes, fetal scalp blood sampling, and operative vaginal delivery). Artificial rupture of membranes (AROM) may be considered for standard obstetric indications in people with HIV RNA <50 copies/mL who are on ART. AROM should be avoided in people with HIV RNA ≥50 copies/mL, unless there is a clear obstetric indication.
- F. Route of delivery for a person previously diagnosed with HIV is determined by the person’s level of viral suppression.
 - Cesarean delivery should be offered to people with clinically significant viral loads (>1000 copies/ml) as cesarean delivery is associated with a reduced risk of transmission when performed prior to active labor and rupture of membranes. People who are scheduled for cesarean delivery should receive IV ZDV for at least 3 hours prior to surgery.
 - For people with undetectable or low viral loads (<1000 copies/ml) and receiving ART, the risks of cesarean delivery may outweigh any theoretical benefit of reduced transmission. The 24/7 Illinois Perinatal HIV Hotline is available for consultation regarding mode of delivery.



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- G.** Route of delivery should be carefully considered for people who test preliminarily positive in labor by a rapid HIV test and whose confirmed HIV status is unknown.
- If the person is confirmed to have HIV infection and has not received ART, a cesarean delivery performed early in labor with intact membranes may still be beneficial.
 - Consultation should be sought with a Maternal-Fetal Medicine or Infectious Disease Specialist experienced in perinatal HIV. The 24/7 Illinois Perinatal HIV Hotline is available for this consultation. For example, in an individual with a preliminarily or known positive HIV test result whose membranes are ruptured and transition to active labor has occurred, there may be little benefit to cesarean delivery for the purpose of prevention of HIV transmission.
- H.** If the pregnant person does not have documentation of a negative HIV test result from 27w0d or later in the current pregnancy and refuses HIV testing for themselves, **then their newborn must be administered a rapid HIV test according to Illinois law.** It is not necessary to do a rapid HIV test on a newborn if the birthing parent was previously diagnosed with HIV or has already been administered a rapid test. When rapid HIV tests are performed on newborns, they may need to be performed “off-label”, as the tests are for individuals over age 2 years; this is acceptable and appropriate, as the test is not testing for neonatal infection, but rather is testing for maternal antibodies, which would indicate HIV exposure.

II. Considerations for BIRTHING PARENT-BABY RECOVERY

- A.** Newborns should be given an early bath.
- They should be suctioned and bathed as soon as possible to remove maternal blood contamination **before** vitamin K and antibiotic eye prophylaxis (erythromycin) administration. This early infant bath should occur in the delivery room if possible and should be documented in the medical record.
 - If Narcan or other medications need to be given urgently, cleanse the site with alcohol followed by Betadine prior to injection.
- B.** Newborns should be assessed for risk of HIV acquisition and antiretroviral management.
- If presumptive HIV therapy using a three-drug regimen is indicated, the pharmacy should be notified of the need for ZDV and 3TC plus either NVP or RAL.
 - *See Section III Table 1. Antiretroviral Management and Neonatal Testing for Infants with In Utero or Intrapartum Exposure to HIV.*
 - Infant ZDV syrup and other antiretroviral medications should be given as soon as possible after birth, **with the goal of within 1 hour.** The pharmacy should be notified of the imminent need for a stat ZDV syrup order when the pregnant PWH is admitted to Labor and Delivery.
 - *See Section III Table 2. Drug Dosing Recommendations for Antiretroviral Prophylaxis and Presumptive HIV Therapy in Infants with In Utero or Intrapartum Exposure to HIV.*
 - For questions or more information, call the Hotline at 1-800-439-4079.

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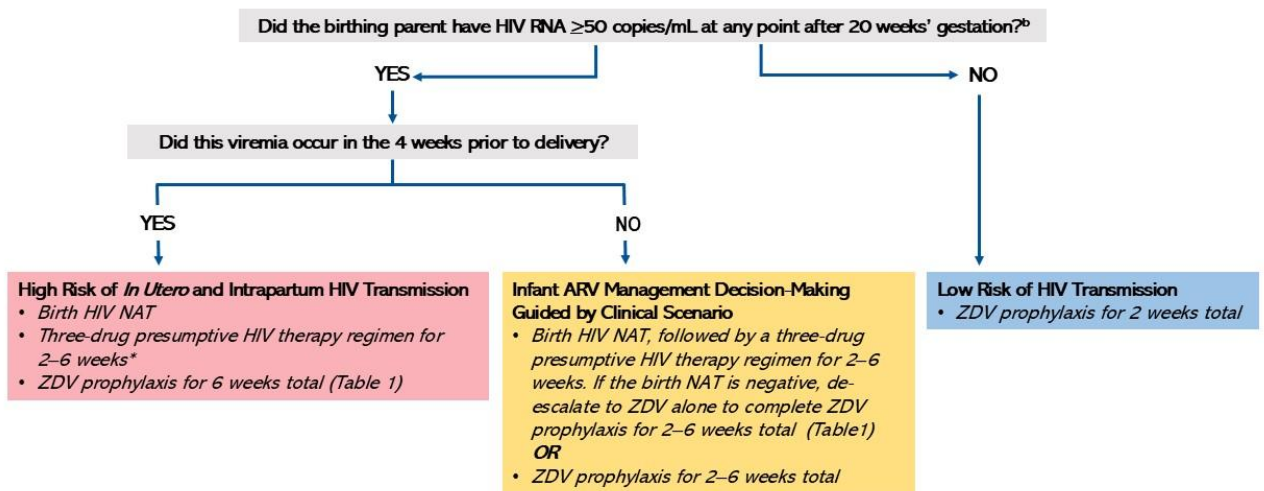
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III. Considerations for NEWBORNS WITH PERINATAL (IN UTERO OR INTRAPARTUM) HIV EXPOSURE

A. DETERMINATION OF RISK FOR INFANT HIV ACQUISITION

- Selection of ARV regimen for infants with perinatal (in utero or intrapartum) HIV exposure should be based on the risk for HIV acquisition which is associated with the birthing parent's HIV RNA levels and gestational timing of viremia.
- Infants at high risk for perinatal HIV infection are those born to a pregnant person with viremia (HIV RNA ≥ 50 copies/mL) in the 4 weeks prior to delivery.
- Infants at low risk for perinatal HIV infection are those born to a pregnant person with virologic suppression (HIV RNA < 50 copies/mL) from 20 weeks gestation through delivery.
- Infants not meeting criteria for high or low risk may be considered as other clinical scenarios which warrant consideration based on case-specific factors.
- Figure 1 outlines an approach to identifying risk and subsequent ARV management of infants with perinatal HIV exposure.

Figure 1. Algorithm for Antiretroviral Management of Infants With *In Utero* or Intrapartum HIV Exposure by Risk of HIV Acquisition^a



^a Adapted from the DHHS Recommendations for the Use of Antiretroviral Drugs During Pregnancy and Interventions to Reduce Perinatal HIV Transmission in the United States

^b Early (acute or recent) HIV infection in pregnancy may result in a scenario where viremia occurs early in gestation but is suppressed after 20 weeks and through the remainder of pregnancy until delivery. In these situations, decision-making guided by the clinical scenario is recommended (Table 1).

Key: ARV = antiretroviral; NAT = nucleic acid test; PCR = polymerase chain reaction; ZDV = zidovudine



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B. ARV MANAGEMENT OF INFANTS WITH PERINATAL HIV EXPOSURE

- Infants at high risk of perinatal HIV infection should receive birth HIV nucleic acid testing (NAT) and a 3-drug ARV regimen from birth for 2-6 weeks. If the 3-drug regimen is <6 weeks, zidovudine (ZDV) should be continued alone to complete a total of 6 weeks.
- Infants at low risk of perinatal HIV infection should receive ZDV alone for 2 weeks.
- Infants not meeting criteria for high or low risk should be managed based on clinical factors with either of two options:
 - Birth HIV NAT, followed by 3-drug ARV regimen for 2-6 weeks. If the birth NAT is negative, one may consider de-escalating to ZDV alone to complete 2-6 weeks, OR
 - ZDV alone for 2-6 weeks total

C. TESTING AND MONITORING OF INFANTS WITH PERINATAL HIV EXPOSURE

- Infants at high risk for perinatal HIV infection should receive HIV NAT* at the following intervals:
 - Birth
 - 2 weeks of age
 - 4 weeks
 - 8 weeks of age (at least 2 weeks after completing antiretrovirals)
 - 4-6 months of age
- Infants at high risk for perinatal HIV infection should also receive:
 - Urine or saliva CMV PCR before 3 weeks of age
- Infants at low risk for perinatal HIV infection should receive HIV NAT* at the following intervals:
 - 2-3 weeks of age
 - 4-8 weeks of age
 - 4-6 months of age
- Any infant with a positive NAT should be immediately referred to a pediatric HIV specialist.
- Infants may be discharged from HIV specialty care if all of the above HIV NAT are negative.

*** HIV RNA PCR or TNA is preferred for infants born to people who acquired HIV outside of the US or Europe who may have a non-clade B or Group O HIV subtype as most but not all HIV DNA PCR's can detect these subtypes.**



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Table 1. Antiretroviral Management and Neonatal Testing for Infants with *In Utero* or Intrapartum Exposure to HIV

ZDV=Zidovudine or AZT; 3TC=Lamivudine; NVP=Nevirapine or Viramune; RAL=Raltegravir

Clinical Setting	Risk of Acquisition		Neonatal ARV Management ^{a,b}	Neonatal Testing and Monitoring
	<i>In Utero</i>	Intrapartum		
High Risk of Acquisition				
HIV RNA ≥ 50 copies/mL in the 4 weeks prior to delivery Viremia can be documented by lab or presumed by other clinical factors (e.g., new diagnosis, ART adherence problems, reports of having stopped ART prior to delivery).	High	High	Presumptive HIV therapy using a three-drug regimen of ZDV and 3TC plus either NVP (treatment dose) or RAL. If birth PCR is negative, administer the three-drug regimen for 2 weeks, then continue ZDV alone through 6 weeks of age ^c .	Perform HIV DNA PCR or RNA PCR or Total Nucleic Acid (TNA) at: Birth ^{d,e} 2 weeks of age 4 weeks of age 8 weeks of age (at least 2 weeks after completing therapy) 4-6 months of age Obtain urine or saliva for CMV PCR before 3 weeks of age. If NAT testing is positive, consult a pediatric HIV specialist immediately. Infant may be discharged from HIV specialty care if all PCR testing is negative.
Low Risk of Acquisition				
HIV RNA < 50 copies/mL from 20 weeks' gestation through delivery Ideally documented by at least two consecutive tests at least four weeks	Low	Low	ZDV for 2 weeks	Perform HIV DNA PCR or RNA PCR or Total Nucleic Acid (TNA) at: 2-3 weeks 4-8 weeks 4-6 months



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Clinical Setting	Risk of Acquisition		Neonatal ARV Management ^{a,b}	Neonatal Testing and Monitoring
	<i>In Utero</i>	Intrapartum		
apart with HIV RNA <50 copies/mL				If NAT testing is positive, consult a pediatric HIV specialist immediately. Infant may be discharged from HIV specialty care if all PCR testing is negative.
Other Clinical Scenarios^f				
HIV RNA ≥50 copies/mL at >20 weeks' gestation, but HIV RNA <50 copies/mL in the 4 weeks prior to delivery	Low to Moderate	Low	<p><i>Two Options for ARV Management</i></p> <p>Presumptive HIV therapy with a three-drug regimen, as described above for infants at high risk. If the birth HIV NAT is negative, de-escalate to ZDV alone to complete 2–6 weeks total^c</p> <p>OR</p> <p>ZDV prophylaxis for 2–6 weeks</p>	<p>Perform HIV DNA PCR or RNA PCR or Total Nucleic Acid (TNA) at:</p> <p>Birth^{d,e}</p> <p>2 weeks of age</p> <p>4 weeks of age</p> <p>8 weeks of age (at least 2 weeks after completing therapy)</p> <p>4-6 months of age</p>
Early (acute or recent) HIV at any point during pregnancy	Moderate to High (depending on the birthing parent's HIV RNA levels and weeks' gestation)	High (if HIV RNA ≥ 50 copies/mL in the last 4 weeks of pregnancy)	Manage infant ARVs according to the level and timing of the birthing parent's viremia as described in the rows above (just as for an infant of a birthing parent with established infection).	<p>Perform HIV DNA PCR or RNA PCR or Total Nucleic Acid (TNA) at:</p> <p>Birth^{d,e}</p> <p>2 weeks of age</p> <p>4 weeks of age</p> <p>8 weeks of age (at least 2 weeks after completing therapy)</p> <p>4-6 months of age</p>



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Clinical Setting	Risk of Acquisition		Neonatal ARV Management ^{a,b}	Neonatal Testing and Monitoring
	<i>In Utero</i>	Intrapartum		
Birthing parent with unconfirmed HIV status and who has at least one positive HIV test at delivery or postpartum or Birthing parent whose newborn has a positive HIV antibody test	High/Uncertain	High/Uncertain	Presumptive HIV therapy with a three-drug regimen as described above for newborns with a high risk of <i>in utero</i> or intrapartum HIV acquisition If supplemental testing confirms that the birthing parent does not have HIV, discontinue infant ARV drugs immediately.	Perform HIV DNA PCR or RNA PCR or Total Nucleic Acid (TNA) at: Birth ^{d,e} 2 weeks of age ^g 4 weeks of age ^g 8 weeks of age (at least 2 weeks after completing therapy) ^g 4-6 months of age ^g

^a Infant ARVs should be initiated in the first 6 hours after delivery, especially for infants with a high risk of acquisition. See Table 2 for ARV dosing.

^b If the birthing parent has HIV-2 infection or HIV-1 and HIV-2 coinfection, the infant ARV regimen should be based on the determination of low or high risk of HIV-1 transmission as described in the above table using ARVs that are active against HIV-2. Because HIV-2 is not susceptible to NVP, RAL should be used in presumptive HIV therapy regimens for infants at high risk of HIV acquisition with exposure to HIV-2 or to both HIV-1 and HIV-2.

^c The optimal duration of three-drug regimen in newborns who are at a high risk for HIV acquisition is unknown. Newborns who are at a high risk for HIV acquisition should receive the ZDV component for 6 weeks. The other two ARVs, (3TC and NVP) or (3TC and RAL), may be administered for 2 to 6 weeks; the recommended duration for treatment with three ARVs varies depending on infant HIV NAT results, the birthing parent’s viral load at the time of delivery, and the additional risk factors for HIV transmission. Consultation with an expert in pediatric HIV is recommended when selecting a therapy duration because this decision should be based on case-specific risk factors and interim infant HIV NAT results.

^d NAT test at birth should be obtained before or immediately after starting ARVs.

^e When a newborn HIV NAT is positive, infant ART should be initiated without waiting for the results of confirmatory HIV NAT testing, given the low likelihood of a false-positive HIV.

^f The IL Perinatal HIV Hotline (1-800-439-4079) or a pediatric HIV specialist should be consulted.

^g Not necessary if birthing parent is confirmed negative for HIV.



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Table 2. Drug Dosing Recommendations for Antiretroviral Prophylaxis and Presumptive HIV Therapy in Infants with *In Utero* or Intrapartum Exposure to HIV^a

ARV Drug	Drug Doses by Gestational Age at Birth								
<p>ZDV</p> <p>Note: For newborns who are unable to tolerate oral agents, the IV dose is 75% of the oral dose while maintaining the same dosing interval.</p>	<p>≥35 Weeks of Gestation at Birth</p> <p><i>Birth to Age ≤6 Weeks</i></p> <ul style="list-style-type: none"> ZDV 4 mg/kg per dose orally twice daily or alternative simplified weight-band dosing (see table below) <p>Simplified Weight-Band Dosing for Newborns Aged ≥35 Weeks of Gestation From Birth to 4 Weeks</p> <table border="1" data-bbox="565 814 1414 1024"> <thead> <tr> <th>Weight Band</th> <th>Volume of ZDV 10 mg/mL Oral Syrup Twice Daily</th> </tr> </thead> <tbody> <tr> <td>2 kg to <3 kg</td> <td>1 mL</td> </tr> <tr> <td>3 kg to <4 kg</td> <td>1.5 mL</td> </tr> <tr> <td>4 kg to <5 kg</td> <td>2 mL</td> </tr> </tbody> </table> <p>≥30 Weeks to <35 Weeks of Gestation at Birth</p> <p><i>Birth to Age 2 Weeks</i></p> <ul style="list-style-type: none"> ZDV 2 mg/kg per dose orally twice daily <p><i>Age 2 Weeks to ≤6 Weeks</i></p> <ul style="list-style-type: none"> ZDV 3 mg/kg per dose orally twice daily <p><30 Weeks of Gestation at Birth</p> <p><i>Birth to Age 4 Weeks</i></p> <ul style="list-style-type: none"> ZDV 2 mg/kg per dose orally twice daily <p><i>Age 4 Weeks to ≤6 Weeks</i></p> <ul style="list-style-type: none"> ZDV 3 mg/kg per dose orally twice daily 	Weight Band	Volume of ZDV 10 mg/mL Oral Syrup Twice Daily	2 kg to <3 kg	1 mL	3 kg to <4 kg	1.5 mL	4 kg to <5 kg	2 mL
Weight Band	Volume of ZDV 10 mg/mL Oral Syrup Twice Daily								
2 kg to <3 kg	1 mL								
3 kg to <4 kg	1.5 mL								
4 kg to <5 kg	2 mL								
<p>3TC</p> <p>Only oral formulations of 3TC are available.</p>	<p>≥32 Weeks of Gestation at Birth</p> <p><i>Birth to Age <4 Weeks</i></p> <ul style="list-style-type: none"> 3TC 2 mg/kg per dose orally twice daily <p><i>Age ≥4 Weeks to ≤6 weeks</i></p> <ul style="list-style-type: none"> 3TC 4 mg/kg per dose orally twice daily 								



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ARV Drug	Drug Doses by Gestational Age at Birth	
<p>NVP^b</p> <p>Note: These are NVP treatment doses for a presumptive HIV therapy regimen. Only oral formulations of NVP are available. NVP dosing for extended ARV prophylaxis during breastfeeding is provided in Table 4.</p>	<p>≥37 Weeks of Gestation at Birth</p> <p><i>Birth to Age ≤6 Weeks</i></p> <ul style="list-style-type: none"> • NVP 6 mg/kg per dose orally twice daily 	
	<p>≥34 Weeks to <37 Weeks of Gestation at Birth</p> <p><i>Birth to Age <1 Week</i></p> <ul style="list-style-type: none"> • NVP 4 mg/kg per dose orally twice daily <p><i>Age ≥1 Week to ≤6 Weeks</i></p> <ul style="list-style-type: none"> • NVP 6 mg/kg per dose orally twice daily 	
	<p>≥32 Weeks to <34 Weeks of Gestation at Birth</p> <p><i>Birth to Age <2 Weeks</i></p> <ul style="list-style-type: none"> • NVP 2 mg/kg per dose orally twice daily <p><i>Age ≥2 Weeks to <4 Weeks</i></p> <ul style="list-style-type: none"> • NVP 4 mg/kg per dose orally twice daily <p><i>Age ≥4 Weeks to ≤6 Weeks</i></p> <ul style="list-style-type: none"> • NVP 6 mg/kg per dose orally twice daily 	
<p>RAL</p> <p>Only oral formulations of RAL are available.</p>	<p>≥37 Weeks of Gestation at Birth and Weighing ≥2 kg^c</p> <p><i>Birth to Age 6 Weeks</i></p>	
	<p>Body Weight</p>	<p>Volume (Dose) of RAL 10 mg/mL Suspension</p>
	<p>Birth to 1 Week: Once-Daily Dosing</p>	
	<p>2 kg to <3 kg</p>	<p>0.4 mL (4 mg) once daily</p>
	<p>3 kg to <4 kg</p>	<p>0.5 mL (5 mg) once daily</p>
	<p>4 kg to <5 kg</p>	<p>0.7 mL (7 mg) once daily</p>
	<p>1 to 4 Weeks: Twice-Daily Dosing</p> <p>Approximately 3 mg/kg per dose</p>	



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ARV Drug	Drug Doses by Gestational Age at Birth	
	2 kg to <3 kg	0.8 mL (8 mg) twice daily
	3 kg to <4 kg	1 mL (10 mg) twice daily
	4 kg to <5 kg	1.5 mL (15 mg) twice daily
	4 to 6 Weeks: Twice-Daily Dosing	Approximately 6 mg/kg per dose
	3 kg to <4 kg	2.5 mL (25 mg) twice daily
	4 kg to <6 kg	3 mL (30 mg) twice daily
	6 kg to <8 kg	4 mL (40 mg) twice daily

^a The optimal duration of three-drug regimens for newborns at high risk of HIV acquisition is unknown; all infants should receive the ZDV component of the three-drug regimen for 6 weeks. The other two ARVs, (3TC and NVP) or (3TC and RAL), may be administered for 2 to 6 weeks; the recommended duration for these ARVs varies depending on infant HIV NAT results, viral load of the birthing parent at the time of delivery, and additional risk factors for HIV transmission. Consultation with an expert in pediatric HIV is recommended when selecting a therapy duration because this decision should be based on case-specific risk factors and interim infant HIV NAT results.

^b The NVP doses for infants ≥32 to <37 weeks' gestation at birth and infants ≥37 weeks' gestation at birth are not yet approved by the FDA. The FDA also has not approved a dose of NVP for infants aged <1 month. The doses for infants ≥32 to <34 weeks' gestation at birth are based on modeling and might underestimate potential toxicity in infants of 32 to <34 weeks gestational age because the doses used to develop the model were lower than the doses now recommended.

^c RAL dosing is increased at 1 week and 4 weeks of age because metabolism by UGT1A1 is low at birth and increases rapidly during the next 4 to 6 weeks of life. No dosing information is available for preterm infants or infants weighing <2 kg at birth. The current dosing regimen with two dose changes in the first month of life may be challenging for some families. To minimize dosing changes, some experts increase to the 3-mg/kg twice-daily dose upon discharge on day 4 or 5 of life.



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IV. Considerations for POSTPARTUM CARE AND INFANT FEEDING

A. Postpartum Care

- Universal precautions should be reviewed prior to discharge with particular attention to vaginal bleeding and disposal of sanitary pads.
- Contraceptive and STI counseling should be performed prior to the person's discharge.
- Social work consultation is advised to address disclosure counseling and partner notification. Disclosure of HIV status is a sensitive issue and should be addressed in a confidential and non-judgmental manner.
- Follow-up appointments for the PWH and newborn must be scheduled prior to discharge. The Hotline is available to provide a list of resources for referral as well as case management for people at risk of loss to follow-up.
- For birthing parents or newborns with a preliminarily positive rapid HIV test, confirmatory HIV testing must be sent prior to discharge. **The positive rapid HIV test result must be reported to the 24/7 Illinois Perinatal HIV Hotline (800-439-4079) within 12 hours, but no later than 24 hours, of the test result.** Follow-up for this confirmatory testing is essential

B. Infant Feeding

- Providers should routinely discuss infant feeding plans, ideally during antenatal care.
- Formula feeding is the only way to eliminate breastmilk transmission of HIV, however, if a PWH expresses interest in breast/chestfeeding, non-judgmental counseling should be provided as outlined in the DHHS Perinatal Guidelines [Infant Feeding for Individuals with HIV in the United States | NIH](#)
- **Clinicians should consult experts in pediatric HIV if a PWH chooses to breast/chestfeed.**
- If a person with a preliminarily positive result from a rapid HIV test is awaiting confirmatory testing and desires to breast/chestfeed, they can be offered the option of pumping and storing the breast milk until the confirmatory test results are available. This can be done to optimize development of a milk supply for someone who desires to breast/chestfeed if the confirmatory HIV test result comes back negative. The person needs clear counseling regarding the importance of not using the breast milk to feed the baby until the confirmatory test result is negative.
- Engaging Child Protective Services or similar agencies is not an appropriate response if a PWH chooses to breast/chestfeed.
- When lactation suppression is desired, PWH should be instructed in measures to suppress lactation such as supportive/tight bras, ice, or cold compresses and ibuprofen to reduce discomfort.
- Counseling against pre-mastication should be provided.

An HIV NAT at birth is recommended for all breastfeeding infants. A NAT should be obtained before or immediately after starting ARVs.



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Table 3. Antiretroviral Management of Infants with Exposure to HIV During Breastfeeding

Level of Transmission Risk During Breastfeeding by HIV RNA Levels in Breastfeeding Parent	Infant ARV Management During Breastfeeding
<p>Sustained Viral Suppression (HIV RNA <50 copies/mL measured twice at least 1 month apart) and No Concerns About Future Risk</p>	<ul style="list-style-type: none"> • In infants at low risk of <i>in utero</i> or intrapartum transmission after completion of 2-week ZDV prophylaxis, options are: <ul style="list-style-type: none"> ○ no additional ARV prophylaxis ○ extended prophylaxis with NVP or 3TC during breastfeeding to be continued until 6 weeks after last exposure to breast milk. Consult an expert if considering early discontinuation of extended prophylaxis.
<p>Current HIV RNA Levels <50 copies/mL But Concerns About Future Risk</p>	<ul style="list-style-type: none"> • Consider extended ARV prophylaxis with NVP or 3TC until 6 weeks after last exposure to breast milk. Provide added adherence support as indicated.
<p>New Viremia During Breastfeeding (HIV RNA ≥200 copies/mL) or Presumed Viremia (non-adherence, interrupted access to ARVs)</p>	<ul style="list-style-type: none"> • Breastfeeding should be stopped temporarily or discontinued and replacement feeding initiated. • Consider permanent discontinuation of breastfeeding if HIV RNA ≥200 copies/mL; can consider resuming breastfeeding once re-suppressed. • Perform infant HIV NAT^a. • Initiate presumptive HIV therapy using a three-drug regimen of either ZDV, 3TC, and NVP (treatment dose) or ZDV, 3TC, and (RAL or DTG). • Duration of 2–6 weeks. • If the duration of the three-drug regimen is <6 weeks, and the NAT is negative, continue ZDV alone to complete a total of 6 weeks of prophylaxis. • Consultation with the IL Perinatal HIV Hotline or a pediatric HIV specialist is recommended.
<p>New Viremia During Breastfeeding (HIV RNA <200 copies/mL)</p>	<ul style="list-style-type: none"> • Breastfeeding should be stopped temporarily or discontinued and replacement feeding initiated. • Perform infant HIV NAT^a. • Consider initiation of presumptive ARV therapy (as described for new viremia ≥200 copies/mL, above); or initiation of single-drug ARV prophylaxis (see Table 4 below). • Consultation with the IL Perinatal HIV Hotline or a pediatric HIV specialist is recommended.



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INTRAPARTUM AND POSTPARTUM CARE FOR PREGNANT PEOPLE WITH HIV, PEOPLE WITH A PRELIMINARILY POSITIVE RAPID HIV TEST, AND NEWBORNS WITH HIV EXPOSURE

Level of Transmission Risk During Breastfeeding by HIV RNA Levels in Breastfeeding Parent	Infant ARV Management During Breastfeeding
Parent With a New Diagnosis of HIV When Breastfeeding	<ul style="list-style-type: none"> • Stop breastfeeding and initiate replacement feeding. • Perform infant HIV NAT^a. • Initiate presumptive HIV therapy using three-drug regimen of ZDV, 3TC, and DTG^b. For infants aged <4 weeks, NVP (treatment dose) or RAL should be used. See Table 4 for dosing information. • Duration of 2 to 6 weeks. • If the duration of the three-drug regimen is <6weeks and the NAT is negative, continue ZDV alone to complete a total of 6 weeks of prophylaxis. • Consultation with the IL Perinatal HIV Hotline or a pediatric HIV specialist is recommended.

^a An HIV NAT at birth is recommended for all breastfeeding infants. A NAT should be obtained before or immediately after starting ARVs.

^b DTG may be used in infants >4 weeks and weighing >3 kg.

Table 4. Antiretroviral Prophylaxis Dosing for Breastfeeding Infants

ARV Prophylaxis for Infants When the Breastfeeding Parent has Sustained Viral Suppression	
Recommended Regimen	Recommended Duration and Dosing
ZDV	ZDV administered for 2 weeks after birth (see Table 2 for dosing)
Options for Extended Postnatal Prophylaxis	
Recommended Regimen	Recommended Duration and Dosing
ZDV	ZDV administration continued for 4–6 weeks after birth (See Table 2 for dosing; note that ZDV is not recommended for prophylaxis beyond this initial postnatal period.)
NVP ^a	NVP administered starting at birth or after completion of initial prophylaxis ZDV, through 6 weeks after cessation of breastfeeding. Simplified Age-Based NVP Dosing for Newborns ≥32 Weeks' Gestation Receiving Extended NVP Prophylaxis During Breastfeeding



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	Age	Dose and Volume of NVP 10 mg/mL Oral Syrup Administered Once Daily										
	Birth to 6 weeks	2.0 to < 3.0 kg: 10 mg (1.0 mL) ≥ 3.0 kg: 15 mg (1.5 mL)										
	6 weeks to 6 months	20 mg (2.0 mL)										
	6 months to 9 months	30 mg (3.0 mL)										
	9 months to 18 months	40 mg 4.0 mL										
3TC^{a,b}	<p>3TC administered starting after completion of initial prophylaxis ZDV, through 6 weeks after cessation of breastfeeding.</p> <p>Age 2 Weeks to <4 Weeks</p> <ul style="list-style-type: none"> 3TC 2 mg/kg per dose orally twice daily <p>Age ≥4 Weeks to 12 months</p> <ul style="list-style-type: none"> Use simplified weight-band dosing outlined in the table below. <p>Simplified Weight-Band Dosing for 3TC (10 mg/ml Solution) When Used as Prophylaxis During Breastfeeding</p> <table border="1"> <thead> <tr> <th>Weight Band</th> <th>Dose and Volume of 3TC 10 mg/mL Oral Solution Administered Twice Daily</th> </tr> </thead> <tbody> <tr> <td>2 to < 3 kg</td> <td>10 mg (1 mL)</td> </tr> <tr> <td>3 kg to <4 kg</td> <td>15 mg (1.5 mL)</td> </tr> <tr> <td>4 kg to <8 kg</td> <td>25 mg (2.5 mL)</td> </tr> <tr> <td>≥8 kg</td> <td>50 mg (5 mL)</td> </tr> </tbody> </table>		Weight Band	Dose and Volume of 3TC 10 mg/mL Oral Solution Administered Twice Daily	2 to < 3 kg	10 mg (1 mL)	3 kg to <4 kg	15 mg (1.5 mL)	4 kg to <8 kg	25 mg (2.5 mL)	≥8 kg	50 mg (5 mL)
Weight Band	Dose and Volume of 3TC 10 mg/mL Oral Solution Administered Twice Daily											
2 to < 3 kg	10 mg (1 mL)											
3 kg to <4 kg	15 mg (1.5 mL)											
4 kg to <8 kg	25 mg (2.5 mL)											
≥8 kg	50 mg (5 mL)											
Recommended Infant ARV Management When a Breastfeeding Parent Develops Viremia or Is Diagnosed With HIV During Breastfeeding												
Presumptive HIV Therapy Regimens	Recommended Duration and Dosing											
ZDV plus 3TC plus DTG	<p>Consultation with the IL Perinatal HIV Hotline or a pediatric HIV specialist is recommended.</p> <p>Three-drug presumptive HIV therapy regimen. NVP or RAL should be used in place of DTG for infants aged <4 weeks and/or weighing <3 kg. See Table 2 for dosing of ZDV and 3TC in infants aged <6 weeks.</p>											

BEST PRACTICES: LABOR & DELIVERY CARE FOR PREGNANT PEOPLE WITH HIV AND CARE OF INFANTS WITH PERINATAL EXPOSURE TO HIV



1-800-439-4079

INTRAPARTUM AND POSTPARTUM CARE FOR PREGNANT PEOPLE WITH HIV, PEOPLE WITH A PRELIMINARILY POSITIVE RAPID HIV TEST, AND NEWBORNS WITH HIV EXPOSURE

	Presumptive HIV therapy is recommended for a duration of 2–6 weeks (see Table 3).
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^a Consider periodic CBC and LFTs in breastfeeding infants receiving ARV prophylaxis beyond 6 weeks of life. The American Academy of Pediatrics recommends periodic monitoring of hematologic and liver toxicity in breastfeeding infants receiving ARV prophylaxis beyond this period and for extended durations. Source: Lisa Abuogi, Lawrence Noble, Christiana Smith, COMMITTEE ON PEDIATRIC AND ADOLESCENT HIV, SECTION ON BREASTFEEDING; Infant Feeding for Persons Living With and at Risk for HIV in the United States: Clinical Report. Pediatrics June 2024; 153 (6): e2024066843. 10.1542/peds.2024-066843.

^b 3TC should be used as extended ARV prophylaxis during breastfeeding when there is evidence or concern for NVP resistant virus (including HIV-2 infection or HIV-1/HIV-2 co-infection) in breastfeeding parent or when an infant cannot tolerate NVP. Dosing for extended 3TC prophylaxis during breastfeeding, based on established 3TC dosing for treatment and weight-band dosing used in PROMISE-EPI Source: Mennecier A, Kankasa C, et al. Optimised prevention of postnatal HIV transmission in Zambia and Burkina Faso (PROMISE-EPI): a phase 3, open-label, randomised controlled trial. Lancet. 2024;403(10434):1362-1371. <https://pubmed.ncbi.nlm.nih.gov/38484756>.

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The 24/7 Illinois Perinatal HIV Hotline’s BEST PRACTICES: LABOR & DELIVERY CARE FOR PREGNANT PEOPLE WITH HIV AND CARE OF INFANTS WITH PERINATAL EXPOSURE TO HIV were adapted from the U.S. Department of Health and Human Services Recommendations for the Use of Antiretroviral Drugs During Pregnancy and Interventions to Reduce Perinatal HIV Transmission in the United States available at hivinfo.nih.gov. They were developed by Dr. Lynn Yee, Director of the Women’s Infectious Disease Program at Northwestern Memorial Hospital and Medical Director of the 24/7 Illinois Perinatal HIV Hotline; Dr. Jennifer Jao, Director, Section of Pediatric and Maternal HIV Infection and Dr. Sahera Dirajlal-Fargo, both at the Northwestern Feinberg School of Medicine and Ann & Robert H. Lurie Children’s Hospital of Chicago; and Dr. Julia Rosebush, Director of Pediatric/Adolescent HIV, Comer Children’s Hospital at the University of Chicago.