HIV in Pregnancy - Updates

Jane Hitti, MD, MPH, MHA
Professor, Maternal-Fetal Medicine, University of Washington Medical Center

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Disclaimer

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Learning Objectives

After this lecture, participants will be able to:

1. Discuss the role of long-acting injectable antiretroviral medication for the treatment of HIV during pregnancy.

2. Provide information to support shared decision-making for parents with HIV regarding infant feeding options.

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Long-Acting Injectable Antiretrovirals in Pregnancy

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Antiretroviral medications in pregnancy: *a conceptual framework*

Who have they shared HIV diagnosis with?	Do they have access to a refrigerator? How about food?	Do they have safe housing? Who do they live with?	Can they swallow pills?
Are there language barriers?	Are there transportation challenges?	Do they have significant nausea, vomiting, GERD?	What trauma have they experienced?

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Antiretroviral medications in pregnancy

Recommended first-line regimens for pregnant patients with no previous antiretroviral treatment (and no previous cabotegravir-LA):

- Bictegravir plus TAF / FTC
- Dolutegravir plus TAF/FTC or TDF/FTC

Perinatal HIV Clinical Guidelines 6/12/25
https://clinicalinfo.hiv.gov/en/guidelines/perinatal/

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A common-sense approach to HIV medications in pregnancy

"In most cases, the Panel recommends continuing the current regimen during pregnancies impacted by HIV, provided that the regimen is tolerated and effective in suppressing viral replication (defined as a regimen that maintains an HIV viral load less than the lower limits of detection of the assay)."

- Perinatal Guidelines, 6/12/2025

Perinatal HIV Clinical Guidelines 6/12/25
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Approach to regimens that are not preferred or alternative options:

- Counsel about the benefits and risks of continuing the current ART or switching to another ARV regimen.
- When ARVs for which data about use in pregnancy are insufficient (e.g., long-acting cabotegravir [CAB-LA]) or ARVs with pharmacokinetic (PK) changes that could lead to lower drug levels and loss of viral suppression (e.g., cobicistat-boosted regimens) are being taken, discuss whether to continue the current regimen with frequent viral load monitoring (i.e., every 1 to 2 months) or consider switching … Consider the tolerability of each drug, the ability to maintain viral suppression, the risk of perinatal HIV transmission, and the risk of potential adverse outcomes.

Perinatal HIV Clinical Guidelines 6/12/25
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Long-acting cabotegravir / rilpivirine in pregnancy

- CAB-LA is approved for prophylaxis and treatment in nonpregnant adults
- No significant change in CAB PK during pregnancy
- RPV-LA has lower drug concentrations during pregnancy
- Thus, CAB/RPV LA is not recommended in pregnancy due to concern regarding RPV – however, it may be the best option in some circumstances

UW experience: 3 pregnancies on CAB/RPV LA: one delivered & breastfeeding, 2 ongoing pregnancies. All have maintained viral suppression.

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CAB / RPV Management in Pregnancy – HMC/UW Approach

- Dosing frequency
  - Ascertain how long the patient has been on CAB/RPV
  - If q4w dosing, continue q4w dosing throughout pregnancy
  - If q8w dosing, continue q8w dosing through first trimester, then offer switch to PO or change to q4w dosing for 2nd and 3rd trimesters
- VL monitoring frequency
  - 1st and 2nd trimester: Q2month VL, unless on CAB/RPV for < 44 weeks, in which case Q4W VL
  - 3rd trimester: VL q4w
- Breastfeeding
  - If on q4w dosing prior to pregnancy, continue q4w dosing
  - If on q8w dosing prior to pregnancy, may return to q8w dosing after delivery (SDM)
  - If they prefer to continue q4w dosing during breastfeeding, that's ok

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Lenacapavir (LEN) in pregnancy?

- Capsid inhibitor, FDA approved for treatment-experienced adults with MDR-resistant HIV-1 whose current ARV regimen is failing
- Limited data in pregnancy regarding PK, placental transfer, teratogenicity and toxicity in pregnancy
- LEN for PrEP clinical trial among girls / young women in South Africa & Uganda (PURPOSE 1): 193 pregnancies in LEN group with pregnancy outcomes similar to general population

UW recommendation: Until more data are available, avoid LEN use in pregnancy unless maternal health benefit outweighs potential risks

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Shared Decision-Making for Infant Feeding

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Breastfeeding with HIV

- Risk of HIV transmission is less than 1% (but not 0) if the birth parent and infant are both taking medication, and the birth parent has an undetectable viral load
- Infant medication: no consensus among Pediatric Virology providers
- Exclusive breastfeeding encouraged
- Donor breast milk is an option to support breastfeeding initiation

Photo courtesy of Northwest Mother's Milk Bank

Perinatal HIV Clinical Guidelines 6/12/25
https://clinicalinfo.hiv.gov/en/guidelines/perinatal/

UW recommendation: ZDV for 2 weeks, then NVP until at least 6 weeks PP or for duration of breastfeeding (shared decision-making with parents)

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Infant feeding and HIV

LEARN MORE ABOUT THE DECISION TO FEED YOUR BABY

Let's get started

Qin J, Infant Feeding and HIV Decision Aid (unpublished)

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This is your decision

Fed is best. Both breastmilk and formula will give your child everything they need to grow and thrive. This guide will help you think through the considerations and values that commonly come up for birthing people living with HIV when they are trying to decide how to feed their baby.

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Qin J, Infant Feeding and HIV Decision Aid (unpublished)

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Values

As you think about your decision, it may be helpful to review some of the values that others have felt were important in making their decision.

Social Support

Assessing Risk

Confidentiality

Medication

Testing

Time

Finances

Cultural Beliefs

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Qin J, Infant Feeding and HIV Decision Aid (unpublished)

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Social Support

The newborn period can be stressful in general. Having support from a partner, friends, or family can be helpful as you care for your baby.

Think about the people around you who you may count on for support after you deliver. How do they feel about different types of infant feeding?

If your support system is unaware of your HIV status, they may put more pressure on you to breastfeed. if they are aware of your status, they may share their own opinions of what you should do, even if it's different from what you plan.

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Qin J, Infant Feeding and HIV Decision Aid (unpublished)

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CLICK ON THE RESPONSE THAT BEST REPRESENTS HOW YOU FEEL:

- My support people would support me in any decision I make regarding infant feeding
- My support people would support me only if I wanted to breastfeed
- My support people would support me only if I wanted to feed with formula
- I am not sure how my support people feel about infant feeding
- The way my support people feel is not a factor in my decision to infant feed

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Qin J, Infant Feeding and HIV Decision Aid (unpublished)

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Summary

You can print this for your next prenatal visit or email it to yourself for reference.

1. Social Support
I am not sure how my support people feel about infant feeding

2. Assessing Risk
I am uncertain if the risks of HIV transmission to my baby outweigh the benefits of breastfeeding

3. Confidentiality
I am not worried that my choice of feeding my baby will share information about my HIV status

4. Medication
I can't imagine making a decision that will lead to giving my baby medications for a longer period of time

5. Testing
If I have more support, I would feel prepared to bring them into testing as long as it is needed

6. Time
When it comes to infant feeding, I have concerns about the amount of time that it will take

7. Finances
I have financial concerns regarding infant feeding

8. Cultural Beliefs
Because of cultural beliefs around breastfeeding, I feel pressure from my community to breastfeed

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UW HIV Pregnancy Cohort, 2009-2022 (n=306)

Characteristic	n	(%)
New HIV diagnosis in pregnancy	54	(18.1%)
Antiretroviral class:		
- Integrase inhibitor	152	(51.0%)
- Non-nucleoside reverse transcriptase inhibitor	31	(10.4%)
- Protease inhibitor	100	(33.6%)
- 3 nucleoside reverse transcriptase inhibitors, zidovudine only or no medication	15	(5.0%)
HIV RNA < 1000 at delivery	287	(96.3%)
Cesarean delivery	162	(54.4%)
Any lactational feeding	6	(2.0%)

Hitti et al, CROI 2025, poster 999

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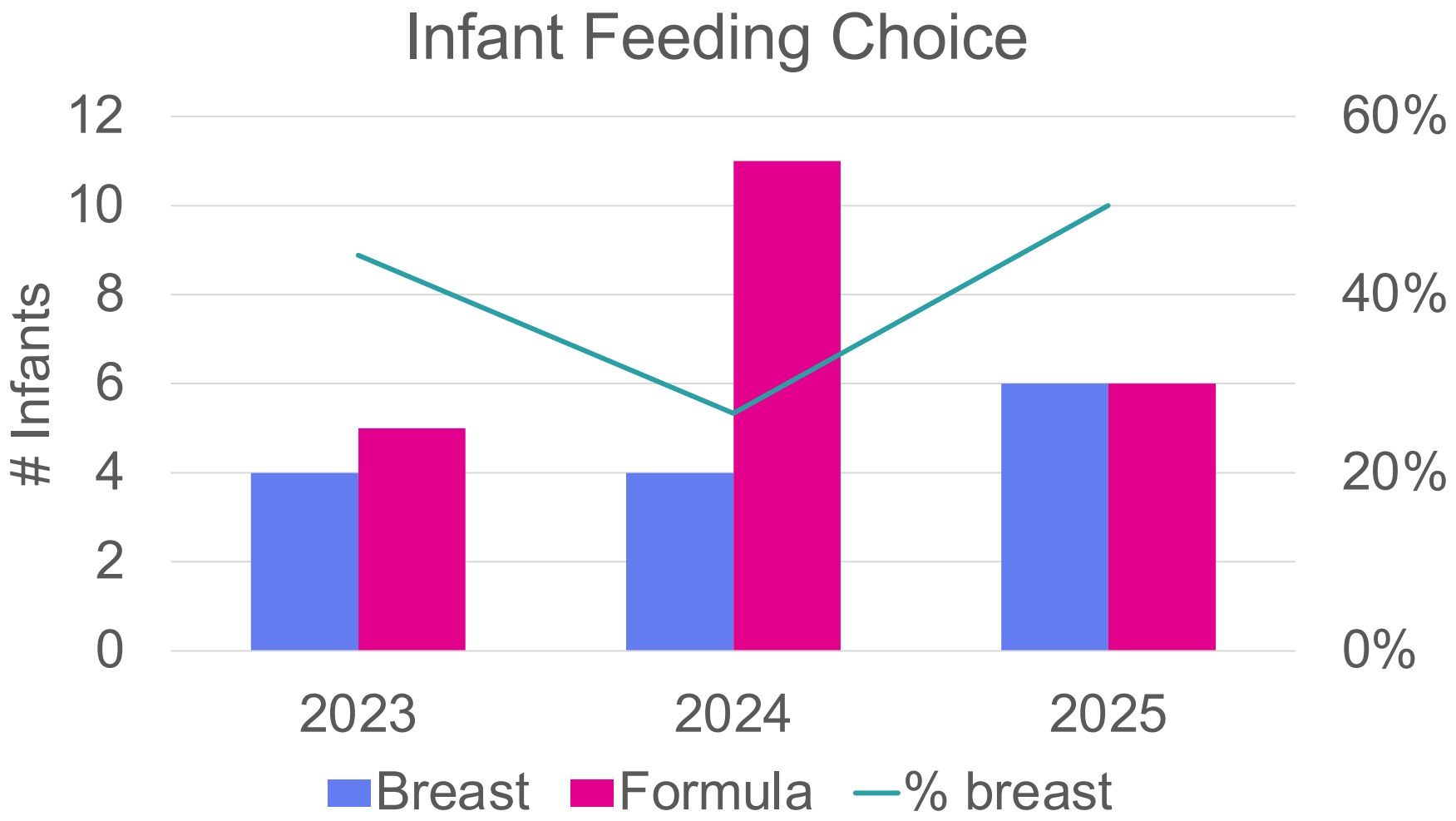
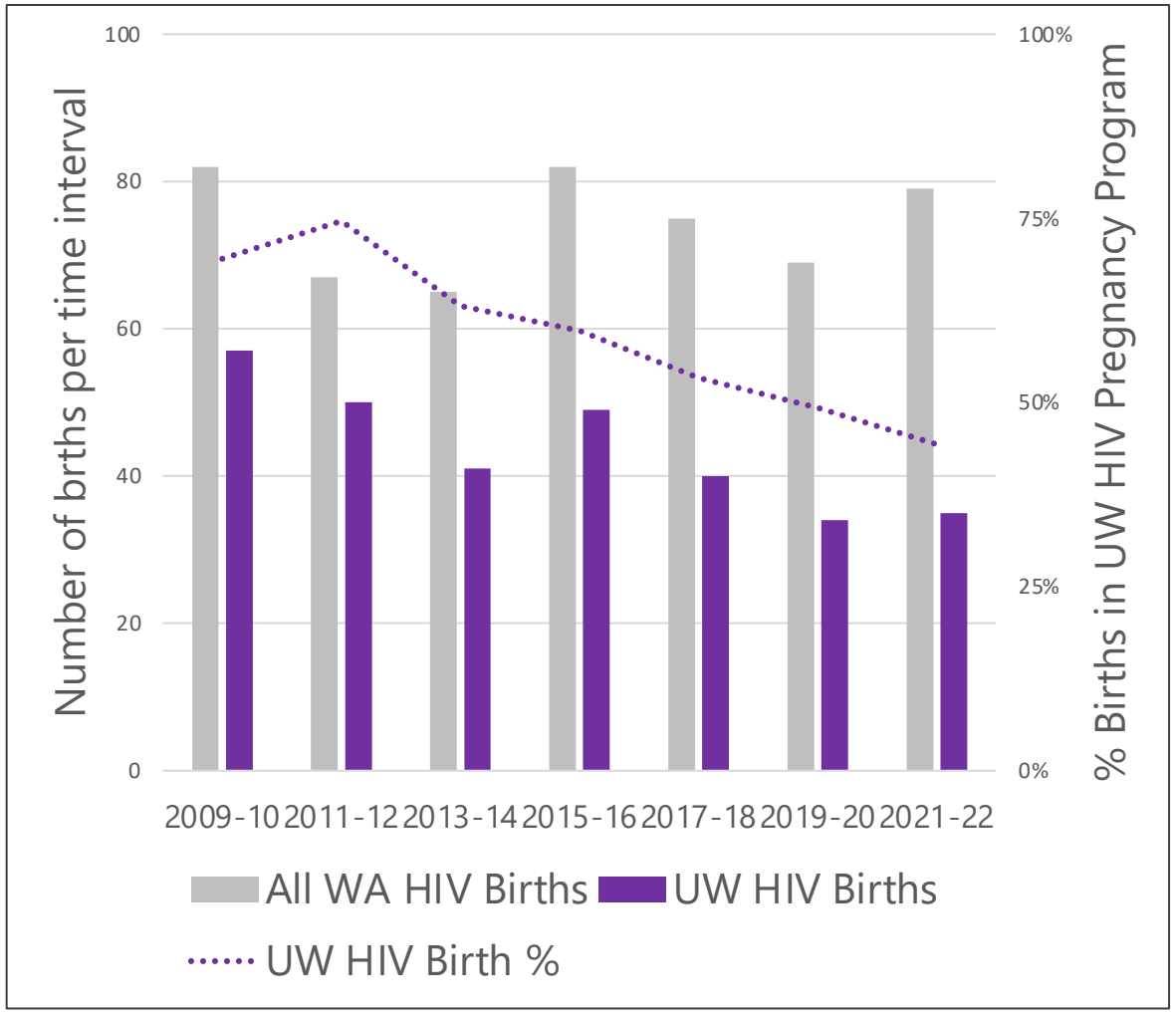
UW HIV Pregnancy Cohort – Infant Feeding Choice



Hitti, unpublished data

UW HIV Pregnancy Cohort – Pregnancy Outcomes



- There were 0/306 HIV-1 transmissions in UW HIV and 6/213 (2.8%) among other WA PLWH (P =0.0046).
- Among singletons, LBW occurred more frequently among UW HIV (11.7%) compared to all WA births (5.0%); OR 2.5, 95% CI 1.8-3.6.
- PTB rates were marginally higher among UW HIV (11.7%) compared to all WA births (8.5%); OR 1.4, 95% CI 1.0-2.0).

Hitti et al, CROI 2025, poster 999

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Perinatal HIV transmission, WA State

8 transmission events from infants born in WA State, 2009-2024:

- 5 infants diagnosed at ≤ 1 month age, 1 at 8 months, 1 at 2 years
- 5 birth parents diagnosed during pregnancy, 1 before and 2 after pregnancy
- 4 birth parents US born, 3 not US born, 1 unknown
- 3 Pierce County, 2 Grays Harbor, 1 each Thurston, Snohomish, Chelan

  - *opportunity for focus in South Sound?*

DOH alert states “Medical providers ***reported*** three cases of perinatally acquired HIV in 2024” – ***however only 1 was born in 2024***

Personal communication, WA DOH HIV Surveillance team, Office of Infectious Diseases

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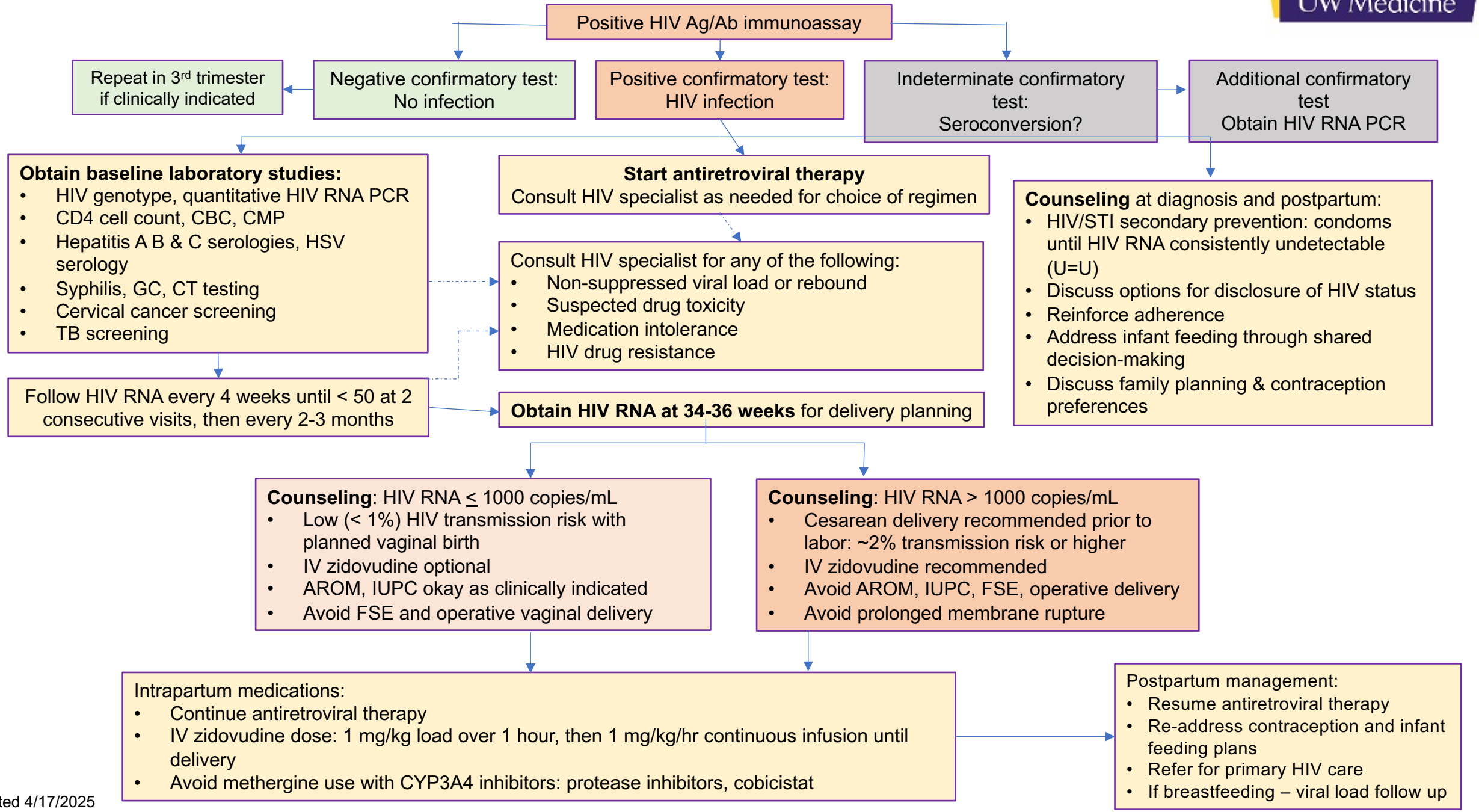
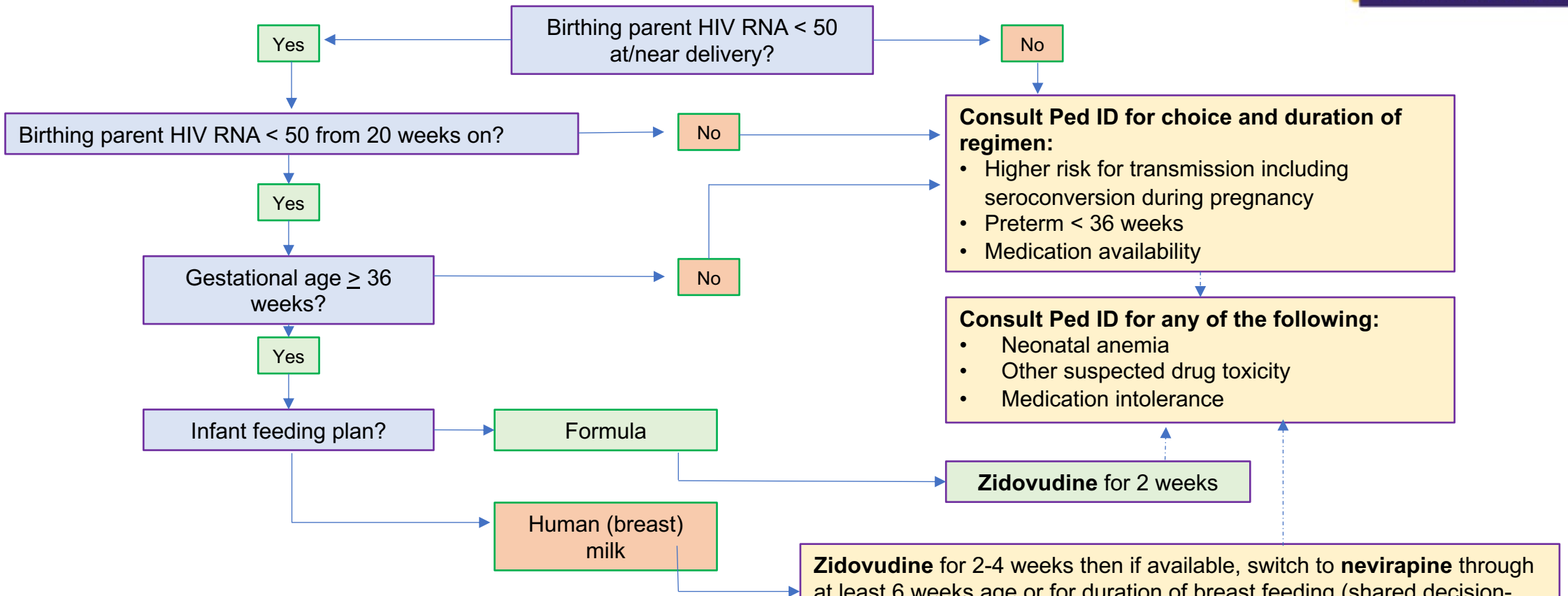
Figure 1. Algorithm for new HIV diagnosis and management in pregnancy

UW Medicine



Updated 4/17/2025

Figure 2. Antiretroviral prophylaxis and diagnostic testing for HIV-exposed infants



Neonatal diagnostic testing schedule: (HIV DNA preferred)
- Birth: HIV DNA or RNA, ALT, CBC; urine CMV
- 2 weeks: HIV DNA or RNA, CBC
- 6-8 weeks: HIV DNA or RNA, CBC
- 4-6 months: HIV DNA or RNA
- Breastfeeding (q2 months until 4-6 months after weaning): HIV DNA or RNA

Neonatal medication dosing:
Zidovudine: 4 mg/kg oral every 12 hours
Nevirapine: consult guidelines; weight & age dependent
Consult Ped ID for other medication dosing

Reference: https://clinicalinfo.hiv.gov/en/guidelines/perinatal/whats-new
Updated 6/12/2025