

BHIVA pregnancy guidelines 2025: non-technical summary

HIV in pregnancy

The British HIV Association (BHIVA) produces medical guidelines about HIV treatment and care. All guidelines review the evidence for the best care. These guidelines are for clinicians providing HIV care, but it is important that you also know what is in them, and what they might mean for you if you are thinking about becoming pregnant or are pregnant when you are diagnosed with HIV. This non-technical summary aims to provide the main points about how you and your baby should be cared for, so not all the recommendations in the guidelines are included. You can find more details in the full guidelines at: <https://www.bhiva.org/pregnancy-guidelines>.

What is covered in the HIV in pregnancy guidelines?

- Involvement in decision-making and general recommendations for supporting the wellbeing of pregnant women/people living with HIV.
 - What antiretroviral treatment combinations are recommended when planning for, during and after pregnancy.
 - Recommendations for the care and monitoring of women/people living with HIV during pregnancy and birth, and afterwards.
 - Recommendations for the care of babies born to women/people living with HIV and infant feeding.
 - Recommendations for the care of pregnant women/people with HIV and hepatitis.
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General recommendations

Pregnant women/people living with HIV should be looked after by a multidisciplinary team (MDT) during and after pregnancy which should be led by a named healthcare professional. You should be offered peer support and asked about your mental health throughout pregnancy and after birth. You should have the same routine pregnancy monitoring as women/people who are not living with HIV (for example, ultrasound scans as per national pregnancy guidelines). You should be offered the same tests as other women/people living with HIV who are not pregnant (for example, CD4 count and viral load) and also tests for sexually transmitted diseases.

Involvement in decision-making

The guidelines emphasise that you should be involved in all decisions about your care and pregnancy and that peer support from other people living with HIV is important. There is a network of women living with HIV who are trained as mentor mothers who can share their knowledge and experience to help you to be involved effectively in the choices you make around your pregnancy and health (<https://4mmm.org/>). Some clinics also have peer navigators; these are people living with HIV themselves who are trained to help you to find the healthcare professionals you need to provide support. There are also many HIV organisations that will support you during pregnancy and birth, and beyond.

Treatment

All pregnant women/people living with HIV should start combination antiretroviral treatment. This should be continued after giving birth and throughout life. Women/people who are diagnosed with HIV when pregnant should start treatment as soon as possible, especially if they have a high viral load which means that the level of virus in their blood is high. This is so that the level of virus can be reduced as soon as possible, to a very low level (below 50 copies/mL), to lower the risk of transmission to the baby to the lowest possible level.

Women/people who are not on treatment when becoming pregnant are recommended to start tenofovir plus emtricitabine or abacavir plus lamivudine along with a third drug, often dolutegravir, as there is a lot of information to show how safe these particular drugs are in pregnancy. However, there are other alternatives listed in the main guidelines.

If you are happy with your antiretroviral combination and have an undetectable viral load you should be able to continue taking the same medication. However, there are exceptions because the effectiveness of some medications can be reduced in pregnancy. For example, combinations that include the booster cobicistat may need to be changed as cobicistat does not boost effectively enough in pregnancy. Also, raltegravir 1200 mg once daily should be changed to raltegravir 400 mg twice daily. Women/people who start antiretroviral treatment during pregnancy and do not reach an undetectable viral load should be tested for HIV resistance, have their medications reviewed by a doctor or pharmacist and be supported with taking their medications.

Care during pregnancy and birth

Pregnancy monitoring (including ultrasound scans) should follow national pregnancy guidelines. Invasive tests on the unborn baby (such as amniocentesis and chorionic villus sampling) should be delayed until you have an undetectable viral load, if possible. According to national guidelines published by the National Institute for Health and Care Excellence (NICE: <https://www.nice.org.uk/guidance/ng192/chapter/Recommendations>), women/people should plan with their care team how they would like to give birth, weighing up the risks and benefits of vaginal birth or caesarean section. Women/people on HIV treatment who have an undetectable viral load (below 50 copies/mL) near the end of pregnancy can aim to have a vaginal delivery, unless there is another reason not to do so related to the pregnancy. If your viral load is between 50 and 399 copies/mL, your care team may recommend a caesarean section. If your viral load is 400 copies/mL or more, you should plan to have a caesarean section to minimise the risk of passing HIV to your baby.

Infant care

You will be asked to give your baby medication for between 2 and 4 weeks after birth to reduce the chance of HIV being transmitted. If your viral load is undetectable throughout the pregnancy and when you give birth, this will be a single drug called zidovudine, which is given in a liquid form into the baby's mouth for 2 weeks. Your care team may recommend a combination of three medications for the baby in certain circumstances if your viral load was not undetectable.

Your baby should have an HIV test at birth, and then at 4–6 weeks, 10–12 weeks and 24 months after birth. If you choose to breast/chestfeed, your baby will be tested more frequently: every 4 weeks during breast/chestfeeding and for 2 months afterwards. In addition, if you have been newly diagnosed with HIV during pregnancy, your other children should be offered HIV testing if appropriate (and your partner).

Infant feeding

HIV can be passed to the baby through human milk. To avoid the risk of postnatal transmission of HIV it is recommended that your baby is fed exclusively with formula milk. This may be provided free of charge if you cannot afford bottles and sterilising equipment. However, schemes vary from clinic to clinic. You can choose whether to take the drug cabergoline just after birth to stop the production of milk, to make you more comfortable. Women/people with an undetectable viral load (below 50 copies/mL) who take their medication regularly every day may choose to breastfeed after weighing up the risks and benefits. Women/people with an undetectable viral load who choose to breastfeed should be supported by their clinical team to do this in the safest way possible (for a maximum of 6 months).

Care after giving birth

A named member of the clinical team should review your health 4–6 weeks after you have given birth, including an assessment of your mental health needs. All women/people living with HIV should continue their antiretroviral medication and be offered contraception. All women/people living with HIV should have a smear test 3 months after giving birth, and then every year.

Care of women/people with HIV and hepatitis

Women/people with HIV and hepatitis B or C should have extra tests and monitoring during pregnancy and receive combination treatment (medication) that contains tenofovir. Women/people with an undetectable HIV viral load and hepatitis B or C can plan a vaginal delivery. Babies born to women/people with HIV and hepatitis B should be immunised against hepatitis B, and may need extra treatment to prevent hepatitis B. Currently, there is very little evidence on the safe use of hepatitis C treatments in pregnancy and therefore these treatments are not recommended. Women/people with HIV and hepatitis C who are planning to get pregnant should be prioritised for treatment and should delay pregnancy until treatment is completed.

Glossary

Multidisciplinary team or MDT: a clinical team consisting of people with different skills and expertise; for example, HIV doctor, specialist midwife, pharmacist, health advisor, specialist nurse, obstetrician, paediatric doctor, support worker, social worker, peer navigator/support worker and community nurse specialist.

Peer navigator/supporter: a person living with HIV who is trained to support others.

Sexually transmitted infection: an infection you can get from having sex with someone.

CD4 count: the number of CD4 cells in the blood, which is low in advanced HIV infection. CD4 cells are a type of white cell and are part of the immune system.

HIV viral load: the amount of HIV virus in the blood.

Antiretroviral treatment: a combination of medications that treat HIV.

Hepatitis B: a viral infection that affects the liver. It is transmitted through contact with body fluids, such as blood, saliva and urine, and can be passed to the child during pregnancy or birth.

Hepatitis C: a viral infection that affects the liver. It is transmitted through contact with blood, sharing drug-taking equipment and through sex, and can be passed to the child during pregnancy or birth.

Further information and support

4M (<https://4mmm.org/>) is an organisation led by women living with HIV who train others to become Mentor Mothers who provide peer support to women/people throughout and after pregnancy. Community organisations in the UK that produce information and resources about HIV treatment include the UK Community Advisory Board (UK-CAB: <https://ukcab.net>), HIV i-Base (<https://www.i-base.info>) and Terrence Higgins Trust (<https://www.tht.org.uk> and <https://www.aidsmap.com>).

BHIVA

The British HIV Association (BHIVA; <https://bhiva.org>) is the leading UK association representing professionals in HIV care in the UK. Members include doctors, nurses, researchers, pharmacists and people living with HIV/community advocates. Since 1995, BHIVA has been committed to providing excellent care for people living with and affected by HIV. BHIVA is a national advisory body on all aspects of HIV care and provides a national platform for HIV care issues.

To help promote and monitor high standards of care, BHIVA publishes a range of clinical guidelines: <https://bhiva.org/clinical-guidelines/>. Information about how BHIVA guidelines are developed can be found at: <https://bhiva.org/guideline-development/>.