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Screening for HIV Infection in Pregnant Women: A Systematic Review for the U.S. Preventive Services Task Force

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Structured Abstract

Background: A 2012 systematic review on HIV screening for the U.S. Preventive Services Task Force (USPSTF) found strong evidence that antiretroviral therapy (ART) greatly decreases the risk of mother-to-child HIV transmission but that use of ART may be associated with increased risk of preterm delivery. The USPSTF previously found HIV screening tests to be highly accurate.

Purpose: To systematically update the 2012 USPSTF review on HIV screening in pregnancy, focusing on research gaps identified in the prior review.

Data Sources: We searched the Cochrane Central Register of Controlled Trials, the Cochrane Database of Systematic Reviews, and MEDLINE (2012 to June 2018) and manually reviewed reference lists, with surveillance through January 25, 2019.

Study Selection: We selected randomized, controlled trials (RCTs) and cohort studies of pregnant women that reported risk of mother-to-child transmission or maternal or infant harms associated with prenatal HIV screening or ART during pregnancy.

Data Extraction: One investigator abstracted data and a second investigator checked data abstraction for accuracy. Two investigators independently assessed study quality using methods developed by the USPSTF.

Data Synthesis (Results): We identified no studies on the benefits or harms of prenatal HIV screening versus no screening, or on the yield of repeat versus one-time screening or screening at different intervals. One new RCT and five new cohort studies were consistent with the 2012 USPSTF review in finding combination ART highly effective at reducing the risk of mother-to-child transmission of HIV infection, especially if started early in pregnancy (rate of mother-to-child transmission <1%). As in the prior USPSTF review, one new RCT and several observational studies found certain ART regimens associated with increased risk of preterm delivery without increased risk of low birth weight. One RCT conducted in Africa found prenatal tenofovir-based ART associated with very preterm delivery and early infant death versus zidovudine-based ART, but the trial had methodological limitations. Prenatal exposure to most currently recommended ART drugs was not associated with increased risk of overall birth defects, but limited evidence found certain ART agents and regimens associated with increased risk of congenital abnormalities, cardiac anomalies, and echocardiographic changes, with no association with adverse neurodevelopmental outcomes. Evidence on long-term maternal harms associated with short-term exposure to ART during pregnancy remains limited, with some evidence of short-term harms.

Limitations: Only English-language articles were included. Observational studies were included. Studies conducted in resource-poor settings were included, which might limit applicability to screening in the United States.

Conclusions: Combination ART is highly effective at reducing risk of mother-to-child HIV transmission. The USPSTF previously determined that avoidance of breastfeeding and Caesarean

delivery in women with HIV ribonucleic acid levels greater than 1,000 copies/mL near the time of delivery is also effective at reducing mother-to-child transmission, and that prenatal screening is accurate at diagnosing HIV infection. Use of certain ART regimens during pregnancy is associated with increased risk of preterm delivery and may be associated with other adverse pregnancy outcomes. Although more evidence is required to better understand short- and long-term maternal and infant harms, selection of ART regimens may help mitigate or reduce harms.

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Chapter 1. Introduction and Background

Purpose

HIV infection is transmissible during pregnancy and the postpartum period. The purpose of this report is update a previous review[1,2] commissioned by the U.S. Preventive Services Task Force (USPSTF) on benefits and harms of prenatal screening for HIV infection. This report will be used to update the USPSTF's 2013 recommendation, which states that clinicians screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown ("A" recommendation),[3,4] a confirmation of the USPSTF's 2005 recommendation on prenatal HIV screening. The confirmation was based on prior findings that antiretroviral therapy (ART) is acceptable to pregnant women and that early detection and treatment of HIV is associated with large reductions in the risk of mother-to-child transmission, as well as some evidence that newer antiretroviral regimens are more effective than older regimens for preventing perinatal transmission. Although the USPSTF found some evidence that perinatal ART is associated with increased risk of preterm delivery, there was no clear association with low birth weight, congenital abnormalities, or impaired infant neurodevelopment, and no data indicating serious maternal harms.[1,2]

Condition Background

Condition Definition

HIV is a ribonucleic acid (RNA) retrovirus that infects human immune cells, in particular CD4+ helper T lymphocyte (CD4) cells. Left untreated, HIV infection results in progressive immunodeficiency and AIDS.[5] AIDS is a life-threatening condition characterized by presence of HIV infection and severe immune dysfunction (CD4 count $\leq$200 cells/mm^3) or one or more AIDS-defining neoplastic conditions or opportunistic infections.[5] HIV-1 infection is the most common variant in the United States. HIV-2 infection is rare in the United States, less clinically severe, and endemic in parts of West Africa.[6]

In HIV-infected pregnant women, HIV can cross the placenta, is present in cervical secretions in blood, and is present in breast milk. Therefore, transmission of HIV infection from mother to child can occur during pregnancy, during labor and delivery, and in the postpartum period through breastfeeding.[7]

Prevalence and Burden of Disease/Illness

In 2017, women accounted for 19 percent of all new diagnoses of HIV infection among adults and adolescents in the United States.[8] Between 2012 and 2017, the number of new HIV diagnoses in women declined 11 percent.[9] About 235,004 women in the United States were living with HIV infection in 2016, with 7,312 new cases.[9] Approximately 258 new diagnoses were in women ages 13 to 19 years.[9] An estimated 60 percent of infections were in black

women, 20 percent in white women, and 15 percent in Hispanic/Latina women.[9] An estimated 12 percent of women with HIV infection are unaware of their status.[10]

Approximately 8,500 HIV-positive women give birth each year in the United States.[7] In 2005 to 2008, approximately 30 percent of HIV-infected women were unaware of their status prior to pregnancy and approximately 4 percent were undiagnosed prior to the time of delivery.[11] Mother-to-child transmission accounts for approximately three-quarters of pediatric HIV infections in the United States and 90 percent of pediatric cases of AIDS.[7] Through 2013, there have been nearly 5,000 cumulative deaths of U.S. children younger than age 13 years with perinatally acquired HIV infection.[7] The number of cases of perinatal HIV infection in the United States peaked at about 1,650 in 1992, declining dramatically following the widespread adoption of routine prenatal screening, coupled with the use of effective therapies for preventing mother-to-child transmission. There were an estimated 215 to 370 cases of perinatal transmission in 2005[12] and 99 cases in 2016.[8] The Centers for Disease Control and Prevention (CDC) estimates that between 1994 and 2010, 21,956 cases of perinatally acquired HIV infection were prevented.[13,14] The overall annual rate of perinatally acquired HIV infection decreased from 6.0 cases per 100,000 live births in 2008 to 1.8 cases per 100,000 live births in 2013.[15] Rates of perinatally acquired HIV infection differ according to age group. In 2013, among black persons, the rate of HIV infection was 11.3 cases per 100,000 live births (from 23.6 cases per 100,000 live births in 2008), compared with 1.8 cases among Hispanic persons and 0.6 cases in white persons.

Etiology and Natural History

Peripartum transmission of HIV infection can occur during pregnancy (intrauterine), during labor and delivery (intrapartum), and following delivery (postpartum). In the absence of breastfeeding, intrauterine transmission is thought to account for 25 to 40 percent of vertically infected infants, with the remaining cases occurring during labor and delivery.[16] Most intrauterine transmission is thought to occur shortly before delivery.[17] HIV is present in and transmitted through breast milk[18] and breastfeeding is thought to be the only important mode of postpartum transmission to newborns and infants.[19,20] In resource-poor settings in which women breastfeed for prolonged periods, postpartum transmission accounts for about 44 percent of infant cases.[21] Antiretroviral treatment of the mother and infant does not completely eliminate breastfeeding transmission risk.[22] In the United States, HIV-infected women are advised against breastfeeding, given the risk of transmission and the availability of affordable and safe alternatives.[23]

Risk Factors

Most (87%) new HIV diagnoses in women (regardless of pregnancy status) are attributed to acquisition via heterosexual sex, followed by injection drug use (12%).[24] In HIV-infected pregnant women, about 50 percent were exposed to HIV through heterosexual contact, 8 percent through injection drug use, and 8 percent through some other exposure category (such as blood transfusion or perinatal exposure).[11] In about one-third of women, HIV exposure was unknown.

Well-established risk factors for perinatal transmission include higher viral load,

immunologically or clinically advanced disease in the mother, prolonged rupture of membranes, maternal infection with other sexually transmitted infections, and labor and delivery procedures and events associated with an increased probability of bodily fluid contact between mother and infant (such as abruptio placentae, fetal scalp electrode use, episiotomy, and second-degree or greater perineal laceration).[25]

Risk factors for clinical progression of HIV infection (in particular, high viral load and low CD4 count) appear to be similar for pregnant and nonpregnant women. In developed countries, pregnancy itself does not appear to be an important independent predictor of clinical progression in chronically-infected HIV-positive women.[26,27]

Rationale for Screening/Screening Strategies

A major goal of prenatal screening for HIV is to reduce the risk of mother-to-child transmission through provision of subsequent interventions. Other important goals are to improve long-term clinical outcomes in HIV-infected women through initiation of ART and other interventions (e.g., prophylaxis for opportunistic infections in women with immunologically advanced disease), facilitate early identification of infected newborns, help women to make more informed future reproductive choices, and reduce risk of horizontal transmission through effects on risky behaviors. The prior USPSTF review on prenatal HIV screening found that ART in combination with avoidance of breastfeeding and elective Caesarean delivery in women with viremia substantially reduces risk of mother-to-child transmission, from 9 to 22 percent with no ART to less than 1 to 2.4 percent with full-course combination ART.[3,4]

Interventions/Treatment

The current standard of care to prevent perinatal transmission of HIV infection in the United States is combination ART started at the time of diagnosis in all HIV-infected women (regardless of viral load or CD4 count), intravenous zidovudine and elective Caesarean delivery before labor or rupture of membranes in women with HIV RNA levels greater than 1,000 copies/mL or unknown HIV RNA levels near the time of delivery, antiretroviral treatment of the infant in the postnatal period, and avoidance of breastfeeding.[23] The selection of antiretroviral drugs is based on evidence on effectiveness for reducing perinatal transmission, risks to the fetus, side effect profile, and other factors, such as the potential for drug interactions or the possibility of inducing antiretroviral drug resistance, and may be informed by results of antiretroviral drug resistance testing. Because delayed treatment may reduce effectiveness of ART on risk of mother-to-child transmission, current guidelines recommend that clinicians consider initiating ART as soon as HIV is diagnosed during pregnancy, and not delay selection of the initial ART while awaiting results of drug resistance testing.[23] For women who present in labor with unknown HIV status, rapid testing with initiation of maternal (intravenous zidovudine during labor) and infant (combination ART) prophylaxis is recommended, with continuation of infant prophylaxis based on results of confirmatory testing. Consistent with management of nonpregnant persons with HIV infection, guidelines now recommend that HIV-positive women diagnosed during pregnancy be offered long-term ART following delivery, regardless of CD4 count.[23,28]

HIV-positive women identified during pregnancy may also benefit from other interventions that would be considered in nonpregnant persons with HIV infection, including long-term ART, prophylaxis for opportunistic infections, immunizations, and counseling to reduce high-risk behaviors for horizontal transmission; in addition, male sexual partners may benefit from pre-exposure prophylaxis with ART.[29]

Current Clinical Practice/Recommendations of Other Groups

The diagnostic accuracy of standard HIV testing is thought to be similar for pregnant and nonpregnant persons.[30] A large, prospective cohort study of 5,744 pregnant women presenting in labor in six U.S. cities (HIV prevalence, 0.59%) found rapid testing (prior to confirmation) associated with a sensitivity of 100 percent, specificity of 99.9 percent, positive predictive value of 90 percent, and negative predictive value of 100 percent.[31] Point-of-care rapid tests are recommended for women presenting in labor who have not received prenatal care or who were not tested earlier in pregnancy for other reasons.[32] Basing therapeutic decisions on a positive rapid test prior to confirmation is only recommended in situations in which decisions to initiate treatments cannot wait, such as in women presenting in active labor. Otherwise, confirmation of positive rapid tests prior to initiating interventions is recommended due to the possibility of false-positive tests,[31] which could result in unnecessary exposure to antiretroviral or other therapies.

Current practice in the United States for HIV screening in pregnant women includes "opt-out" HIV screening at the initial prenatal visit as part of the standard prenatal test panel.[23] Opt-out screening refers to screening that is performed after informing the woman about the test, unless the woman specifically declines. The CDC recommends that clinicians consider repeat testing in all women in the third trimester for those who test negative initially, and recommends repeat testing for women who continue to practice high-risk behaviors or who live in a high-incidence setting.[32]

In the United States, about 85 percent of HIV-infected women receive ART during pregnancy, with about 40 percent undergoing an elective cesarean delivery.[11] More than 95 percent of infants born to HIV-infected women receive ART during the postnatal period.

Many groups, including the American College of Obstetricians and Gynecologists,[33] the American Academy of Pediatrics,[34,35] the American College of Physicians,[36] and the CDC[32,37] recommend voluntary "opt out" testing for HIV in all pregnant women as part of routine prenatal care. The CDC[32,37] and the American College of Obstetricians and Gynecologists[33] recommend repeat testing for women with risk factors and those who live or receive care in high-incidence settings, and recommend that clinicians consider repeat testing for all women with a negative test result early in pregnancy. The USPSTF recommends that women screened during a previous pregnancy be rescreened in subsequent pregnancies, but does not address repeat screening during the same pregnancy.[4] The American Academy of Family Physicians follows the 2013 USPSTF recommendation.[38]

Chapter 2. Methods

Key Questions and Analytic Framework

Using the methods developed by the USPSTF,[39] the USPSTF and the Agency for Healthcare Research and Quality determined the scope and Key Questions for this review. Investigators created an analytic framework with the Key Questions and the patient populations, interventions, and outcomes reviewed (**Figure 1**). Key informants with expertise in HIV screening and HIV infection during pregnancy were surveyed for input, and the draft Research Plan was posted for public comment prior to finalization. The target population for HIV screening was pregnant women (including adolescents, defined as women ages 13 to <18 years) without signs or symptoms of HIV infection.

Key Questions

1. What are the benefits of screening for HIV infection in pregnant women on risk of mother-to-child transmission of HIV infection?
2. What is the yield of repeat HIV screening at different intervals in pregnant women, and how does the yield of screening vary in different risk groups?
3. What are the harms of screening for HIV infection in pregnant women?
4. What is the effectiveness of currently recommended ART regimens for reducing mother-to-child transmission of HIV infection?
5. What are the harms of currently recommended ART regimens given during pregnancy to the mother and infant?

Search Strategies

We searched the Cochrane Central Register of Controlled Trials, Cochrane Database of Systematic Reviews, and Ovid MEDLINE (2012 through June 2018) for relevant studies and systematic reviews. Search strategies are available in **Appendix A1**. We also reviewed reference lists of relevant articles.

After June 2018, we conducted surveillance through article alerts and targeted searches of high-impact journals to identify major studies that may affect conclusions. The last surveillance was conducted on January 25, 2019 and identified no primary research that would meet inclusion criteria for this review.

Study Selection

All titles and abstracts identified through searches were independently reviewed by two members of the research team for eligibility against predefined inclusion and exclusion criteria, as specified using the PICOTS (population, intervention, comparator, outcome, timing, study

design/setting) framework (**Appendix A2**). Studies marked for possible inclusion by either reviewer underwent full-text review. All results were tracked using EndNote® reference management software (Thomson Reuters, New York, NY).

Each full-text article was independently reviewed by two trained members of the research team for inclusion or exclusion on the basis of the eligibility criteria. If the reviewers disagreed, conflicts were resolved by discussion and consensus or by consulting another member of the review team. Results of the full-text review were also tracked in the EndNote database, including the reason for exclusion for full-text publications. The selection of literature is summarized in the literature flow diagram (**Appendix A3**). **Appendix A4** lists the included studies, and **Appendix A5** lists the excluded studies with reasons for exclusion.

Scope of Review

The prior USPSTF recommendation on prenatal HIV screening was an "A" recommendation, based on convincing evidence that the benefits of prenatal screening substantially outweigh harms. This review focuses on key areas for which evidence was lacking in the prior USPSTF review, including direct evidence on benefits and harms (including false-positive results and anxiety) of screening and the yield of repeat screening during pregnancy. Given changes in ART regimens that are used in pregnant women, this review addresses evidence on effectiveness and harms of ART,[23] with a focus on regimens currently recommended by the U.S. Department of Health and Human Services Panel on Treatment of Pregnant Women with HIV Infection and Prevention of Perinatal Transmission. A list of currently recommended ART regimens in pregnant women is shown in **Appendix B Table 1**. Most studies that reviewed various ART regimens evaluated outcomes associated with components of ART regimens, rather than entire regimens; we included studies that evaluated currently recommended regimens or ART agents that are part of currently recommended regimens. We excluded regimens and ART agents that are no longer recommended in current U.S. practice.

This update does not address diagnostic accuracy of screening, which the USPSTF previously found to be high.[40,41] This update also does not rereview effects of avoidance of breastfeeding and elective cesarean delivery in women with viremia on risk of perinatal transmission, as the effectiveness of these interventions is well established[4,40,41] and part of standard U.S. practice. Effects of early initiation of long-term ART are addressed in a separate report on screening for HIV infection in nonpregnant adolescents and adults.[42]

The population of interest for prenatal screening is asymptomatic pregnant women not known to be HIV-positive. For Key Questions on benefits and harms of ART, the population was HIV-infected pregnant women. Patient subgroups included those defined by age and race/ethnicity. The screening intervention was standard or rapid HIV antibody testing with confirmatory testing. Outcomes were mother-to-child transmission, yield of screening (number of cases of HIV infection identified per number of tests performed), harms of screening (including labeling, anxiety, and other harms), and maternal and infant harms of treatment, including long-term harms following in utero exposure to ART. For Key Questions on screening, comparisons were screening versus no screening, one-time versus repeat screening, and repeat screening at different intervals. For Key Questions on benefits and harms of ART, we included studies that compared

full-course (initiated in first or early second trimester) combination ART versus no ART, abbreviated courses of ART, or one- or two-drug therapy. For all Key Questions, we included randomized, controlled trials (RCTs), cohort studies, and case-control studies. We included studies conducted in primary care–applicable settings (e.g., prenatal, antenatal, and family planning clinics) and other health care settings in which screening is commonly performed (e.g., emergency room, urgent care, or labor and delivery). Although the target for treatment studies was those conducted in the United States and other high-income/low HIV prevalence countries, we also included RCTs on effects of ART on mother-to-child transmission conducted in low- and middle-income settings. For harms associated with prenatal ART, we included RCTs and cohort studies from any setting but restricted cohort studies to those that adjusted for potential confounders.

Data Abstraction and Quality Rating

For studies meeting inclusion criteria, we abstracted data on characteristics of study populations, interventions, comparators, outcomes, study designs, settings, and methods. For each study, data abstraction was conducted by one investigator and reviewed for completeness and accuracy by another investigator.

Predefined criteria were used to assess the quality of individual controlled trials, systematic reviews, and observational studies developed by the USPSTF. Studies were rated as "good," "fair," or "poor" quality in accordance with USPSTF methods, based on the seriousness of the methodological shortcomings (**Appendix A6**).[39] For each study, quality assessment was independently performed by two team members. Any disagreements were resolved by consensus.

Data Synthesis

We did not attempt meta-analysis of studies on effectiveness of ART on mother-to-child transmission or on harms of ART due to differences across studies in ART regimens and comparisons evaluated, harms outcomes, geographic settings, and methodological factors (e.g., observational studies performed statistical adjustment on different variables). There were too few studies to consider meta-analysis for other Key Questions.

For all Key Questions, the overall quality of evidence was determined using the approach described in the USPSTF Procedure Manual.[39] Evidence was rated "good," "fair," or "poor," based on the number, quality, and size of studies, consistency of results between studies, and directness of evidence, and is summarized in a table.[39]

External Review

The draft report was reviewed by content experts (**Appendix A7**), USPSTF members, Agency for Healthcare Research and Quality Project Officers, and collaborative partners, and was posted

for public comment; it has been revised accordingly.

Response to Public Comments

The draft report was posted for public comment from November 20, 2018 to December 26, 2018, and few comments were received. In response to the comments, we added a reference in the Discussion section to a systematic review on the safety of tenofovir disoproxil fumarate (TDF) in pregnancy.[43]

Chapter 3. Results

A total of 1,232 new references from electronic database searches and manual searches of recently published studies were reviewed and 162 full-text papers were evaluated for inclusion. Twenty-nine new studies (in 36 articles)[44-79] were included, and 33 studies (in 35 articles)[80-114] were carried forward from the prior USPSTF report. Included studies and quality ratings are described in **Appendix B**.

Key Question 1. What Are the Benefits of Screening for HIV Infection in Pregnant Women on Risk of Mother-to-Child Transmission of HIV Infection?

As in the prior USPSTF review, no RCT or observational study compared clinical outcomes (including risk of perinatal transmission) between pregnant women screened and not screened for HIV infection. As previously noted by the USPSTF, the number of infants with perinatally-acquired HIV transmission has markedly declined in the United States, likely due to a combination of screening during pregnancy and increased effectiveness and use of interventions to prevent transmission.

Key Question 2. What Is the Yield of Repeat HIV Screening at Different Intervals in Pregnant Women, and How Does the Yield of Screening Vary in Different Risk Groups?

Summary

No study compared the yield of one-time versus repeat screening or different frequencies of screening for HIV in pregnancy. Three studies conducted in the United States or the United Kingdom identified no cases of HIV infection among women who were rescreened for HIV during the third trimester of pregnancy; details regarding HIV risk status were not reported and not all women were rescreened.[115-117]

Evidence

As in the prior USPSTF review, we identified no RCT or observational study on the yield of repeat prenatal HIV screening compared with one-time screening, or that compared the yield of different strategies for repeat screening (e.g., risk-based repeat screening vs. a routine repeat test). Three studies reported rescreening rates and positive screening results in 3,473 pregnant women, but did not meet inclusion criteria because they did not compare different screening strategies.[115-117] One retrospective study of pregnant women (n=1,632) was conducted in Baltimore, Maryland, a state that mandates that pregnant women be screened for syphilis at presentation and again in the third trimester, providing an opportunity for HIV rescreening as

well.[115] HIV rescreening was performed in 28 percent of women, with no cases of HIV infection identified. A second study of 2,392 women in the United Kingdom with an initial negative prenatal HIV screening result found no cases of HIV infection in those retested during the third trimester.[116] The third study retested 75 women in ambulatory obstetrics-gynecology clinics in Philadelphia with a rapid HIV test in the third trimester and identified no new cases of HIV infection.[117] In these studies, details were unavailable regarding risk of HIV acquisition (e.g., HIV risk category or prevalence of HIV risk behaviors), and not all women were rescreened.

Repeat screening and the optimal timing of repeat testing during pregnancy depends on the incidence of new HIV infections following an initial negative prenatal screening result. One modeling study discussed in the 2005 USPSTF review estimated that repeat testing in the third trimester after a negative test in the first trimester would detect 5.3 new infections per 100,000 average-risk women tested and 192 infections per 100,000 high-risk women tested.[118]

Key Question 3. What Are the Harms of Screening for HIV Infection in Pregnant Women?

As in the prior USPSTF review, no study compared psychological or other harms associated with screening for HIV infection in pregnant women or adverse clinical consequences of interventions given as a result of false-positive results.

Key Question 4. What Is the Effectiveness of Currently Recommended ART Regimens for Reducing Mother-to-Child Transmission of HIV Infection?

Summary

The 2012 USPSTF review included eight cohort studies[105-108,110-113] that found full-course (starting in first trimester or early in second trimester) combination ART associated with rates of mother-to-child transmission of less than 1 to 2.4 percent, compared with 9 to 22 percent with no ART. Consistent with the prior USPSTF review, five new European, North American, and Israeli cohort studies published since 2012 found perinatal full-course triple ART associated with a risk of mother-to-child transmission that ranged from less than 1 to 2.8 percent.[51,60,61,63,74]

Two African RCTs included in the prior USPSTF review found combination ART started at 26 to 28 weeks of gestation associated with mother-to-child transmission rates of 1 to 5 percent.[86,87] One new RCT conducted primarily in Africa found combination ART after 14 weeks of gestation associated with a lower rate of mother-to-child transmission than zidovudine monotherapy (0.5% vs. 1.8%).[44] Across studies, including four African RCTs included in the prior USPSTF review,[80,81,84,88] later initiation of ART during pregnancy or treatment with fewer than three antiretroviral medications was associated with increased risk of mother-to-child transmission.

Evidence

The landmark Pediatric AIDS Clinical Trials Group protocol 076 study found that a three-phase maternal and infant zidovudine regimen starting at 14 to 34 weeks of gestation through 6 weeks postpartum decreased the risk of mother-to-child transmission in nonbreastfeeding women to 8 percent compared with 25 percent with placebo.[119] The 2012 USPSTF review identified no completed trials on full-course combination ART during pregnancy in nonresource-poor, nonbreastfeeding settings. It included eight U.S. or European cohort studies that found full-course combination ART associated with rates of mother-to-child transmission ranging from less than 1 to 2.4 percent, compared with 9 to 22 percent with no ART. The prior USPSTF review also included two RCTs of breastfeeding women in Africa that found triple ART started at 26 to 28 weeks of gestation associated with mother-to-child transmission rates of 1 to 5 percent.[86,87] Four other African trials in the prior USPSTF review found shorter courses of perinatal ART and regimens using fewer than three drugs associated with a lower risk of mother-to-child transmission of HIV infection compared with the expected transmission rate without therapy, but generally higher transmission rates than with full-course, three-drug regimens.[80,81,84,88] These RCTs are likely to be most applicable in the United States to HIV-infected women identified later in pregnancy, who cannot receive full-course regimens.

We identified no new RCTs on full-course combination ART during pregnancy in nonresource-poor, nonbreastfeeding settings. Five fair-quality cohort studies conducted in high-income settings and published since the prior USPSTF review evaluated the effectiveness of combination ART during pregnancy on risk of mother-to-child transmission[51,60,61,63,74] (**Table 1, Appendix B Tables 2–5**). Results were consistent with the findings from the prior review (**Table 1**). One large study (n=4,459) conducted an individual patient data meta-analysis of infants born between 1996 and 2010 in seven cohorts from six European countries who were at high risk of acquiring HIV infection (mother with viral load >50 copies/mL in the last 8 weeks of pregnancy, or mother only received intrapartum ART or received no antenatal or intrapartum ART).[51] More than 25 percent of women did not receive ART during pregnancy. In women who received ART, the timing of initiation during pregnancy was not reported. Treatment with three or more antiretroviral drugs was associated with decreased risk of mother-to-child transmission compared to zero drugs (2.8% vs. 14.3%; adjusted odds ratio (OR), 0.36 [95% confidence interval (CI), 0.23 to 0.57]). One or two antiretroviral drugs were also associated with decreased risk of mother-to-child transmission compared with no ART (adjusted OR, 0.33 [95% CI, 0.19 to 0.55] and OR, 0.12 [95% CI, 0.04 to 0.40], respectively).

The French Perinatal Cohort is an ongoing observational study involving 95 percent of all HIV-infected women in 90 perinatal centers throughout France.[61] Between 2000 and 2011, combination ART was initiated during pregnancy in 4,583 women (8% in the first trimester, 32% in the second trimester, 12% in the third trimester, and 47% before conception). Most regimens were protease inhibitor–based triple therapy (82.5%). There were 50 cases of mother-to-child HIV transmission (1.2% of births). The rate of mother-to-child HIV transmission was highest in women who initiated ART during the third trimester and in whom viral loads nearest delivery were detectable (4.4% [95% CI, 2.1 to 7.9]). There were no HIV transmissions among 2,651 women who started ART before pregnancy, continued ART throughout pregnancy, and had a viral load less than 50 copies/mL at the time of delivery.

Two smaller cohort studies, one from Canada[60] and one from the United Kingdom and Ireland,[74] reported rates of mother-to-child HIV transmission with combination ART of 1 and 0.5 percent, respectively. In the U.K./Ireland study, ritonavir-boosted lopinavir was associated with a higher transmission rate when ART was initiated during the third trimester (1.9%).[74] Some mother-infant pairs in this study may have been included in the individual patient data meta-analysis discussed above. An Israeli cohort study[63] found combination ART during pregnancy associated with decreased risk of vertical transmission (adjusted OR, 0.4 [95% CI, 0.1 to 0.8]); transmission rates were 1.5 percent with vaginal delivery and 0.6 percent with Caesarean delivery. Results were not stratified by timing of ART delivery.

One new fair-quality RCT (the Promoting Maternal and Infant Survival Everywhere [PROMISE] trial; n=3,490) was conducted in India and Africa among HIV-infected women with CD4 counts at or above 350 cells/mm^3 who were at or beyond 14 weeks of gestation (**Table 2**).[44] The rate of mother-to-child transmission at 1 week after birth was 1.8 percent with zidovudine alone; 0.5 percent with ART with zidovudine, lamivudine, and lopinavir-ritonavir; and 0.6 percent with ART with tenofovir, emtricitabine, and lopinavir/ritonavir (difference in rate for combined ART regimens vs. zidovudine alone, -1.3% [95% CI, -2.1 to -0.4]). The proportion of women who breastfed was 92 percent.

Key Question 5. What Are the Harms of Currently Recommended ART Regimens Given During Pregnancy to the Mother and Infant?

Summary

New evidence (two trials[44,45] and 21 cohort studies in 30 publications)[46-50,52-59,61,62,64-73,75-79] on infant and maternal harms associated with perinatal exposure to ART was generally consistent with the evidence included in the 2012 USPSTF review. One fair-quality RCT conducted in Africa and seven cohort studies published since the last review found antenatal ART associated with increased risk of preterm birth compared with no treatment or zidovudine monotherapy. The trial and 12 cohort studies found mixed results for the association between ART given during pregnancy and low birth weight, small size for gestational age, and stillbirth. Five cohort studies, including the Antiretroviral Pregnancy Registry,[47] found that most antiretroviral drugs recommended in the United States as initial therapy for HIV in pregnancy were not associated with increased risk of birth defects. The trial reported increased risk of neonatal death with ART with tenofovir, emtricitabine, and lopinavir/ritonavir (4.4%) compared with ART with zidovudine, lamivudine, and lopinavir/ritonavir (0.6%), but there was no difference between the tenofovir combination ART regimen and zidovudine monotherapy in risk of early infant death (4.4% vs. 3.2%,;p=0.43). Some methodological limitations were present in this trial.

Evidence

Birth Outcomes

The 2012 USPSTF review[1] included one RCT[83] and three prospective cohort studies[92,94,99] published after 2005 that found maternal exposure to combination ART with a protease inhibitor associated with increased risk of preterm delivery (<37 weeks) compared with nonnucleoside reverse transcriptase-based ART (OR, 2.0 [95% CI, 1.3 to 3.3]),[83] combination ART without a protease inhibitor (adjusted OR, 1.8 [95 % CI, 1.1 to 3.0]),[92] dual therapy (adjusted OR, 1.2 [95% CI, 1.0 to 1.4]),[99] or monotherapy (adjusted OR, 3.4 [95% CI, 1.1 to 10])[94] (**Table 3**). A fourth cohort study[100] found combination therapy associated with increased risk of preterm delivery (adjusted OR, 1.4 [95% CI, 1.1 to 1.8]) compared with monotherapy or dual therapy, with no difference in risk according to whether the antiretroviral regimen included a protease inhibitor or not. There was no clear association between maternal exposure to ART and increased risk of other adverse birth outcomes (e.g., low birth weight, small size for gestational age).

One open-label, Africa-based RCT[44] and 21 cohort studies in 30 publications[46-50,52-59,61,62,64-73,75-79] published since the prior USPSTF review evaluated the association between maternal exposure to ART and risk of preterm delivery, low birth weight, and other birth outcomes (**Table 3; Appendix B Tables 2–5**). Sample sizes ranged from 183 to 13,124 (total N=71,472). Eight studies were conducted in the United States, seven studies in Canada or Europe, and the remainder in Africa or Latin America. One cohort study, the Antiretroviral Pregnancy Registry[47] (n=22,360), is an international (69 countries) voluntary registry with 74 percent of data currently from the United States and its territories. ART regimens and comparisons varied across studies. Most cohort studies did not include a control group of women who did not receive ART; other methodological limitations were high attrition and unclear blinding of outcome assessors or data analysts.

The new fair-quality RCT (PROMISE; n=3,490) (see Key Question 4 for study details)[44] found ART with zidovudine, lamivudine, and lopinavir/ritonavir associated with increased risk of preterm delivery versus zidovudine monotherapy (20.5% vs. 13.1%; p<0.001). Zidovudine-containing combination therapy was also associated with increased risk of low birth weight (23% vs. 12%; p<0.001) and "any adverse birth outcome" (defined as low birth weight, preterm delivery, spontaneous abortion, stillbirth, or congenital anomaly; 40% vs. 27.5%; p<0.001). ART with tenofovir, emtricitabine, and lopinavir/ritonavir was associated with increased risk of low birth weight (16.9% vs. 8.9%; p=0.004) and any neonatal adverse event (34.7% vs. 27.2%; p=0.04) versus zidovudine monotherapy; effects on risk of preterm delivery were not statistically significant (18.5% vs. 13.5%; p=0.09). Tenofovir-containing ART was associated with increased risk of early infant death versus zidovudine-containing ART (4.4% vs. 0.6%; p<0.001) and increased risk of very preterm (<34 weeks) delivery (6.0% vs. 2.6%; p=0.04), but there was no difference between tenofovir-containing ART versus zidovudine monotherapy in risk of early infant death (4.4% vs. 3.2%; p=0.43). There were also no differences in the rates of stillbirth between treatments. Methodological limitations of the trial included open-label design and changes in randomization from two ART groups (period 1) to three groups (period 2), resulting in a smaller sample for tenofovir-containing ART. Comparisons between zidovudine-containing

ART and zidovudine monotherapy included outcomes from both period 1 and period 2 (N=3,084), whereas comparisons between tenofovir-containing ART (N=406) and zidovudine-containing ART (N=410) or zidovudine monotherapy (N=413) included only outcomes from period 2. In addition, there were unexplained differences in rates of events with zidovudine-containing ART between period 1 and period 2 for neonatal death (1.2% vs. 0.6%) and stillbirth (3.3% vs. 0.9%).

Consistent with the prior USPSTF review, one new RCT[44] and three new cohort studies[54,72,75,78] found ART containing a boosted protease inhibitor associated with an approximate 30 percent increased risk of preterm birth versus treatment not containing a boosted protease inhibitor (N=7,584). However, two new cohort studies (N=1,140) found treatment with a protease inhibitor associated with a 50 percent decreased risk of preterm delivery[54] or no difference in risk[52] when compared with no ART.

Like the prior review,[1] new evidence identified for this update also found mixed evidence on other adverse birth outcomes. Four new cohort studies evaluated effects of ART on risk of low birth weight.[56,62,66,69] Two studies found combination ART associated with an approximate 80 percent decreased risk of low birth weight versus no ART (two studies; N=3,192),[56,62] one study found no association between ART versus no ART and low birth weight (one study; N=2,599),[66] and two studies found no difference between tenofovir-containing versus nontenofovir-containing ART in risk of low birth weight (two studies; N=3,650).[67,69]

Ten new cohort studies (in 11 publications) evaluated the association between ART and risk of small for gestational age.[46,50,52,57,62,66,69,73,75,78,79] Four new cohort studies found about a 40 percent decreased risk of small for gestational age with some regimens (three studies, N=8,404),[46,78,79] and one study (n=1,814) reported a decrease risk of small for gestational age with the ART regimen tenofovir, emtricitabine, and efavirenz compared with no ART (adjusted OR, 0.25 [95% CI, 0.07 to 0.87]).[62] Other studies found no effect between different ART regimens on risk of small for gestational age,[46,52,69,73,75] or no effect of ART versus no ART on risk of small for gestational age.[52,66] One new cohort study (n=5,726) found treatment with the ART regimen zidovudine, lamivudine, and either nevirapine- or ritonavir- boosted lopinavir associated with increased risk of small for gestational age versus zidovudine monotherapy (adjusted OR, 1.5 [95% CI, 1.2 to 1.9]),[50] while two other studies reported no difference between ART and zidovudine monotherapy.[57,66]

Five studies evaluated the association between ART and risk of stillbirth.[56,62,65,78,79] One cohort study (n=5,726) found treatment with ART associated with increased risk of stillbirth versus zidovudine monotherapy (adjusted OR, 2.5 [95% CI, 1.6 to 3.9]),[50] while two studies reported a significantly decreased risk of stillbirth compared with no ART.[56,62] Stillbirth was less likely with the regimen tenofovir, emtricitabine, and efavirenz compared with zidovudine, lamivudine, and nevirapine (n=3,837; adjusted relative risk [RR], 0.43 [95% CI, 0.31 to 0.61]),[78] but the difference was not statistically significant when tenofovir, emtricitabine, and efavirenz was compared with other ART regimens grouped together (n=3,226; adjusted OR, 0.6 [95% CI, 0.3 to 1.3]).[79] Two new cohort studies (n=4,381) reported no increase in risk of neonatal death with tenofovir-based ART[65,78] but one study (n=2,639) found increased risk of neonatal death with the ART regimen zidovudine, lamivudine, and ritonavir-boosted lopinavir compared with tenofovir,

emtricitabine, and efavirenz (adjusted RR, 4.01 [95% CI, 1.78 to 9.11]).[78] A combined analysis of two studies (n=1,621) found no difference in risk of fetal loss (undefined in this study but normally would include spontaneous abortion, fetal demise, and stillbirth) between initial therapy with tenofovir and emtricitabine combined with either ritonavir-boosted lopinavir or atazanavir versus zidovudine and lamivudine combined with ritonavir-boosted lopinavir.[67] This study also found no difference in risk of neonatal death within 14 days after birth between the three treatment regimens.

Overall Congenital Abnormalities

The 2012 USPSTF review found no association between perinatal exposure to ART and overall congenital abnormalities, based on three cohort studies.[90,91,98] Five new cohort studies (N=40,436),[53,55,71,76] including the Antiretroviral Pregnancy Registry,[47] evaluated the association between combination ART in HIV-infected pregnant women and risk of congenital anomalies (**Table 3**). All of the newer cohort studies included patients who received one or more of the preferred nucleoside reverse transcriptase inhibitors for use in pregnancy (abacavir, lamivudine, tenofovir, or emtricitabine). Most antiretroviral agents and classes were not associated with an increased risk of congenital abnormalities, but findings were limited by small numbers of studies, imprecision in estimates, and multiple comparisons. One study found no antiretroviral agent associated with increased risk of birth defects.[53] One study found an association between atazanavir, ritonavir, or any protease inhibitor and increased risk of congenital abnormalities versus nonexposure;[76] one study found an association between lamivudine, first-trimester exposure to abacavir, and first-trimester exposure to zidovudine and risk of congenital abnormalities;[71] one study found an association between first-trimester exposure to efavirenz and risk of congenital abnormalities;[55] and one study found emtricitabine associated with decreased risk of congenital anomalites.[71] The Antiretroviral Pregnancy Registry found zidovudine associated with increased risk of overall birth defects, but ritonavir associated with decreased risk.[47]

One of the cohort studies (n=2,580) also reported specific categories of birth defects in children exposed in utero to ART.[76] Atazanavir was associated with increased risk of congenital musculoskeletal and skin anomalies (adjusted OR, 2.57 [95% CI, 1.30 to 5.08] and 6.01 [95% CI, 1.43 to 25.3], respectively). Ritonavir as booster therapy was associated with musculoskeletal birth defects (adjusted OR, 1.79 [95% CI, 1.02 to 3.14]) and zidovudine was associated with increased risk of male genital defects (primarily hypospadias and cryptorchidism; adjusted OR, 3.18 [95% CI, 1.10 to 9.22]). An additional cohort study found exposure to ART during the first trimester associated with malformation of the small intestine (adjusted OR, 10 [95% CI, 2.85 to 37]),[48] but there was no increase in risk of birth defects with prenatal ART exposure on the urogenital, musculoskeletal, nervous, and circulatory systems.

Cardiovascular Congenital Anomalies

The 2012 USPSTF review included one cohort study[95] that found no association between in utero exposure to zidovudine and acute or chronic abnormalities in left ventricular structure or function, although another study[96] found an association between in utero ART and echocardiographic findings of unknown clinical significance in children age 2 years or younger.

We identified one subsequent RCT and two cohort studies (in three publications) that also reported somewhat mixed results on the association between ART exposure and cardiac findings[58,70,76] (**Appendix B Tables 2 and 3**). A U.S.-based cohort study (the Surveillance Monitoring for ART Toxicities [SMARTT] study) of 2,580 HIV-uninfected children born between 1995 and 2008 with in utero ART exposure found no currently recommended ART drug associated with increased risk of cardiovascular defects, although there was a trend toward increased risk with ritonavir (adjusted OR, 1.83 [95% CI, 0.96 to 3.49]).[76] A large French cohort study of 12,888 children born between 1994 and 2010 found first-trimester exposure to zidovudine associated with congenital heart defects compared with no zidovudine exposure (1.5% vs. 0.77%; adjusted OR, 2.2 [95% CI, 1.5 to 3.2]).[70,71] The most common condition was ventricular septal defect. A second analysis of 400 HIV-uninfected children exposed to ART in utero[58] found that at age 2 to 7 years (median, 4 years), exposure to some antiretroviral drugs, particularly during the first trimester, was associated with reduced stress velocity index, reduced left ventricular short-axis dimension, and increased left ventricular posterior wall thickness. None of the echocardiographic findings were associated with significant cardiovascular compromise.

Another study evaluated the association between in utero exposure to ART and echocardiographic measures. A nested RCT within a cohort (Protease Inhibitor Monotherapy Evaluation [PRIMEVA] French National Agency for Research on AIDS and Viral Hepatitis [ANRS] 135 study) of combination ART (zidovudine, lamivudine, and ritonavir-boosted lopinavir) versus protease inhibitor monotherapy (ritonavir-boosted lopinavir alone) performed echocardiographic assessments at 1 month (n=53) and 1 year (n=42). There was no difference in echocardiographic parameters in boys, but in girls combination therapy was associated with higher left ventricular shortening fraction at 1 month (a measure of decreased left ventricular systolic function; p=0.02) and a trend toward increased posterior wall thickness at 1 year (p=0.07).[70]

A third study (n=367) found no effect of ART versus no ART exposure during the first trimester on cardiovascular congenital anomalies (adjusted OR, 0.75 [95% CI, 0.31 to 1.85]).[48]

Neurodevelopmental Outcomes in Children

The 2012 USPSTF review included three cohort studies that found no association between in utero exposure to ART and long-term adverse effects on child growth and development.[89,93,103] We identified two publications of a U.S.-based surveillance cohort (the SMARTT study) of HIV-exposed, uninfected infants and children (**Appendix B Table 2**).[64,77] One study measured the Wechsler Preschool and Primary Scale of Intelligence-III at age 5 years (n=369) and the Wechsler Abbreviated Scale of Intelligence and the Wechsler Individual Achievement Test at ages 7, 9, 11, and 13 years (n=451).[64] There was no association between in utero exposure to ART and lower scores on these tests, although test scores were lower overall than in population norms. In younger children, in utero exposure to tenofovir was associated with higher performance intelligence quotient, based on the Wechsler Preschool and Primary Scale of Intelligence-III, compared with children not exposed to tenofovir (p<0.05). Another publication from the SMARTT study found in utero exposure to combination ART associated with less neurodevelopmental impairment than no in utero exposure to ART (adjusted RR, 0.47 [95% CI,

0.27 to 0.83]) (**Appendix B Tables 2 and 3**).[77]

Maternal Harms

The 2012 USPSTF review included one study that found receipt of ART during pregnancy associated with increased risk of gestational diabetes (adjusted OR, 3.5 [95% CI, 1.2 to 10]) and anemia (adjusted OR, 1.6 [95% CI, 1.1 to 2.4]) compared with no ART.[101] Two additional studies reported a trend toward increased risk of gestational diabetes with ART compared with monotherapy or no ART (RR, 9.37 [95% CI, 0.57 to 153][102] and RR, 1.86 [95% CI, 0.65 to 5.29][97]). We identified no new studies on the association between use of ART during pregnancy versus no ART and risk of diabetes or gestational diabetes. One RCT conducted in three African countries (n=8,848) of women with CD4 counts of 200 to 500 cells/mm^3 found no difference in risk of anemia between combination ART (zidovudine, lamivudine, and ritonavir-boosted lopinavir) beginning between 28 and 36 weeks of gestation and zidovudine monotherapy starting from 34 to 36 weeks of gestation until onset of labor followed by zidovudine and a single dose of nevirapine at the onset of labor (**Appendix B Tables 2 and 3**).[45] Women were given iron and folic acid supplementation upon study enrollment.

In the previously discussed PROMISE trial (n=3,490; see Key Question 4 for study details), antenatal zidovudine-based combination ART was associated with a higher rate of maternal grade 2 or higher adverse events than zidovudine alone (21% vs. 17%; p=0.008; specific adverse events not reported) and increased risk of abnormalities in blood chemistry values (5.8% vs. 1.3%; p<0.001), primarily elevation in alanine aminotransferase levels.[44] There was also an increased risk of abnormal blood chemistry values (not specified) with tenofovir-based ART than with zidovudine monotherapy (2.9% vs. 0.8%; p=0.03). Few women withdrew from the study due to adverse events.

Chapter 4. Discussion

Summary of Review Findings

This report updates a 2012 USPSTF review on prenatal screening for HIV infection.[1,2] Evidence reviewed for this update is summarized in **Table 4**. As in the 2012 USPSTF review, we found no direct evidence on effects of prenatal screening versus no screening on risk of mother-to-child HIV transmission or maternal or infant clinical outcomes. We also identified no studies on the yield of repeat prenatal screening versus one-time screening or different frequencies of screening for HIV in pregnancy. Although three studies conducted in the United States or the United Kingdom identified no cases of HIV infection among women who were rescreened for HIV during the third trimester of pregnancy,[115-117] results were difficult to interpret because the HIV risk of women who underwent rescreening was unclear, and not all women underwent rescreening. As discussed in the prior USPSTF report, the yield of repeat prenatal screening depends on HIV infection incidence during pregnancy. In addition, detecting HIV acquired during pregnancy may be important because some data suggest markedly higher risk of mother-to-child transmission compared with HIV acquired prior to pregnancy.[120]

New evidence identified for this update[51,60,61,74] confirm findings from the 2012 USPSTF review that full-course combination ART is highly effective at reducing the risk of mother-to-child transmission, with some cohort studies reporting rates of mother-to-child transmission of less than 1 percent when started early in pregnancy.[61,74] Cohort studies and RCTs also found that combination therapy started in the second or third trimester are effective at reducing the risk of mother-to-child transmission. Shorter courses of ART were not as effective as full-course regimens, but also reduce risk of mother-to-child transmission compared with no ART, supporting benefits of screening and initiation of therapy later in pregnancy.[44,80-82]

New evidence on harms of ART was also largely consistent with the 2012 USPSTF review. Although some ART agents and regimens may be associated with increased risk of infant or maternal harms, such harms may be mitigated or reduced through appropriate selection of ART regimens. As in the prior USPSTF review, evidence from primarily observational studies found prenatal combination ART with a boosted protease inhibitor associated with increased risk of preterm delivery.[44,54,72,78] An African RCT found tenofovir-containing, lopinavir/ritonavir-based combination ART associated with greater risk of early infant death than zidovudine-containing, lopinavir/ritonavir-based combination ART.[44] However, there were methodological limitations with this trial, including two periods with different randomization protocols, and different rates of some adverse birth outcomes depending on period of randomization. The RCT found no difference in early infant death between tenofovir-based combination ART and treatment with zidovudine alone and no difference between treatments in risk of stillbirth. Tenofovir is a preferred nucleoside reverse transcriptase inhibitor for use in pregnancy in most, but not all, guidelines due to its demonstrated efficacy, acceptable toxicity, ease of use, and no established teratogenicity; however, the use of lopinavir, rather than a preferred protease inhibitor, makes the ART combination evaluated in this trial an alternative regimen (lopinavir is associated with more nausea than preferred protease inhibitors).[47] The increased risk of early infant death in the trial could be related to a higher risk of very preterm delivery associated with this tenofovir-

containing ART regimen, which is associated with increased risk of infant mortality in low-income settings. Other African studies found no association between tenofovir-based ART and risk of stillbirth[62,78,79] or neonatal death.[65,78] A recent review of TDF in pregnancy and breastfeeding did not identify safety issues versus non-TDF regimens, but included HIV-negative women and unpublished studies.[43]

For other birth outcomes (low birth weight, small for gestational age, stillbirth, and overall birth defects), results were mixed and depended on the specific antiretroviral drug or drug regimen given and timing of prenatal therapy. As in the prior USPSTF review, some evidence indicated that ART may be associated with cardiac findings such as ventricular septal defects[70,71] and echocardiographic changes,[58,70] although the clinical significance of findings is unclear. Evidence on congenital abnormalities was limited by small numbers of studies and imprecise estimates, although some studies found exposure to different drugs in the first trimester associated with increased risk of congenital abnormalities. Studies in older children exposed to ART in utero suggested no association with worse neurodevelopmental outcomes compare with unexposed children.[64,77]

Evidence on long-term maternal harms associated with short-term exposure to ART during pregnancy or ART started during pregnancy and continued after pregnancy remains sparse, although one new study found evidence of increased short-term nonspecific adverse events.[44] Women found to be HIV-infected through prenatal screening would also benefit from standard HIV treatments following pregnancy, including long-term combination ART, prophylaxis for opportunistic infections, immunizations, and indicated screenings.[47,121]

Limitations

We excluded non-English–language articles, which could result in language bias, although we identified no non-English–language studies that would have met inclusion criteria. We did not attempt to pool studies because of differences in study designs, populations, study setting, antiretroviral regimens evaluated, and outcomes assessed. Because we could not pool studies, we also could not formally assess for publication bias with graphical or statistical methods. We included observational studies, which are more susceptible to bias and confounding than well-conducted RCTs, although we restricted inclusion to observational studies that performed statistical adjustment for potential confounding. Another limitation is that RCTs of combination ART have only been conducted in Africa. The applicability of studies conducted in resource-poor and high-prevalence settings to U.S. practice is limited by differences in the antiretroviral drugs evaluated, evaluation of shorter regimens, inclusion of women who breastfeed, and other factors. Although we focused on new studies published since 2012, in most studies results were reported for individual ART agents and classes, rather than for currently recommended ART regimens, which could reduce applicability of findings to current U.S. practice. Restricting analyses to studies in which patients received treatment after 2006 (the earliest year a current preferred regimen was approved), or in whom results for currently recommended regimens could clearly be identified, did not appear to change conclusions, although formal stratified analyses were not possible.

Emerging Issues/Next Steps

ART regimens for use during pregnancy and indications for initiating long-term ART continue to evolve. Regularly updated guidelines on selection of ART in pregnant women are available.[47]

Relevance for Priority Populations, Particularly Racial/Ethnic Minorities

HIV disproportionately affects women from racial/ethnic minority populations, who often have less access to prenatal care, leading to reduced opportunities for early screening and initiation of ART during pregnancy. Identification of HIV infection during pregnancy provides an opportunity to link affected women to long-term care and treatment. Therefore, improving access to prenatal care is an important challenge for reducing the effect of HIV infection in these populations.

Future Research

Although there are no studies comparing the effects of screening for HIV in pregnancy versus no screening, such studies may no longer be indicated given epidemiological evidence showing marked decreases in the number of children with perinatally acquired HIV infection in the United States and strong evidence on the effectiveness of ART on preventing mother-to-child transmission. Studies comparing one-time screening versus repeat screening or that perform rescreening in well-defined cohorts of women would be helpful for understanding the yield of rescreening and for understanding when rescreening is indicated. Future research is needed to further clarify the effectiveness and harms of currently recommended antiretroviral regimens, effects of in utero exposure to ART on pregnancy outcomes, and long-term harms in exposed children to optimize selection of ART regimens during pregnancy and to understand the effects of screening and treatment with ART in pregnant adolescents.

Conclusions

Combination ART is highly effective at reducing risk of mother-to-child HIV transmission. The USPSTF previously determined that avoidance of breastfeeding and Caesarean delivery in women with HIV RNA levels greater than 1,000 copies/mL near the time of delivery is also effective at reducing mother-to-child transmission, and that prenatal screening is accurate at diagnosing HIV infection. Use of certain ART regimens during pregnancy is associated with increased risk of preterm delivery and other adverse pregnancy outcomes. Although more evidence is required to better understand short- and long-term maternal and infant harms, selection of ART regimens may help mitigate or reduce harms.

References

1. Chou R, Cantor A, Zakher B, et al. Screening for HIV in pregnant women: systematic review to update the 2005 U.S. Preventive Services Task Force recommendation. Ann Intern Med. 2012;457:719-28. doi: 10.7326/0003-4819-157-10-201211200-00009. PMID: 23165663.
2. Chou R, Cantor A, Bougatsos C, et al. Screening for HIV in pregnant women: systematic review to update the U.S. Preventive Services Task Force Recommendation. Evidence synthesis No. 96. Agency for Healthcare Research and Quality. AHRQ Publication No. 12-05173-EF-2. Rockville, MD: 2012. PMID: 23256219.
3. Moyer VA, on behalf of the U.S. Preventive Services Task Force. Screening for HIV: U.S. Preventive Services Task Force Recommendation Statement. Ann Intern Med. 2013 Jul 2;159(1):51-60. doi: 10.7326/0003-4819-159-1-201307020-00645. PMID: 23698354.
4. U.S. Preventive Services Task Force. Recommendation: Human Immunodeficiency Virus (HIV) Infection: Screening. 2013. www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/human-immunodeficiency-virus-hiv-infection-screening?ds=1&s=pregnant. Accessed December 12, 2017.
5. Centers for Disease Control and Prevention. 1993 Revised classification system for HIV infection and expanded surveillance case definition for AIDS among adolescents and adults. MMWR Recomm Rep. 1992 December 18;41(RR-17):1-19. PMID: 1361652.
6. Centers for Disease Control and Prevention. HIV-2 infection surveillance- United States: 1987-2009. 2011. www.cdc.gov/mmwr/preview/mmwrhtml/mm6029a3.htm. Accessed December 8, 2017.
7. Centers for Disease Control and Prevention. HIV/AIDS HIV among pregnant women, infants, and children. 2016. http://www.cdc.gov/hiv/group/gender/pregnantwomen/index.html. Accessed October 28, 2016.
8. Centers for Disease Control and Prevention. HIV Surveillance Report: Diagnoses of HIV Infection in the United States and Dependent Areas, 2016. www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-report-2016-vol-28.pdf Accessed December 12, 2017.
9. Centers for Disease Control and Prevention. HIV Surveillance Report, 2017; vol. 29. http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html Published November 2018. Accessed 4/8/19. 2017.
10. Centers for Disease Control and Prevention. HIV Among Women. https://www.cdc.gov/hiv/group/gender/women/index.html Accessed 4/8/19.
11. Centers for Disease Control and Prevention. HIV Surveillance Supplemental Report: Commentary; Vol 16. No. 2. 2010. http://www.cdc.gov/hiv/surveillance/resources/reports/2010supp_vol16no2/pdf/commentary.pdf. Accessed October 31, 2016.
12. Fowler MG, Gable AR, Lampe MA, et al. Perinatal HIV and its prevention: progress toward an HIV-free generation. Clin Perinatol. 2010;37(4):699-719. PMID: 21078445.
13. Centers for Disease Control and Prevention. HIV Among Pregnant Women, Infants, and Children. 2017. www.cdc.gov/hiv/pdf/group/gender/pregnantwomen/cdc-hiv-pregnant-

women.pdf Accessed December 23, 2017.
14. Little KM, Taylor AW, Borkowf CB, et al. Perinatal antiretroviral exposure and prevented mother-to-child HIV infections in the era of antiretroviral prophylaxis in the United States, 1994-2010. Pediatr Infect Dis J. 2017 Jan;36(1):66-71. doi: 10.1097/INF.0000000000001355. PMID: 27749662.
15. Nesheim SR, Wiener J, Fitz Harris LF, et al. Brief report: estimated incidence of perinatally acquired HIV infection in the United States, 1978-2013. J Acquir Immune Defic Syndr. 2017 Dec 15;76(5):461-4. doi: 10.1097/QAI.0000000000001552. PMID: 28991886.
16. American Congress of Obstetricians and Gynecologists. Committee opinion: scheduled cesarean delivery and the prevention of vertical transmission of HIV infection. No. 234, May 2000; reaffirmed 2010. 2010. www.acog.org/~/media/Committee%20Opinions/Committee%20on%20Obstetric%20Practice/co234.ashx?dmc=1&ts=20120105T1247277577. Accessed October 31, 2016.
17. Read JS, AIDS CoP. Human milk, breastfeeding, and transmission of human immunodeficiency virus type 1 in the United States. Pediatrics. 2003 November 1, 2003;112(5):1196-205. PMID: 14595069.
18. Dunn DT, Newell ML, Ades AE, et al. Risk of human immunodeficiency virus type 1 transmission through breastfeeding. Lancet. 1992;340(8819):585-8. doi: 10.1016/0140-6736(92)92115-v. PMID: 1355163.
19. Nduati R. Breastfeeding and HIV-1 infection: short and long term effects of breast feeding on child health. In: Koletzko B, Michaelsen KF, Hernell O, eds. Short and Long Term Effects of Breast Feeding on Child Health. Vol. 478. Springer US; 2002:201-10.
20. Department of Health and Human Services. Reducing Obstetrician Barriers to offering HIV Testing. 2002. http://www.cdc.gov/hiv/topics/perinatal/resources/meetings/2002/pdf/ps_oig.pdf. Accessed October 31, 2016.
21. Breastfeeding and HIV International Transmission Study Group, Coutsoudis A, Dabis F, et al. Late postnatal transmission of HIV-1 in breast-fed children: an individual patient data meta-analysis. J Infect Dis. 2004 June 15, 2004;189(12):2154-66. doi: 10.1086/420834. PMID: 15181561.
22. Mofenson LM. Antiretroviral drugs to prevent breastfeeding HIV transmission. [Review]. Antivir Ther. 2010;15(4):537-53. PMID: 20587847.
23. Panel on Treatment of Pregnant Women with HIV Infection and Prevention of Perinatal Transmission. Recommendations for Use of Antiretroviral Drugs in Pregnant Women with HIV Infection and Interventions to Reduce Perinatal HIV Transmission in the United States. Version December 7, 2018. https://aidsinfo.nih.gov/guidelines/html/3/perinatal/224/whats-new-in-the-guidelines.
24. Centers for Disease Control and Prevention. HIV/AIDS HIV Among Women. 2016. http://www.cdc.gov/hiv/group/gender/women/. Accessed October 28, 2016.
25. Kourtis AP, Bulterys M. Mother-to-child transmission of HIV: pathogenesis, mechanisms and pathways. Clin Perinatol. 2010;37:721-37. PMID: 21078446.
26. French R, Brocklehurst P. The effect of pregnancy on survival in women infected with HIV: a systematic review of the literature and meta-analysis. Br J Obstet Gynaecol. 1998 Aug;105(8):827-35. PMID: 9746374.
27. Minkoff H, Hershow R, Watts DH, et al. The relationship of pregnancy to human

immunodeficiency virus disease progression. Am J Obstet Gynecol. 2003;189(2):552-9. doi: 10.1067/s0002-9378(03)00467-8. PMID: 14520233.
28. American Congress of Obstetricians and Gynecologists. ACOG committee opinion: prenatal and perinatal human immunodeficiency virus testing: expanded recommendations. June 2015, No. 635. Obstet Gynecol. 2011;125(6):1544-7. doi: 10.1097/01.AOG.0000466370.86393.d2. PMID: 26000543.
29. Centers for Disease Control and Prevention. Preexposure prophylaxis for the prevention of HIV infection in the United States - 2014. 2014. http://www.cdc.gov/hiv/pdf/guidelines/PrEPguidelines2014.pdf Accessed October 28, 2016.
30. Celum CL, Coombs RW, Jones M, et al. Risk factors for repeatedly reactive HIV-1 EIA and indeterminate western blots. A population-based case-control study. Arch Intern Med. 1994 May 23;154(10):1129-37. PMID: 7910452.
31. Bulterys M, Jamieson DJ, O'Sullivan MJ, et al. Rapid HIV-1 testing during labor: a multicenter study. JAMA. 2004 Jul 14;292(2):219-23. PMID: 15249571.
32. Branson BM, Handsfield HH, Lampe MA, et al. Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings. MMWR Recomm Rep. 2006 Sep 22;55(RR-14):1-17. PMID: 16988643.
33. American Congress of Obstetricians and Gynecologists. ACOG Committee Opinion No. 752: Prenatal and Perinatal Human Immunodeficiency Virus Testing. Obstet Gynecol. 2018;132(3):e138-e42.
34. American Academy of Pediatrics Committee on Pediatric AIDS. HIV testing and prophylaxis to prevent mother-to-child transmission in the United States. Pediatrics. 2008 Nov;122(5):1127-34. PMID: 18977995.
35. American Academy of Pediatrics. Policy statement: AAP publications reaffirmed and retired: policy statement: HIV testing and prophylaxis to prevent mother-to-child transmission in the United States. Reaffirmed June 2011. Pediatrics; 2011. pediatrics.aappublications.org/content/128/3/e748.full. Accessed December 27, 2017.
36. Qaseem A, Snow V, Shekelle P, et al. Screening for HIV in health care settings: a guidance statement from the American College of Physicians and HIV Medicine Association. Ann Intern Med. 2009;150:125-31. PMID: 19047022.
37. Centers for Disease Control and Prevention. HIV Testing in Clinical Settings. www.cdc.gov/hiv/testing/clinical/index.html. Accessed December 23, 2017.
38. American Academy of Family Physicians. Summary of recommendations for clinical preventive services. 2016. www.aafp.org/dam/AAFP/documents/patient_care/clinical_recommendations/cps-recommendations.pdf Accessed October 28, 2016.
39. U.S. Preventive Services Task Force. Procedure Manual. 2016. www.uspreventiveservicestaskforce.org/Page/Name/methods-and-processes. Accessed October 31, 2016.
40. Chou R, Smits AK, Huffman LH, et al. Prenatal screening for HIV: a review of the evidence for the U.S. Preventive Services Task Force. Ann Intern Med. 2005 Jul 5;143(1):38-54. PMID: 15998754.
41. Chou R, Smits AK, Huffman LH, et al. Screening for human immunodeficiency virus in pregnant women: Evidence synthesis No. 39. Rockville, MD: Agency for Healthcare Research and Quality. 2005. www.ahrq.gov/downloads/pub/prevent/pdfser/hivpresyn.pdf

Accessed October 31, 2016. PMID: 20722135.
42. Chou R. Screening for HIV Infection in Asymptomatic, Nonpregnant Adolescents and Adults: A Systematic Review for the U.S. Preventive Services Task Force. Evidence Synthesis No. 176. AHRQ Publication No. 18-05246-EF-1. Rockville, MD: Agency for Healthcare Research and Quality; 2019.
43. Mofenson ML, Baggaley CR, Mameletzis CI. Tenofovir disoproxil fumarate safety for women and their infants during pregnancy and breastfeeding. AIDS. 2017 Jan 14;31(2):213-32. doi: 10.1097/QAD.0000000000001313. PMID: 27831952.
44. Fowler MG, Qin M, Fiscus SA, et al. Benefits and risks of antiretroviral therapy for perinatal HIV prevention. N Engl J Med. 2016 Nov 03;375(18):1726-37. doi: 10.1056/NEJMoa1511691. PMID: 27806243.
45. Sartorius BK, Chersich MF, Mwaura M, et al. Maternal anaemia and duration of zidovudine in antiretroviral regimens for preventing mother-to-child transmission: a randomized trial in three African countries. BMC Infect Dis. 2013;13:522. doi: 10.1186/1471-2334-13-522. PMID: 24192332.
46. Aaron E, Bonacquisti A, Mathew L, et al. Small-for-gestational-age births in pregnant women with HIV, due to severity of HIV disease, not antiretroviral therapy. Infect Dis Obstet Gynecol. 2012;2012:135030. doi: 10.1155/2012/135030. PMID: 22778533.
47. Antiretroviral Pregnancy Registry Steering Committee. Antiretroviral Pregnancy Registry Interim Report for 1 January 1989 through 31 January 2018. Wilmington, NC: Registry Coordinating Center; 2018. http://www.apregistry.com/forms/interim_report.pdf Accessed July 27, 2018.
48. Berard A, Sheehy O, Zhao JP, et al. Antiretroviral combination use during pregnancy and the risk of major congenital malformations. AIDS. 2017 Oct 23;31(16):2267-77. doi: 10.1097/QAD.0000000000001610. PMID: 28806195.
49. Chagomerana MB, Miller WC, Pence BW, et al. PMTCT option B+ does not increase preterm birth risk and may prevent extreme prematurity: A retrospective cohort study in Malawi. J Acquir Immune Defic Syndr. 2017 Apr 01;74(4):367-74. doi: 10.1097/QAI.0000000000001253. PMID: 27875363.
50. Chen JY, Ribaudo HJ, Souda S, et al. Highly active antiretroviral therapy and adverse birth outcomes among HIV-infected women in Botswana. J Infect Dis. 2012 Dec 1;206(11):1695-705. doi: 10.1093/infdis/jis553. PMID: 23066160.
51. Chiappini E, Galli L, Giaquinto C, et al. Use of combination neonatal prophylaxis for the prevention of mother-to-child transmission of HIV infection in European high-risk infants. AIDS. 2013 Mar 27;27(6):991-1000. doi: 10.1097/QAD.0b013e32835cffb1. PMID: 23211776.
52. Duryea E, Nicholson F, Cooper S, et al. The use of protease inhibitors in pregnancy: maternal and fetal considerations. Infect Dis Obstet Gynecol. 2015doi: 10.1155/2015/563727. PMID: 26617456.
53. Floridia M, Mastroiacovo P, Tamburrini E, et al. Birth defects in a national cohort of pregnant women with HIV infection in Italy, 2001-2011. BJOG. 2013 Nov;120(12):1466-75. doi: 10.1111/1471-0528.12285. PMID: 23721372.
54. Kakkar F, Boucoiran I, Lamarre V, et al. Risk factors for pre-term birth in a Canadian cohort of HIV-positive women: role of ritonavir boosting? J Int AIDS Soc. 2015;18:19933. doi: 10.7448/IAS.18.1.19933. PMID: 26051165.
55. Knapp KM, Brogly SB, Muenz DG, et al. Prevalence of congenital anomalies in infants

with in utero exposure to antiretrovirals. Pediatr Infect Dis J. 2012 Feb;31(2):164-70. doi: 10.1097/INF.0b013e318235c7aa. PMID: 21983213.
56. Kreitchmann R, Li SX, Melo VH, et al. Predictors of adverse pregnancy outcomes in women infected with HIV in Latin America and the Caribbean: a cohort study. BJOG. 2014 Nov;121(12):1501-8. doi: 10.1111/1471-0528.12680. PMID: 24602102.
57. Li N, Sando MM, Spiegelman D, et al. Antiretroviral therapy in relation to birth outcomes among HIV-infected women: a cohort study. J Infect Dis. 2016 Apr 1;213(7):1057-64. doi: 10.1093/infdis/jiv389. PMID: 26265780.
58. Lipshultz SE, Williams PL, Zeldow B, et al. Cardiac effects of in-utero exposure to antiretroviral therapy in HIV-uninfected children born to HIV-infected mothers. AIDS. 2015 Jan 2;29(1):91-100. doi: 10.1097/QAD.0000000000000499. PMID: 25562493.
59. Lopez M, Figueras F, Hernandez S, et al. Association of HIV infection with spontaneous and iatrogenic preterm delivery: effect of HAART. AIDS. 2012 Jan 02;26(1):37-43. doi: 10.1097/QAD.0b013e32834db300. PMID: 22008651.
60. Lu D, Liu J, Samson L, et al. Factors responsible for mother-to-child HIV transmission in Ontario, Canada, 1996-2008. Can J Public Health. 2014 Jan-Feb;105(1):e47-52. PMID: 24735697.
61. Mandelbrot L, Tubiana R, Le Chenadec J, et al. No perinatal HIV-1 transmission from women with effective antiretroviral therapy starting before conception. Clin Infect Dis. 2015 Dec 1;61(11):1715-25. doi: 10.1093/cid/civ578. PMID: 26197844.
62. Moodley T, Moodley D, Sebitloane M, et al. Improved pregnancy outcomes with increasing antiretroviral coverage in South Africa. BMC Pregnancy Childbirth. 2016 Feb 11;16:35. doi: 10.1186/s12884-016-0821-3. PMID: 26867536.
63. Mor Z, Sheffer R, Chemtob D. Mother-to-child HIV transmissions in Israel, 1985-2011. Epidemiol Infect. 2017 Jul;145(9):1913-21. doi: 10.1017/s0950268817000577. PMID: 28374653.
64. Nozyce ML, Huo Y, Williams PL, et al. Safety of in utero and neonatal antiretroviral exposure: cognitive and academic outcomes in HIV-exposed, uninfected children 5-13 years of age. Pediatr Infect Dis J. 2014 Nov;33(11):1128-33. doi: 10.1097/INF.0000000000000410. PMID: 25361407.
65. Pintye J, Baeten JM, Celum C, et al. Maternal tenofovir disoproxil fumarate use during pregnancy is not associated with adverse perinatal outcomes among HIV-infected East African women: A prospective study. J Infect Dis. 2017 Dec 19;216(12):1561-8. doi: 10.1093/infdis/jix542. PMID: 29040666.
66. Ramokolo V, Goga AE, Lombard C, et al. In utero ART exposure and birth and early growth outcomes among HIV-exposed uninfected infants attending immunization services: Results from National PMTCT Surveillance, South Africa. Open Forum Infect. 2017 Fall. Fall;4(4):ofx187. doi: 10.1093/ofid/ofx187. PMID: 29062860.
67. Rough K, Seage GR, 3rd, Williams PL, et al. Birth outcomes for pregnant women with HIV using tenofovir-emtricitabine. N Engl J Med. 2018 04 26;378(17):1593-603. doi: 10.1056/NEJMoa1701666. PMID: 29694825.
68. Short CE, Douglas M, Smith JH, et al. Preterm delivery risk in women initiating antiretroviral therapy to prevent HIV mother-to-child transmission. HIV Med. 2014 Apr;15(4):233-8. doi: 10.1111/hiv.12083. PMID: 24025074.
69. Siberry GK, Williams PL, Mendez H, et al. Safety of tenofovir use during pregnancy: early growth outcomes in HIV-exposed uninfected infants. AIDS. 2012 Jun

1;26(9):1151-9. doi: 10.1097/QAD.0b013e328352d135. PMID: 22382151.
70. Sibiude J, Le Chenadec J, Bonnet D, et al. In utero exposure to zidovudine and heart anomalies in the ANRS French perinatal cohort and the nested PRIMEVA randomized trial. Clin Infect Dis. 2015 Jul 15;61(2):270-80. doi: 10.1093/cid/civ260. PMID: 25838291.
71. Sibiude J, Mandelbrot L, Blanche S, et al. Association between prenatal exposure to antiretroviral therapy and birth defects: an analysis of the French perinatal cohort study (ANRS CO1/CO11). PLoS Med. 2014 Apr;11(4):e1001635. doi: 10.1371/journal.pmed.1001635. PMID: 24781315.
72. Sibiude J, Warszawski J, Tubiana R, et al. Premature delivery in HIV-infected women starting protease inhibitor therapy during pregnancy: role of the ritonavir boost? Clin Infect Dis. 2012 May;54(9):1348-60. doi: 10.1093/cid/cis198. PMID: 22460969.
73. Snijdewind IJM, Smit C, Godfried MH, et al. Preconception use of cART by HIV-positive pregnant women increases the risk of infants being born small for gestational age. PLoS ONE. 2018;13(1):e0191389. doi: 10.1371/journal.pone.0191389. PMID: 29351561.
74. Tookey PA, Thorne C, van Wyk J, et al. Maternal and foetal outcomes among 4118 women with HIV infection treated with lopinavir/ritonavir during pregnancy: analysis of population-based surveillance data from the national study of HIV in pregnancy and childhood in the United Kingdom and Ireland. BMC Infect Dis. 2016;16:65. doi: 10.1186/s12879-016-1400-y. PMID: 26847625.
75. Watts DH, Williams PL, Kacanek D, et al. Combination antiretroviral use and preterm birth. J Infect Dis. 2013 Feb 15;207(4):612-21. doi: 10.1093/infdis/jis728. PMID: 23204173.
76. Williams PL, Crain MJ, Yildirim C, et al. Congenital anomalies and in utero antiretroviral exposure in human immunodeficiency virus-exposed uninfected infants. JAMA Pediatr. 2015;169(1):48-55. doi: 10.1001/jamapediatrics.2014.1889. PMID: 25383770.
77. Williams PL, Hazra R, Van Dyke RB, et al. Antiretroviral exposure during pregnancy and adverse outcomes in HIV-exposed uninfected infants and children using a trigger-based design. AIDS. 2016 Jan 2;30(1):133-44. doi: 10.1097/QAD.0000000000000916. PMID: 26731758.
78. Zash R, Jacobson DL, Diseko M, et al. Comparative safety of antiretroviral treatment regimens in pregnancy. JAMA Pediatr. 2017 Oct 02;171(10):e172222. doi: 10.1001/jamapediatrics.2017.2222. PMID: 28783807.
79. Zash R, Souda S, Chen JY, et al. Reassuring birth outcomes with tenofovir/emtricitabine/efavirenz used for prevention of mother-to-child transmission of HIV in Botswana. J Acquir Immune Defic Syndr. 2016 Apr 1;71(4):428-36. doi: 10.1097/QAI.0000000000000847. PMID: 26379069.
80. Gray G, Violari A, McIntyre J, et al. Antiviral activity of nucleoside analogues during short-course monotherapy or dual therapy: its role in preventing HIV infection in infants. J Acquir Immune Defic Syndr. 2006 Jun;42(2):169-76. doi: 10.1097/01.qai.0000219772.74432.20. PMID: 16639342.
81. Shapiro RL, Thior I, Gilbert PB, et al. Maternal single-dose nevirapine versus placebo as part of an antiretroviral strategy to prevent mother-to-child HIV transmission in Botswana. AIDS. 2006 Jun 12;20(9):1281-8. doi: 10.1097/01.aids.0000232236.26630.35.

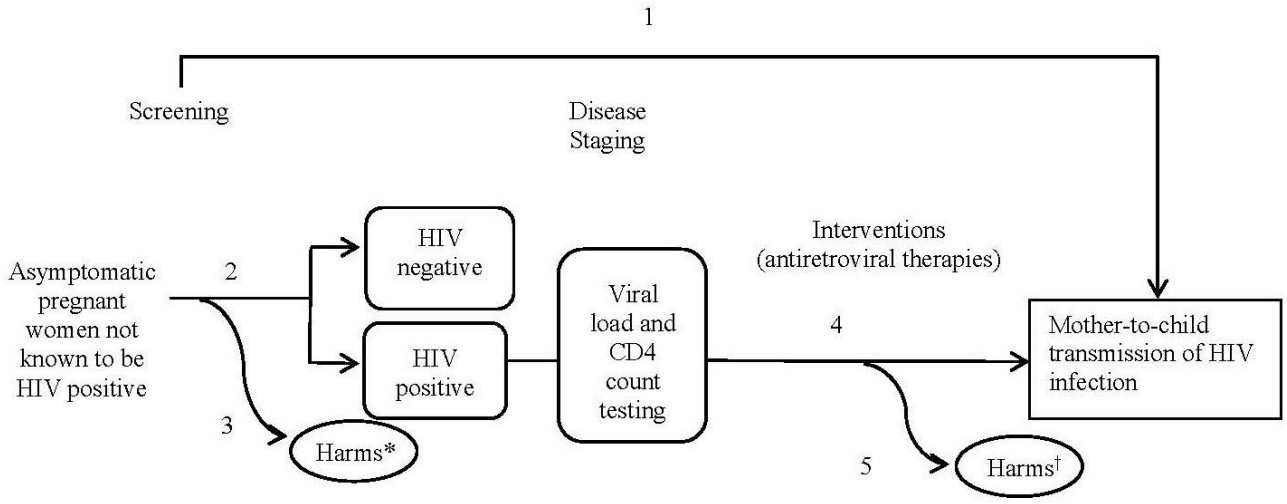
PMID: 16816557.
82. Chi BH, Chintu N, Cantrell RA, et al. Addition of single-dose tenofovir and emtricitabine to intrapartum nevirapine to reduce perinatal HIV transmission. J Acquir Immune Defic Syndr. 2008 Jun 1;48(2):220-3. doi: 10.1097/QAI.0b013e3181743969. PMID: 18520682.
83. Powis KM, Kitch D, Ogwu A, et al. Increased risk of preterm delivery among HIV-infected women randomized to protease versus nucleoside reverse transcriptase inhibitor-based HAART during pregnancy. J Infect Dis. 2011 Aug 15;204(4):506-14. doi: 10.1093/infdis/jir307. PMID: 21791651.
84. Chi BH, Sinkala M, Mbewe F, et al. Single-dose tenofovir and emtricitabine for reduction of viral resistance to non-nucleoside reverse transcriptase inhibitor drugs in women given intrapartum nevirapine for perinatal HIV prevention: an open-label randomised trial. Lancet. 2007;370(9600):1698-705. doi: 10.1016/s0140-6736(07)61605-5. PMID: 1799715.
85. Kesho Bora Study Group. Eighteen-month follow-up of HIV-1-infected mothers and their children enrolled in the Kesho Bora study observational cohorts. J Acquir Immune Defic Syndr. 2010 August 15, 2010;54(5):533-41. PMID: 20543706.
86. Kesho Bora Study Group, de Vincenzi I. Triple antiretroviral compared with zidovudine and single-dose nevirapine prophylaxis during pregnancy and breastfeeding for prevention of mother-to-child transmission of HIV-1 (Kesho Bora study): a randomised controlled trial. Lancet Infect Dis. 2011;11(3):171-80. doi: 10.1016/S1473-3099(10)70288-7. PMID: 21237718.
87. Shapiro RL, Hughes MD, Ogwu A, et al. Antiretroviral regimens in pregnancy and breast-feeding in Botswana. N Engl J Med. 2010;362(24):2282-94. doi: 10.1056/NEJMoa0907736. PMID: 20554983.
88. Thistle P, Spitzer RF, Glazier RH, et al. A randomized, double-blind, placebo-controlled trial of combined nevirapine and zidovudine compared with nevirapine alone in the prevention of perinatal transmission of HIV in Zimbabwe. Clin Infect Dis. 2007 Jan;44(1):111-9. PMID: 17143826.
89. Alimenti A, Forbes JC, Oberlander TF, et al. A prospective controlled study of neurodevelopment in HIV-uninfected children exposed to combination antiretroviral drugs in pregnancy. Pediatrics. 2006 Oct;118(4):e1139-45. doi: 10.1542/peds.2006-0525. PMID: 16940166.
90. Townsend CL, Willey BA, Cortina-Borja M, et al. Antiretroviral therapy and congenital abnormalities in infants born to HIV-infected women in the UK and Ireland, 1990-2007. AIDS. 2009 Feb 20;23(4):519-24. doi: 10.1097/QAD.0b013e328326ca8e. PMID: 19165088.
91. Watts DH, Huang S, Culnane M, et al. Birth defects among a cohort of infants born to HIV-infected women on antiretroviral medication. J Perinat Med. 2011 Mar;39(2):163-70. doi: 10.1515/jpm.2010.139. PMID: 21142844.
92. Cotter AM, Garcia AG, Duthely ML, et al. Is antiretroviral therapy during pregnancy associated with an increased risk of preterm delivery, low birth weight, or stillbirth? J Infect Dis. 2006 May 1;193(9):1195-201. doi: 10.1086/503045. PMID: 16586354.
93. European Collaborative Study. HIV-infected pregnant women and vertical transmission in Europe since 1986. AIDS. 2001 Apr 13;15(6):761-70. PMID: 11371691.
94. Grosch-Woerner I, Puch K, Maier RF, et al. Increased rate of prematurity associated with antenatal antiretroviral therapy in a German/Austrian cohort of HIV-1-infected women.

HIV Med. 2008 Jan;9(1):6-13. doi: 10.1111/j.1468-1293.2008.00520.x. PMID: 18199167.
95. Lipshultz SE, Easley KA, Orav EJ, et al. Absence of cardiac toxicity of zidovudine in infants. Pediatric pulmonary and cardiac complications of vertically transmitted HIV infection study group. N Engl J Med. 2000 Sep 14;343(11):759-66. doi: 10.1056/nejm200009143431102. PMID: 10984563.
96. Lipshultz SE, Shearer WT, Thompson B, et al. Cardiac effects of antiretroviral therapy in HIV-negative infants born to HIV-positive mothers: NHLBI CHAART-1 (National Heart, Lung, and Blood Institute Cardiovascular Status of HAART Therapy in HIV-Exposed Infants and Children cohort study). J Am Coll Cardiol. 2011 Jan 4;57(1):76-85. doi: 10.1016/j.jacc.2010.08.620. PMID: 21185505.
97. Marti C, Pena JM, Bates I, et al. Obstetric and perinatal complications in HIV-infected women. Analysis of a cohort of 167 pregnancies between 1997 and 2003. Acta Obstet Gynecol Scand. 2007;86(4):409-15. doi: 10.1080/00016340601148531. PMID: 17486461.
98. Patel D, Thorne C, Fiore S, et al. Does highly active antiretroviral therapy increase the risk of congenital abnormalities in HIV-infected women? J Acquir Immune Defic Syndr. 2005 Sep 1;40(1):116-8. PMID: 16123696.
99. Schulte J, Dominguez K, Sukalac T, et al. Declines in low birth weight and preterm birth among infants who were born to HIV-infected women during an era of increased use of maternal antiretroviral drugs: Pediatric Spectrum of HIV Disease, 1989-2004. Pediatrics. 2007 Apr;119(4):e900-6. doi: 10.1542/peds.2006-1123. PMID: 17353299.
100. Townsend CL, Cortina-Borja M, Peckham CS, et al. Antiretroviral therapy and premature delivery in diagnosed HIV-infected women in the United Kingdom and Ireland. AIDS. 2007 May 11;21(8):1019-26. doi: 10.1097/QAD.0b013e328133884b. PMID: 17457096.
101. Tuomala RE, Watts DH, Li D, et al. Improved obstetric outcomes and few maternal toxicities are associated with antiretroviral therapy, including highly active antiretroviral therapy during pregnancy. J Acquir Immune Defic Syndr. 2005 Apr 1;38(4):449-73. PMID: 15764963.
102. Watts DH, Balasubramanian R, Maupin RT, Jr., et al. Maternal toxicity and pregnancy complications in human immunodeficiency virus-infected women receiving antiretroviral therapy: PACTG 316. Am J Obstet Gynecol. 2004 Feb;190(2):506-16. doi: 10.1016/j.ajog.2003.07.018. PMID: 14981398.
103. Williams PL, Marino M, Malee K, et al. Neurodevelopment and in utero antiretroviral exposure of HIV-exposed uninfected infants. Pediatrics. 2010 Feb;125(2):e250-60. doi: 10.1542/peds.2009-1112. PMID: 20083530.
104. Briand N, Mandelbrot L, Le Chenadec J, et al. No relation between in-utero exposure to HAART and intrauterine growth retardation. AIDS. 2009 Jun 19;23(10):1235-43. doi: 10.1097/QAD.0b013e32832be0df. PMID: 19424054.
105. Cooper ER, Charurat M, Mofenson L, et al. Combination antiretroviral strategies for the treatment of pregnant HIV-1-infected women and prevention of perinatal HIV-1 transmission. J Acquir Immune Defic Syndr. 2002;29(5):484-94.
106. European Collaborative Study. Mother-to-child transmission of HIV infection in the era of highly active antiretroviral therapy. Clin Infect Dis. 2005;40(3):458-65.
107. Italian Register for Human Immunodeficiency Virus Infection in Children. Determinants of mother-to-infant human immunodeficiency virus 1 transmission before and after the

introduction of zidovudine prophylaxis. Arch Pediatr Adolesc Med. 2002;156(9):915-21.
108. Mandelbrot L, Landreau-Mascaro A, Rekacewicz C, et al. Lamivudine-zidovudine combination for prevention of maternal-infant transmission of HIV-1. JAMA. 2001;285(16):2083-93.
109. Tuomala RE, Shapiro DE, Mofenson LM, et al. Antiretroviral therapy during pregnancy and the risk of an adverse outcome. N Engl J Med. 2002 Jun 13;346(24):1863-70. doi: 10.1056/NEJMoa991159. PMID: 12063370.
110. Garcia-Tejedor A, Maiques V, Perales A, et al. Influence of highly active antiretroviral treatment (HAART) on risk factors for vertical HIV transmission. Acta Obstet Gynecol Scand. 2009;88(8):882-7. PMID: 19557554.
111. Harris NS, Fowler MG, Sansom SL, et al. Use of enhanced perinatal human immunodeficiency virus surveillance methods to assess antiretroviral use and perinatal human immunodeficiency virus transmission in the United States, 1999-2001. Am J Obstet Gynecol. 2007 Sep;197(3 Suppl):S33-41. PMID: 17825649.
112. Tariq S, Townsend CL, Cortina-Borja M, et al. Use of zidovudine-sparing HAART in pregnant HIV-infected women in Europe: 2000-2009.[Erratum appears in J Acquir Immune Defic Syndr. 2011 Aug 15;57(5):e117]. J Acquir Immune Defic Syndr. 2011 Aug 1;57(4):326-33. PMID: 21499113.
113. Townsend CL, Cortina-Borja M, Peckham CS, et al. Low rates of mother-to-child transmission of HIV following effective pregnancy interventions in the United Kingdom and Ireland, 2000-2006. AIDS. 2008 May 11;22(8):973-81. PMID: 18453857.
114. Brocklehurst P. Interventions for reducing the risk of mother-to-child transmission of HIV infection. Cochrane Database Syst Rev. 2002(1):Cd000102. doi: 10.1002/14651858.Cd000102. PMID: 11869564.
115. Liao C, Golden WC, Anderson JR, et al. Missed opportunities for repeat HIV testing in pregnancy: Implications for elimination of mother-to-child transmission in the United States. Aids Patient Care STDS. 2017 Jan;31(1):20-6. doi: 10.1089/apc.2016.0204. PMID: 27936863.
116. Williams B, Costello M, McHugh E, et al. Repeat antenatal HIV testing in the third trimester: a study of feasibility and maternal uptake rates. HIV Med. 2014 Jul;15(6):362-6. doi: 10.1111/hiv.12110. PMID: 24215444.
117. Criniti SM, Aaron E, Levine AB. Using the rapid HIV test to rescreen women in the third trimester of pregnancy. J Midwifery Womens Health. 2009 Nov-Dec;54(6):492-6. doi: 10.1016/j.jmwh.2009.03.009. PMID: 19879522.
118. Sansom SL, Jamieson DJ, Farnham PG, et al. Human immunodeficiency virus retesting during pregnancy: costs and effectiveness in preventing perinatal transmission. Obstet Gynecol. 2003 Oct;102(4):782-90. PMID: 14551009.
119. Connor EM, Sperling RS, Gelber R, et al. Reduction of maternal-infant transmission of human immunodeficiency virus type 1 with zidovudine treatment. Pediatric AIDS Clinical Trials Group Protocol 076 Study Group. N Engl J Med. 1994 Nov 3;331(18):1173-80. doi: 10.1056/nejm199411033311801. PMID: 7935654.
120. Birkhead GS, Pulver WP, Warren BL, et al. Acquiring human immunodeficiency virus during pregnancy and mother-to-child transmission in New York: 2002-2006. Obstet Gynecol. 2010 Jun;115(6):1247-55. doi: 10.1097/AOG.0b013e3181e00955. PMID: 20502297.

121. Department of Health and Human Services. Guidelines for the Prevention and Treatment of Opportunistic Infections in the HIV-Infected Adults and Adolescents. 2017. aidsinfo.nih.gov/contentfiles/lvguidelines/adult_oi.pdf Accessed December 12, 2017.

Figure 1. Analytic Framework and Key Questions



*Harms of screening include false-positive results, anxiety and effects of labeling, and partner discord, abuse, or violence.
† Harms of treatment include adverse maternal and infant outcomes associated with use of antiretroviral therapy.

Abbreviation: CD4=cluster of differentiation 4.

Key Questions

1. What are the benefits of screening for HIV infection in pregnant women on risk of mother-to-child transmission of HIV infection?
2. What is the yield of repeat HIV screening at different intervals in pregnant women, and how does the yield of screening vary in different risk groups?
3. What are the harms of screening for HIV infection in pregnant women?
4. What is the effectiveness of currently recommended ART regimens for reducing mother-to-child transmission of HIV infection?
5. What are the harms of currently recommended ART regimens given during pregnancy to the mother and infant?

Table 1. U.S.-Relevant Studies of Mother-to-Child HIV Transmission While Using Antiretroviral Therapy

Author, Year	Setting	Intervention	Sample	Mother-to-child transmission rates by treatment group	Quality rating
Garcia-Tejedor et al, 2009[110] *Included in prior report*	Spain Maternity hospitals	ART A: No treatment B: Mono/dual therapy C: ART	489 mother-infant pairs analyzed Rate of Caesarean delivery 51% No infants breastfed Followup NR Timing of infant HIV testing NR	A: 18% (39/214) B: 8.6% (10/116) C: 0.6% (1/159) p<0.001	Fair
Harris et al, 2007[111] Enhanced Perinatal Surveillance Project *Included in prior report*	U.S. Population surveillance data from areas reporting ≥60 HIV-positive women giving birth per year	ART A: No treatment B: Prenatal, intrapartum, and neonatal ART*	7,344 HIV-exposed infants with ART data Rate of Caesarean delivery 53% Breastfeeding rate NR Timing of infant HIV testing: Followup by health department every 6 months until HIV status determined; analyses of data over 3 years	A: 22% (59/265); OR referent B: 2.4% (139/5,757); AOR, 0.09 (95% CI, 0.06 to 0.12) Prenatal ART regimen and infant infection status among 3 treatment arms: ZDV: OR referent ZDV + other drugs with PI: AOR, 0.4 (95% CI, 0.3 to 0.7) ZDV + other drugs with no PI: AOR, 0.5 (95% CI, 0.3 to 0.8) Other drugs with PI, no ZDV: AOR, 0.6 (95% CI, 0.2 to 1.4) Other drugs with no PI, no ZDV: AOR, 0.3 (95% CI, 0.1 to 1.5) n=5,602 due to exclusions	Fair
Townsend et al, 2008[113] *Included in prior report*	Ireland, U.K. Population surveillance data from NSHPC	Antepartum treatment A: ART therapy B: Dual therapy C: Monotherapy D: No therapy	5,027 mother-infant pairs with ART data Rate of Caesarean delivery 78% 0.6% of infants breastfed Followup NR Analyses of data over 6-year study period Timing of infant HIV testing: Overall NR; some reported having results within 72 hours of birth	A: 1.0% (40/4,120) B: 0.8% (1/126) C: 0.5% (3/638) D: 9.1% (13/143) A: AOR, 1.0 B: AOR, 1.7 (95% CI, 0.2 to 13); p=0.61 C: AOR, 0.6 (95% CI, 0.2 to 1.9); p=0.37 D: AOR, 3.2 (95% CI, 1.2 to 8.6); p=0.02 n=4,084 due to exclusions	Fair
Tariq et al, 2011[112] *Included in prior report*	U.K., Ireland, Belgium, Denmark, Germany, Italy, the Netherlands, Poland, Spain, Sweden Population surveillance data from the ECS and NSHPC	ART A: ZDV-containing B: ZDV-sparing	7,573 mother-child pairs analyzed Rate of Caesarean delivery 74% Breastfeeding rate NR Followup NR Analyses of data over 9-year study period Timing of infant HIV testing NR	0.9% (56/6,130) (95% CI, 0.7 to 1.0) of infants were infected (infection status available for 80% [6,130/7,645] of infants at analysis) A: 0.9% (n=5,214); AOR, 1 B: 0.8% (n=897); AOR, 1.8 (95% CI, 0.8 to 4.3); p=0.18	Fair

Table 1. U.S.-Relevant Studies of Mother-to-Child HIV Transmission While Using Antiretroviral Therapy

Author, Year	Setting	Intervention	Sample	Mother-to-child transmission rates by treatment group	Quality rating
Chiappini et al, 2013[51]	EPPICC; 7 cohorts from 6 countries; (Ukraine excluded due to heterogeneity)	A. ≥3 drugs B. 2 drugs C. 1 drug D. No therapy E. Unknown	4,459 high-risk mother-infant pairs: no therapy (28%), only intrapartum prophylaxis (17%), and ART received but mother's viral load remained detectable (55%); % screen-detected HIV during pregnancy NR; 45% no antenatal or only intrapartum ART None breastfed (Ukraine cohort not included in transmission analysis) Timing of infant HIV testing NR	A. 2.8% (65/2,355); AOR, 0.36 (95% CI, 0.23 to 0.57); p<0.001 B. 1.2% (3/255); AOR, 0.12 (95% CI, 0.04 to 0.40); p<0.001 C. 3.1% (21/681); AOR, 0.33 (95% CI, 0.19 to 0.55); p<0.005 D. 14.3% (158/1,107); AOR, 1 reference	Fair
Lu et al, 2014[60]	Canada, CPHSP	ART A. Complete ART during pregnancy, ZDV during labor, infant received ZDV B. Incomplete ART C. No therapy	645 mother-child pairs analyzed Rate of Caesarean delivery 43% Breastfeeding rate NR Followup NR Proportion of mothers born in HIV-endemic country 65% Analysis of data over 12-year study period; % screen-detected HIV during pregnancy NR; 13% were considered late diagnoses (diagnosed at or after delivery) Timing of infant HIV testing NR	A. 1% (3/251) B. 2% (8/336) C. 67% (39/58)	Fair
Mandelbrot et al, 2015[61]	France, national prospective multicenter French Perinatal Cohort (ANSR-EPF)	First ART A. Triple NRTI B. PI-based C. NNRTI-based D. Three classes E. Other	8,075 mother-child pairs analyzed Rate of Caesarean delivery 57% Breastfeeding rate 0% Followup: Clinicians encouraged to followup from birth to ages 18 to 24 months Analysis of data over 11-year study period; % screen-detected HIV during pregnancy NR; 57% initiated ART during pregnancy; 72% of mothers born in Africa Timing of infant HIV testing NR	Transmission rates did not differ based on choice of initial ART (PI- vs. NNRTI-based) Transmission based on timing of ART initiation Before conception, 0.2%; AOR, 1 (reference) 1st trimester, 0.4%; AOR, 2.9 (95% CI, 0.6 to 17.7) 2nd trimester, 0.9%; AOR, 6.0 (95% CI, 1.7 to 29.7) 3rd trimester, 2.2%; AOR, 7.8 (95% CI, 2.1 to 28.8)	Fair
Mor et al, 2017[63]	Israel, all HIV-infected women who delivered in Israel (and were citizens) between 1988 and 2011	A. HAART (392) B. No HAART (404)	796 mother-infant pairs; 82% of mothers born in Ethiopia; 8 infants were breastfed Timing of infant HIV testing NR	HAART vs. no HAART during pregnancy: AOR, 0.4 (95% CI, 0.1 to 0.8) Overall transmission: 3% (25/796) Transmission with HAART and vaginal delivery: 1.5% Transmission with HAART and Caesarean delivery: 0.6%	Fair

Table 1. U.S.-Relevant Studies of Mother-to-Child HIV Transmission While Using Antiretroviral Therapy

Author, Year	Setting	Intervention	Sample	Mother-to-child transmission rates by treatment group	Quality rating
Tookey et al, 2016[74]	U.K. and Ireland, NSHPC	A. LPV/r + ZDV + 3TC B. LPV/r + TDF-FTC C. LPV/r + ABC + 3TC D. LPV/r + other or missing NRTIs	4,864 enrolled; 2,406 mother-infant pairs (2008–2012); 67% were given LPV/r + ZDV + 3TC; proportion of mothers born in sub-Saharan Africa 77%; some mother-infant pairs at high risk for HIV transmission likely also counted in the Chiappini study Timing of infant HIV testing NR	By timing of LPV/r initiation: Overall: 12/2,406 (0.5% [95% CI, 0.2% to 0.8%]) Before conception: 2/635 (0.3% [95% CI, 0.1% to 1.1%]) First trimester: 0/77 (0%) Second trimester: 5/1,397 (0.4% [95% CI, 0.2% to 0.8%]) Third trimester: 5/264 (1.9% [95% CI, 0.8% to 4.4%])	Fair

Abbreviations: 3TC=lamivudine; ABC=abacavir; ANRS-EPF=French Agence Nationale de Recherche sur le SIDA-Enquête Périnatale Française; AOR=adjusted odds ratio; ART=antiretroviral therapy; CI=confidence interval; CPHSP=Canadian Perinatal HIV Surveillance Program; ECS=European Collaborative Study; EPPICC=European Pregnancy and Paediatric HIV Cohort Collaboration; FTC=emtricitabine; HAART=highly active antiretroviral therapy; LPV/r=lopinavir/ritonavir; NSHPC=National Study of HIV in Pregnancy and Childhood; NR=not reported; NNRTI=nonnucleoside reverse transcriptase inhibitor; NRTI=nucleoside reverse transcriptase inhibitor; PI=protease inhibitor; OR=odds ratio; TDF=tenofovir disoproxil fumarate; U.K.=United Kingdom; ZDV=zidovudine.

Table 2. African-Based Trials of Mother-to-Child HIV Transmission While Using Antiretroviral Therapy

Author, year	Setting	Prenatal intervention	Peripartum intervention	Postpartum intervention	Sample	Mother-to-child transmission rates by treatment group	Quality rating
Chi et al, 2008[82] Other publication: Chi et al, 2007[84] *Included in prior report*	Zambia	From 32 weeks: ZDV to all groups	A: TDF-FTC + NVP B: NVP	All neonates: NVP dose in hospital + ZDV for 1 week	355 mother-infant pairs analyzed 92% of infants breastfed in both groups	6 weeks postpartum A: 6% B: 8% p=0.4	Fair
de Vincenzi et al, 2011[86] Other publication: Kesho Bora Study Group, 2010[85] *Included in prior report*	Burkina Faso, Kenya, South Africa	From 28 weeks: A: ZDV + 3TC + LPV/r B: ZDV	A: ZDV, 3TC, LPV/r B: ZDV + sdNVP	A: Maternal ZDV, 3TC, LPV/r until cessation of breastfeeding (maximum 6.5 months postpartum) B: Maternal 3TC and ZDV for 1 week postpartum* All neonates: ZDV for 1 week,* NVP dose within 72 hours of birth, cotrimoxazole from age 6 weeks to 12 months unless not HIV infected after cessation of breastfeeding	805 live-born infants 77% of infants in group A and 78% in group B were ever breastfed	Age 12 months A: 5.4% (21/333) (95% CI, 3.6 to 8.1) B: 9.5% (37/305) (95% CI, 7.0 to 13) RR reduction, 0.43 p=0.03	Good
Gray et al, 2006[80] *Included in prior report*	South Africa	From 34 weeks gestation: A: D4T B: ddI C: D4T + ddI D: ZDV	A: D4T B: ddl C: D4T + ddl D: ZDV	Infants received same ART regimen as mother until age 6 weeks	362 mother-infant pairs analyzed No infants breastfed	24 weeks postpartum A: 12% (11/91) (95% CI, 6.2 to 21) B: 11% (10/94) (95% CI, 5.2 to 19) C: 4.6% (4/88) (95% CI, 1.3 to 11) D: 5.6% (5/89) (95% CI, 1.9 to 13) All groups: 8.3% (30/362) (95% CI, 5.7 to 12)	Fair
Shapiro et al, 2010[87] *Included in prior report*	Botswana	Randomization groups† From 26 weeks: A: ABC + ZDV + 3TC B: LPV/r + ZDV + 3TC Observational group‡ From 18 weeks: C: NVP + ZDV + 3TC	A: ABC + ZDV + 3TC B: LPV/r + ZDV + 3TC C: NVP + ZDV + 3TC	A: ABC + ZDV + 3TC B: LPV + RTV + ZDV + 3TC Above to continue until weaning or 6 months postpartum, whichever came first C: NVP + ZDV + 3TC to continue indefinitely All neonates: sdNVP at birth + ZDV from birth to 4 weeks	709 live-born infants (including 156 in the observational group) 97% of live-born infants breastfed and 71% continued for >5 months	Age 6 months A: 2.1% (6/283) B: 0.4% (1/270) Percentage point difference, 1.7 (95% CI, -2.0 to 7.1)§ All groups: 1.1% (8/709) (95% CI, 0.5 to 2.2)	Fair

Table 2. African-Based Trials of Mother-to-Child HIV Transmission While Using Antiretroviral Therapy

Author, year	Setting	Prenatal intervention	Peripartum intervention	Postpartum intervention	Sample	Mother-to-child transmission rates by treatment group	Quality rating
Shapiro et al, 2006[81] *Included in prior report*	Botswana	From 34 weeks: ZDV to all groups‖	A: sdNVP B: Placebo	All neonates: NVP at birth and ZDV from birth to age 1 month¶	694 live first-born infants 50% of infants in both groups were breastfed Infant followup until age 1 month	Age 1 month A: 4.3% ± 2.3 (SD, 2) (15/345) B: 3.7% ± 2.2 (SD, 2) (13/346) 95% CI for difference, -2.4% to 3.8% (met equivalence)	Fair
Thistle et al, 2007[88] *Included in prior report*	Zimbabwe	None	A: ZDV/sdNVP B: sdNVP	A: Infant ZDV for 72 hours after delivery and NVP dose within 72 hours of delivery B: Infant NVP dose within 72 hours of delivery	Study terminated secondary to futility 609 infants with data 89% of infants in group A and 91% in group B were breastfed at 6 weeks (1 infant in group A was breast and formula fed)	Age 6 weeks A: 14% (45/312) HIV+, 7.4% (23/312) mortality, 22% (68/312) met primary outcome (death or HIV infection) B: 17% (49/297) HIV+, 7.1% (21/297) mortality, 24% (70/297) met primary outcome	Fair
Fowler et al, 2016[44]	India, Malawi, South Africa, Tanzania, Uganda, Zambia, Zimbabwe	Randomized From 14 weeks: A. ZDV B. ZDV + 3TC + LPVr C. TDF + FTC + LPVr	A. sdNVP (ZDV-only group)	A. TDF + FTC (6–14 days; ZVD-only group) B. ZDV + 3TC + LPV/r C. TDF + FTC + LPV/r	3,202 live-born infants; mothers primarily black African; 92% breastfed; % screen-detected HIV during pregnancy NR	A. 1.8% (25/1,386) B. 0.5% (7/1,385) C. 0.6% (2/325) B + C vs. A: Difference in percentage point, -1.3 (95% CI, -2.1 to -0.4)	Fair

*Began after protocol change in December 2006 (enrollment commenced June 2005).
†Women with CD4 count >200 cells/mm^3.
‡Women with CD4 count <200 cells/mm^3 or with AIDS-defining illness.
§Study not powered for between-group comparisons of transmission rates.
‖ART was offered to women with CD4 counts <200 cells/mm^3 or AIDS-defining illness at any point in study participation. If women started ART before delivery, they did not receive peripartum nevirapine or placebo.
¶Infants confirmed to be HIV-infected were also given ART.

Abbreviations: 3TC=lamivudine; ABC=abacavir; ART=antiretroviral therapy; CI=confidence interval; D4T=stavudine; ddl=didanosine; FTC=emtricitabine; LPV/r=lopinavir/ritonavir; NVP=nevirapine; RR=relative risk; RTV=ritonavir; sdNVP=single-dose nevirapine; SD=standard deviation; TDF=tenofovir disoproxil fumarate; ZDV=zidovudine.

Table 3. Studies Examining the Association Between Birth Outcomes and HIV Antiretroviral Therapy

Harm category	Study, year Country Study name	ART regimen (n; %)	Birth outcome Definition	Birth outcome Distribution	Magnitude of risk: adjusted OR (95% CI); p-value
Preterm Delivery	Cotter et al, 2006[92] U.S. University of Miami study *Included in prior report*	A. None (n=338; 25%) B. Monotherapy (n=492; 37%) C. Combination therapy with PI (n=134; 10%) D. Combination therapy without PI (n=373; 28%) Total N=1,337	Preterm delivery <37 weeks Very preterm <32 weeks	Median at delivery 39 weeks	Combination with vs. without PI: <37 weeks: 1.8 (1.1 to 3.0); p=0.03 Combination + PI: <37 weeks: 36.6% of women; p<0.05 <32 weeks: 2.2% of women; p-value NS
	Grosch-Warner et al, 2008[94] Germany, Austria *Included in prior report*	A. Monotherapy (n=76; 42%) B. Dual therapy (n=32; 17%) C. ART without PI (n=54; 30%) D. ART with PI (n=21; 11%) Total N=183	Preterm delivery <36 weeks	<36 weeks 34%* (crude rate)	A. 1 reference C. ART (-) PI: 0.89 (0.38 to 2.12); p=0.8 D. ART (+) PI: 3.40 (1.13 to 10.2); p=0.03
	Powis et al, 2011[83] Botswana *Included in prior report*	A. PI group (LPV/r with ZDV/3TC) (n=275; 49%) B. NRTI group, TZV (n=285; 51%) Total N=560	Preterm delivery <37 weeks	<37 weeks 11.8%* Triple NRTI; 21.4% PI-based <32 weeks 2.6% (n=12); 8/12 associated with ART + PI; 4/12 triple NRTI	A. ART (+) PI: 2.03 (1.26 to 3.27); p=0.004 B. ART (-) PI (NRTI-based): 1.0
	Schulte et al, 2007[99] U.S. Pediatric Spectrum of HIV Disease cohort *Included in prior report*	A. None (n=2,565; 29%) B. Monotherapy (n=2,621; 30%) C. Dual therapy (n=1,044; 12%) D. Triple therapy: ART, non-PI (n=1,781; 20%) E. Triple therapy: ART, PI (n=782; 9%) Total N=8,793	Preterm delivery <37 weeks	Mean 37 weeks (range, 26 to 42)	C. 1 reference E. 1.21 (1.04 to 1.48); p-value NR
	Townsend et al, 2007[100] U.K., Ireland *Included in prior report*	A. ART (n=3,384; 69%) B. Mono/dual therapy (n=1,061; 21%) C. Untreated; not included in analyses (n=494; 10%) Total N=4,939	Preterm delivery <37 weeks	<37 weeks 14.1%* <35 weeks 7.8% <32 weeks 1.4%	A. <37 weeks: 1.39 (1.05 to1.83); p=0.02 A. <35 weeks: 2.02 (1.35 to 3.04); p=0.001 A. <32 weeks: 2.63 (1.3 to 5.33); p=0.007 B. 1 reference all comparisons

Table 3. Studies Examining the Association Between Birth Outcomes and HIV Antiretroviral Therapy

Harm category	Study, year Country Study name	ART regimen (n; %)	Birth outcome Definition	Birth outcome Distribution	Magnitude of risk: adjusted OR (95% CI); p-value
Preterm Delivery	Chagomerana et al, 2017[49] Malawi	Started ART before 27 weeks or not at all A. ART (2,909; 95%) B. No ART (165; 5%) Total N=3,074	Preterm delivery 27 to 37 weeks	24%	Delivery after 27 weeks: A. 1 reference B. aRR, 1.14 (0.84 to 1.55)
	Chen et al, 2012[50] Botswana Approximately 87% received ZDV/3TC/NVP	A. Initiated HAART during pregnancy (ZVD/3TC/NVP or ZVD/3TC/LVP/r) (1,101; 12%) B. Initiated ZVD only during pregnancy (4,625; 51%) C. No ART (1,234; 13%) D. HAART continued from before pregnancy (2,189; 24%) Total N=9,149	Preterm delivery <37 weeks	24%*	Initiated HAART vs. initiated ZDV: 1.4 (1.2 to 1.8) Continued HAART vs. all others: 1.2 (1.1 to 1.4)
	Duryea et al, 2015[52] U.S. University of Texas study	A. ART with PI (597; 59%) B. ART without PI (230; 23%) C. No ART (177; 18%) Total N=1,004	Preterm delivery <37 weeks	13% to 21% depending on ART regimen	A. 1 reference B. 0.9 (0.5 to 1.5) C. 1.0 (0.5 to 2.0)
	Kakkar et al, 2015[54] Canada	A. NRTI/NNRTI (159; 30%) B. Boosted PI (119; 23%) C. Unboosted PI (195; 37%) D. No treatment (52; 10%) Total N=525	Preterm delivery <37 weeks	14%*	A. 0.67 (0.27 to 1.63); p=0.37 B. 2.17 (1.05 to 4.51); p=0.038 C. 1 reference D. 1.50 (0.33 to 6.78); p=0.60
	Kreitchmann et al, 2014[56] Latin America Caribbean	At least 28 days in 3rd trimester: A. HAART + PI (888; 59%) B. HAART no PI (410; 27%) C. Non-HAART (134; 9%) D. No ARV (80; 5%) Total N=1,512	Preterm delivery <37 weeks	21%*	Receiving vs. not receiving ART at conception: 1.53 (1.11 to 2.09)
	Li et al, 2016[57] Tanzania	A. Initiated ZDV during pregnancy (1,768; 53%) B. Initiated HAART during pregnancy (512; 15%) C. Continued HAART from before pregnancy (582; 18%) D. No ART (452; 14%) Total N=3,314	Preterm delivery <37 weeks Very preterm <34 weeks	No infants had HIV <37 weeks 29%* <34 weeks 10%*	HAART vs. ZDV started during pregnancy: <37 weeks: 0.85 (0.70 to 1.02); p=0.14 <34 weeks: 0.87 (0.60 to 1.25); p=0.45

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Harm category	Study, year Country Study name	ART regimen (n; %)	Birth outcome Definition	Birth outcome Distribution	Magnitude of risk: adjusted OR (95% CI); p-value
Preterm Delivery	Lopez et al, 2012[59] Spain	A. HAART entire pregnancy (226; 44%) B. HAART 2nd half of pregnancy only (72; 14%) C. PI during pregnancy (178; 34%) D. No HAART (221; 43%) Total N=697	Preterm delivery <37 weeks	20%*	Spontaneous preterm birth: A. 0.55 (0.20 to 1.51) B. 0.55 (0.18 to 1.68) C. 1.95 (0.87 to 4.38) D. HIV-uninfected women Iatrogenic preterm birth: A. 3.42 (0.80 to 14.63) B. 6.16 (1.42 to 26.8) C. 0.44 (0.18 to 1.10) D. HIV-uninfected women
	Moodley et al, 2016[62] South Africa	A. No ART (148; 4%) B. AZT + NVP (974; 26%) C. D4T + 3TC + NVP (907; 25%) D. EFV + TDF-FTC (1,666; 45%) Total N=3,695	Preterm delivery <37 weeks	22.3%	A. 1 reference B. 0.20 (0.08 to 0.51); p=0.001 C. 0.21 (0.08 to 0.55); p=0.001 D. 0.31 (0.11 to 0.90); p=0.03
	Pintye et al, 2017[65] Kenya and Uganda	A. TDF-containing ART (208; 49%) B. Non-TDF–containing ART (214; 51%) Total N=422	Preterm delivery <37 weeks	8%	A vs. B: Adjusted prevalence rate ratio 0.37 (0.15 to 0.89); p=0.03
	Ramokolo et al, 2017[66] South Africa	A. Postconception ART (780; 30%) B. ZDV (873; 34%) C. No ART (330; 13%) D. Preconception ART (616; 24%) Total N=2,599	Preterm delivery <37 weeks	12.5%	A. 1 reference B. 1.4 (0.9 to 2.0); p=0.11 C. 1.9 (1.1 to 3.1); p=0.01 D. 1.7 (1.1 to 2.5); p=0.02
	Rough et al, 2018[67] U.S. PHACS and IMPAACT	A. TDF-FTC + LPV/r (128; 8%) B. ZDV + 3TC + LPV/r (954; 59%) C. TDF-FTC + ATV/r (539; 33%) Total N=1,621	Preterm delivery <37 weeks Very preterm delivery <34 weeks	18% Preterm delivery 5% Very preterm delivery	Preterm delivery, adjusted OR: A vs. B: 0.90 (0.60 to 1.33) C vs. B: 0.69 (0.51 to 0.94) A vs. C: 1.14 (0.75 to 1.72) Very preterm delivery, unadjusted OR: A vs. B: 0.85 (0.34 to 2.13) C vs. B: 1.04 (0.60 to 1.83) A vs. C: 0.82 (0.31 to 2.17)

Table 3. Studies Examining the Association Between Birth Outcomes and HIV Antiretroviral Therapy

Harm category	Study, year Country Study name	ART regimen (n; %)	Birth outcome Definition	Birth outcome Distribution	Magnitude of risk: adjusted OR (95% CI); p-value
Preterm Delivery	Short et al, 2013[68] U.K.	A. ZDV (65; 20%) B. Dual NRTI (7; 2%) C. Triple NRTI (5; 2%) D. Short-term combination ART (59; 18%) E. Preconception combination ART (131; 40%) F. New continuous combination ART (56; 17%) G. No therapy (8; 2%) Total N=331	Preterm delivery <37 weeks	13%*	Short-term combination ART vs. ZVD: 5.00 (1.49 to 16.79)
	Sibiude et all, 2012[72] France	A. HAART (6,738; 59%) HAART with boosted PI (1,066; 9%) HAART without nonboosted PI (187; 2%) B. Dual therapy (1,664; 15%) C. Monotherapy (2,975; 26%) Total N=11,377	Preterm delivery <37 weeks	14%*	A. 1.69 (1.38 to 2.07) Boosted PI, 2.03 (1.06 to 3.89); p=0.03 vs. nonboosted PI B. 1.24 (0.96 to 1.60) C. 1 reference
	Snijdewind et al, 2018[73] The Netherlands	A. PI-based (928; 67%) B. NNRTI-based (438; 31%) C. Both or NRTI (12; 1%) Total N=1,378	Preterm delivery <37 weeks	15%	Unadjusted OR: A. 1 (reference) B. 1.30 (0.95 to 1.77); p=0.11 C. 1.15 (0.41 to 3.19); p=0.78
	Watts et al, 2013[75] U.S. PHACS/SMARTT	A. Combination, with PI (1,319; 74%) B. Combination, with NNRTI, no PI (160; 9%) C. Combination, with ≥3 NRTIs (193; 10%) Total N=1,672	Preterm delivery <37 weeks	Any preterm birth: <37 weeks 19%* Spontaneous preterm birth: <37 weeks 10%*	Any preterm birth: A. 1.49 (0.83 to 2.67); p=0.18 B. 1.28 (0.62 to 2.66); p=0.50 C. 1.04 (0.50 to 2.14); p=0.93) Spontaneous preterm birth: A. 1.41 (0.66 to 2.99); p=0.38 B. 1.53 (0.62 to 3.81); p=0.36 C. 0.88 (0.34 to 2.29); p=0.80) (all vs. monotherapy or dual therapy)
	Zash et al, 2016[79] Botswana	All CD4 counts: A. TDF-FTC/EFV (1,054; 33%) B. Other ART (2,172; 64%) Total N=3,226 CD4 counts >350 cells/mm^3 A. TDF-FTC/EFV (335; 31%) B. ZDF (752; 69%) Total N=1,087	Preterm delivery <37 weeks	27%	A vs. B (all CD4 counts): 0.7 (0.5 to 1.1) A vs. B (CD4 count >350 cells/mm^3): 1.1 (0.6 to 2.1)

Table 3. Studies Examining the Association Between Birth Outcomes and HIV Antiretroviral Therapy

Harm category	Study, year Country Study name	ART regimen (n; %)	Birth outcome Definition	Birth outcome Distribution	Magnitude of risk: adjusted OR (95% CI); p-value
Preterm Delivery	Zash et al, 2017[78] Botswana	A. TDF-FTC/EFV (2,472; 49%) B. TDF-FTC/NVP (760; 15%) C. TDF-FTC/LPV/r (231; 5%) D. ZDV/3TC/NVP (1,365; 27%) E. ZDV/3TC/LPV/r (167; 3%) Total N=4,995	Preterm delivery <37 weeks Very preterm delivery <32 weeks	22% Preterm delivery 5% Very preterm delivery	aRR: A. 1 reference B. 0.88 (0.75 to 1.05) preterm delivery B. 1.23 (0.84 to 1.80) very preterm delivery C. 1.12 (0.88 to 1.43) preterm delivery C. 1.36 (0.76 to 2.45) very preterm delivery D. 1.14 (1.01 to 1.29) preterm delivery D. 1.44 (1.07 to 1.95) very preterm delivery E. 1.36 (1.06 to 1.75) preterm delivery E. 2.21 (1.29 to 3.79) very preterm delivery
Low Birth Weight	Kreitchmann et al, 2014[56] Latin America Caribbean	At least 28 days in 3rd trimester: A. HAART + PI (888; 59%) B. HAART no PI (410; 27%) C. Non-HAART (134; 9%) D. No ARV (80; 5%) Total N=1,512	Low birth weight <2,500 g	16%*	HAART with PI vs. no ART: 0.59 (0.28 to 1.26) HAART with no PI vs. no ART: 0.33 (0.14 to 0.74) Non-HAART vs. no ART: 0.40 (0.15 to 1.05)
	Moodley et al, 2016[62] South Africa	A. No ART (148; 4%) B. AZT + NVP (974; 26%) C. D4T +3TC + NVP (907; 25%) D. EFV + TDF-FTC (1,666; 45%) Total N=3,695	Low birth weight <2,500 g	13.5%	A. 1 reference B. 0.06 (0.02 to 0.18); p<0.001 C. 0.09 (0.03 to 0.24); p<0.001 D. 0.12 (0.04 to 0.37); p<0.001
	Ramokolo et al, 2017[66] South Africa	A. Postconception ART (780; 30%) B. ZDV (873; 34%) C. No ART (330; 13%) D. Preconception ART (616; 24%) Total N=2,599	Low birth weight <2,500 g	10.7%	A. 1 reference B. 0.8 (0.6 to 1.1); p=0.14 C. 1.1 (0.8 to 1.6); p=0.47 D. 0.9 (0.6 to 1.3); p=0.54
	Rough et al, 2018[67] U.S. PHACS and IMPAACT	A. TDF-FTC + LPV/r (128; 8%) B. ZDV + 3TC + LPV/r (954; 59%) C. TDF-FTC + ATV/r (539; 33%) Total N=1,621	Low birth weight <2,500 g Very low birth weight <1,500 g	18% Low birth weight 2% Very low birth weight	Low birth weight, adjusted OR: A vs. B: 1.13 (0.78 to 1.64) C vs. B: 0.80 (0.60 to 1.09) A vs. C: 1.45 (0.96 to 2.17) Very low birth weight, unadjusted OR: A vs. B: 0.41 (0.06 to 3.06) C vs. B: 0.89 (0.40 to 2.00) A vs. C: 0.49 (0.07 to 3.57)

Table 3. Studies Examining the Association Between Birth Outcomes and HIV Antiretroviral Therapy

Harm category	Study, year Country Study name	ART regimen (n; %)	Birth outcome Definition	Birth outcome Distribution	Magnitude of risk: adjusted OR (95% CI); p-value
Low Birth Weight	Siberry et al, 2012[69] U.S. PHACS/SMARTT	A. TDF-containing ART (449; 22%) B. Non-TDF–containing ART (1,580; 78%) Total N=2,029	Low birth weight <2,500 g	19%	A vs. B: 0.73 (0.48 to 1.11); p=0.14
	Snijdewind et al, 2018[73] The Netherlands	A. PI-based (928; 67%) B. NNRTI-based (438; 31%) C. Both or NRTI (12; 1%) Total N=1,378	Low birth weight <2,500 g	16%	Unadjusted OR: A. 1 (reference) B. 1.19 (0.88 to 3.97); p=0.26 C. 1.47 (0.54 to 3.97); p=0.45
Small Size for Gestational Age	Aaron et al, 2012[46] U.S. Drexel University study	A. NRTI + NNRTI (39; 21%) B. NRTI + PI (117; 64%) C. NRTI alone (27; 15%) Total N=183	SGA <10th percentile of birth weight by gestational age (based on infant sex and mother's parity)	<10th percentile 31%* <3rd percentile 13%*	<10th percentile: A. 0.28 (0.10 to 0.75); p<0.05 vs. others B. 1.68 (0.79 to 3.55); p>0.05 vs. others <3rd percentile: A. 0.16 (0.03 to 0.91); p<0.05 vs. others B. 2.73 (0.83 to 9.00); p>0.05 vs. others
	Chen et al, 2012[50] Botswana	A. Initiated HAART during pregnancy (ZVD/3TC/NVP or ZVD/3TC/LVP/r) (1,101; 12%) B. Initiated ZVD only during pregnancy (4,625; 51%) C. No ART (1,234; 13%) D. HAART continued from before pregnancy (2,189; 24%) Total N=9,149	SGA <10th percentile	13.5%*	Initiated HAART vs. initiated ZDV: 1.5 (1.2 to 1.9) Continued HAART vs. initiated HAART: 1.3 (1.0 to 1.5) Continued HAART vs. all others: 1.8 (1.6 to 2.1)
	Duryea et al, 2015[52] U.S. University of Texas study	A. ART with PI (597; 59%) B. ART without PI (230; 23%) C. No ART (177; 18%) Total N=1,004	SGA <10th percentile of birth weight by gestational age	4% to 10% depending on ART regimen	A. 1 reference B. 1.3 (0.8 to 1.9) C. 1.1 (0.6 to 2.0)
	Li et al, 2016[57] Tanzania	A. Initiated ZDV during pregnancy (1,768; 53%) B. Initiated HAART during pregnancy (512; 15%) C. Continued HAART from before pregnancy (582; 18%) D. No ART (452; 14%) Total N=3,314	SGA <10th percentile of birth weight by gestational age <3rd percentile for severe SGA	3rd–10th percentile 9%* <3rd percentile 11%*	HAART vs. ZDV started during pregnancy: 3rd–10th percentile: 1.09 (0.88 to 1.35); p=0.41 <3rd percentile: 1.47 (1.09 to 1.98); p=0.01
	Moodley et al, 2016[62] South Africa	A. No ART (148; 4%) B. AZT + NVP (974; 26%) C. D4T + 3TC + NVP (907; 25%) D. EFV + TDF-FTC (1,666; 45%) Total N=3,695	SGA	8.2%	A. 1 reference B. 0.37 (0.10 to 1.45); p=0.15 C. 0.29 (0.08 to 1.07); p=0.06 D. 0.25 (0.07 to 0.87); p=0.03

Table 3. Studies Examining the Association Between Birth Outcomes and HIV Antiretroviral Therapy

Harm category	Study, year Country Study name	ART regimen (n; %)	Birth outcome Definition	Birth outcome Distribution	Magnitude of risk: adjusted OR (95% CI); p-value
Small Size for Gestational Age	Ramokolo et al, 2017[66] South Africa	A. Postconception ART (780; 30%) B. ZDV (873; 34%) C. No ART (330; 13%) D. Preconception ART (616; 24%) Total N=2,599	SGA <10th percentile of birth weight by gestational age	14.9%	A. 1 reference B. 0.7 (0.5 to 1.0); p=0.05 C. 0.7 (0.4 to 1.1); p=0.08 D. 0.9 (0.6 to 1.3); p=0.52
	Siberry et al, 2012[69] U.S. PHACS/SMARTT	A. TDF-containing ART (449; 22%) B. Non-TDF–containing ART (1,580; 78%) Total N=2,029	SGA	8.6%	A vs. B: 0.96 (0.60 to 1.52); p=0.85
	Snijdewind et al, 2018[73] The Netherlands	A. PI-based (928; 67%) B. NNRTI-based (438; 31%) C. Both or NRTI (12; 1%) Total N=1,378	SGA <10th percentile of birth weight by gestational age	24%	Unadjusted OR: A. 1 (reference) B. 1.04 (0.80 to 1.16); p=0.76 C. 2.51 (1.16 to 5.53); p=0.02 Adjusted OR: A. 1 (reference) B. 0.95 (0.71 to 1.27); p=0.73 C. 2.11 (0.98 to 4.57); p=0.06
	Watts et al, 2013[75] U.S. PHACS/SMARTT	A. Combination, with PI (1,319; 74%) B. Combination, with NNRTI, no PI (160; 9%) C. Combination, with ≥3 NRTIs (193; 10%) Total N=1,672	SGA <10th percentile of birth weight by gestational age	7%*	All vs. no ARV in 1st trimester: A. 0.79 (0.49 to 1.26); p=0.32 B. 1.17 (0.54 to 2.54); p=0.70 C. 0.99 (0.34 to 2.86); p=0.99 All vs. monotherapy or dual therapy: A. 1.79 (0.64 to 5.04); p=0.27 B. 1.77 (0.53 to 5.99); p=0.36 C. 1.45 (0.43 to 4.89); p=0.55
	Zash et al, 2016[79] Botswana	All CD4 counts: A. TDF-FTC/EFV (1,054; 33%) B. Other ART (2,172; 64%) Total N=3,226 CD4 count >350 cells/mm^3 A. TDF-FTC/EFV (335; 31%) B. ZDF (752; 69%) Total N=1,087	SGA <10th percentile of birth weight by gestational age (Botswana norms)	19%	A vs. B (all CD4 counts): 0.4 (0.3 to 0.6) A vs. B (CD4 >350 cells/mm^3): 0.6 (0.4 to 1.0)

Table 3. Studies Examining the Association Between Birth Outcomes and HIV Antiretroviral Therapy

Harm category	Study, year Country Study name	ART regimen (n; %)	Birth outcome Definition	Birth outcome Distribution	Magnitude of risk: adjusted OR (95% CI); p-value
Small Size for Gestational Age	Zash et al, 2017[78] Botswana	A. TDF-FTC/EFV (2,472; 49%) B. TDF-FTC/NVP (760; 15%) C. TD-/FTC/LPV/r (231; 5%) D. ZDV/3TC/NVP (1,365; 27%) E. ZDV/3TC/LPV/r (167; 3%) Total N=4,995	SGA <10th percentile of birth weight by gestational age VSGA <3rd percentile	22% SGA 10% VSGA	aRR: A. 1 reference B. 1.44 (1.24 to 1.68) SGA B. 1.52 (1.18 to 1.94) VSGA C. 1.56 (1.25 to 1.97) SGA C. 1.81 (1.26 to 2.59) VSGA D. 1.66 (1.46 to 1.87) SGA D. 1.76 (1.44 to 2.16) VSGA E. 1.13 (0.82 to 1.56) SGA E. 1.70 (1.10 to 2.62) VSGA
Stillbirth	Chen et al, 2012[50] Botswana	A. Initiated HAART during pregnancy (ZDV/3TC/NVP or ZDV/3TC/LVPr (1,101; 12%) B. Initiated ZDV only during pregnancy (4,625; 51%) C. No ART (1,234; 13%) D. HAART continued from before pregnancy (2,189; 24%) Total N=9,149	Stillbirth (fetal death with APGAR of 0)	3.3%*	HAART initiation vs. ZDV initiation: 2.5 (1.6 to 3.9) Continued HAART vs. all others: 1.5 (1.2 to 1.8)
	Kreitchmann et al, 2014[56] Latin America Caribbean	At least 28 days in 3rd trimester: A. HAART with PI (888; 59%) B. HAART with no PI (410; 27%) C. Non-HAART (134; 9%) D. No ARV (80; 5%) Total N=1,512	Stillbirth Birth at 20 weeks of gestation or later with no signs of life	2%*	HAART with PI vs. no ART: 0.14 (0.05 to 0.34) HAART with no PI vs. no ART: 0.11 (0.04 to 0.34)
	Moodley et al, 2016[62] South Africa	A. No ART (148; 4%) B. AZT + NVP (974; 26%) C. D4T + 3TC + NVP (907; 25%) D. EFV + TDF-FTC (1,666; 45%) Total N=3,695	Stillbirth	3.1%	A. 1 reference B. 0.08 (0.04 to 0.16); p<0.001 C. 0.20 (0.11 to 0.38); p<0.001 D. 0.18 (0.10 to 0.34); p<0.001
	Rough et al, 2018[67] U.S. PHACS and IMPAACT	A. TDF-FTC + LPV/r (128; 8%) B. ZDV + 3TC + LPV/r (954; 59%) C. TDF-FTC + ATV/r (539; 33%) Total N=1,621	Fetal loss was undefined, included stillbirth (likely also included spontaneous abortion and fetal demise)	0.6%	Unadjusted OR (our analysis) for initial drug regimen: A vs. B: 2.51 (0.50 to 13) A vs. C: 4.26 (0.60 to 31) B vs. C: 1.70 (0.34 to 8.45)

Table 3. Studies Examining the Association Between Birth Outcomes and HIV Antiretroviral Therapy

Harm category	Study, year Country Study name	ART regimen (n; %)	Birth outcome Definition	Birth outcome Distribution	Magnitude of risk: adjusted OR (95% CI); p-value
Stillbirth	Zash et al, 2016[79] Botswana	All CD4 counts: A. TDF-FTC/EFV (1,054; 33%) B. Other ART (2,172; 64%) Total N=3,226 CD4 counts >350 cells/mm^3 A. TDF-FTC/EFV (335; 31%) B. ZDF (752; 69%) Total N=1,087	Stillbirth	3%	A vs. B (all CD4 counts): 0.6 (0.3 to 1.3) A vs. B (CD4 >350 cells/mm^3): 0.9 (0.4 to 2.1)
	Zash et al, 2017[78] Botswana	A. TDF-FTC/EFV (2,472; 49%) B. TDF-FTC/NVP (760; 15%) C. TDF-FTC/LPV/r (231; 5%) D. ZDV/3TC/NVP (1,365; 27%) E. ZDV/3TC/LPV/r (167; 3%) Total N=4,995	Stillbirth	3.6%	aRR: A. 1 reference B. 1.15 (0.70 to 1.89) C. 1.81 (0.94 to 3.50) D. 2.31 (1.64 to 3.26) E. 1.53 (0.67 to 3.49)
Neonatal Death	Pintye et al, 2017[65] Kenya and Uganda	A. TDF-containing ART (208; 49%) B. Non-TDF–containing ART (214; 51%) Total N=422	Neonatal death within 3 days of live birth	2%	A vs. B: Adjusted prevalence rate ratio, 0.55 (0.17 to 1.77); p=0.30
	Rough et al, 2018[67] U.S. PHACS and IMPAACT	A. TDF-FTC + LPV/r (128; 8%) B. ZDV + 3TC + LPV/r (954; 59%) C. TDF-FTC + ATV/r (539; 33%) Total N=1,621	Neonatal death within 14 days of live birth	0.1% (2 events)	Unadjusted OR (our analysis) for initial drug regimen: A vs. B: 2.47 (0.10 to 61) A vs. C: 1.40 (0.06 to 34) B vs. C: 0.56 (0.04 to 9.04)
	Zash et al, 2017[78] Botswana	A. TDF-FTC/EFV (2,472; 49%) B. TDF-FTC/NVP (760; 15%) C. TDF-FTC/LPV/r (231; 5%) D. ZDV/3TC/NVP (1,365; 27%) E. ZDV/3TC/LPV/r (167; 3%) Total N=4,995	Neonatal death at less than 28 days	1.6%	aRR: A. 1 reference B. 1.57 (0.81 to 3.06) C. 1.60 (0.56 to 4.56) D. 1.94 (1.13 to 3.33) E. 4.01 (1.78 to 9.11)

Table 3. Studies Examining the Association Between Birth Outcomes and HIV Antiretroviral Therapy

Harm category	Study, year Country Study name	ART regimen (n; %)	Birth outcome Definition	Birth outcome Distribution	Magnitude of risk: adjusted OR (95% CI); p-value
Congenital Abnormalities	Antiretroviral Pregnancy Registry Interim Report (1989 through 2018)[47] Multinational (69 countries), 75% U.S. and its territories	Preferred initial treatment drugs in U.S.: A. ABC (1,131; 12%) B. 3TC (5,008; 54%) C. TDF (3,535; 38%) D. FTC (2,785; 30%) E. ATV (1,279; 14%) F. RTV (3,155; 34%) G. DRV (456; 5%) H. RAL (291; 3%) Alternative initial treatment drugs in U.S.: I. ZDV (4,178; 45%) J. LPV (1,418; 15%) K. EFV (1,023; 11%) L. RPV (297; 3%) Total N=9,336	Birth defects Centers for Disease Control and Prevention guidelines	2.73% First trimester exposure 2.77% Any trimester exposure	1st-trimester exposed vs. unexposed, unadjusted OR (our analysis): A. 1.04 (0.72 to 1.52) B. 1.26 (0.98 to 1.63) C. 0.77 (0.59 to 1.01) D. 0.85 (0.64 to 1.13) E. 0.77 (0.52 to 1.15) **F. 0.74 (0.56 to 0.97)** G. 0.88 (0.48 to 1.61) H. 1.14 (0.58 to 2.24) **I. 1.38 (1.08 to 1.77)** J. 0.74 (0.50 to 1.09) K. 0.84 (0.55 to 1.29) L. 0.36 (0.11 to 1.12)
	Floridia et al, 2013[53] Italy	Preferred initial treatment drugs in U.S.: A. ABC (88; 7%) B. 3TC (544; 43%) C. TDF (173; 14%) D. FTC (87; 7%) E. ATV (63; 5%) F. RTV (231; 18%) Alternative initial treatment drugs in U.S.: G. ZDV (358; 28%) H. LPV (140; 11%) I. EFV (80; 6%) J. Any NRTI (716; 56%) K. Any PI (353; 28%) L. Any NNRTI (273; 21%) Total N=1,257	Birth defects Not defined	3.4%*	Not clear if ORs are adjusted; 1st-trimester exposure vs. unexposed: ABC, 1.01 (0.29 to 3.47); p=0.99 3TC, 1.14 (0.61 to 2.15); p=0.67 TD,F 0.85 (0.31 to 2.31); p=0.75 FTC, 0.67 (0.15 to 2.93); p=0.60 ATV, 0.93 (0.21 to 4.11); p=0.93 RTV, 1.02 (0.44 to 2.37); p=0.96 ZDV, 0.65 (0.28 to 1.51); p=0.32 LPV, 1.28 (0.50 to 3.26); p=0.61 EFV, 0.73 (0.17 to 3.20); p=0.68 Any NRTI, 0.95 (0.51 to 1.76); p=0.86 Any PI, 0.92 (0.43 to 1.95); p=0.82 Any NNRTI, 1.20 (0.56 to 2.55); p=0.64

Table 3. Studies Examining the Association Between Birth Outcomes and HIV Antiretroviral Therapy

Harm category	Study, year Country Study name	ART regimen (n; %)	Birth outcome Definition	Birth outcome Distribution	Magnitude of risk: adjusted OR (95% CI); p-value
Congenital Abnormalities	Knapp et al, 2012[55] U.S. (IMPAACT) These patients may also be represented in the Antiretroviral Pregnancy Registry	Preferred initial treatment drugs in U.S.: A. ABC (312; 28%) B. 3TC (979; 88%) C. TDF (235; 21%) D. FTC (121; 11%) E. ATV (104; 9%) F. RTV (131; 12%) Alternative initial treatment drugs in U.S.: G. ZDV (924; 83%) H. LPVr (306; 28%) I. EFV (56; 5%) J. Any NRTI (1,097; 99%) K. Any PI (804; 72%) L. Any NNRTI (205; 18%) Total N=1,112	Birth defects MACDP classification	5%*	All vs. unexposed: ABC 1st T, 1.45 (0.68 to 3.10) ABC 2-3 T, 1.25 (0.62 to 2.51) 3TC 1st T, 1.68 (0.61 to 4.58) 3TC 2-3 T, 1.52 (0.56 to 4.08) TDF 1st T, 1.69 (0.83 to 3.44) TDF 2-3 T, 1.01 (0.38 to 2.65) FTC 1st T, 1.33 (0.49 to 3.60) FTC 2-3 T, 0.56 (0.06 to 2.31) ATV 1st T, 1.83 (0.73 to 4.58) ATV 2-3 T, 0.87 (0.10 to 3.65) RTV 1st T, 1.60 (0.64 to 3.99) RTV 2-3 T, 1.18 (0.29 to 3.54) ZDV 1st T, 1.02 (0.45 to 2.28) ZDV 2-3 T, 1.02 (0.48 to 2.17) LPVr 1st T, 1.66 (0.81 to 3.38) LPVr 2-3 T, 0.80 (0.35 to 1.82) **EFV 1st T, 2.84 (1.13 to 7.16)** EFV 2-3 T, NA (0 to 9.05) Any NRTI 1st T, 0.84 (0.11 to 39.45) Any NRTI 2-3 T, 0.62 (0.08 to 29.05) Any PI 1st T, 1.32 (0.64 to 2.71) Any PI 2-3 T, 1.15 (0.58 to 2.29) Any NNRTI 1st T, 1.53 (0.72 to 3.25) Any NNRTI 2-3 T, 0.77 (0.14 to 2.69)

Table 3. Studies Examining the Association Between Birth Outcomes and HIV Antiretroviral Therapy

Harm category	Study, year Country Study name	ART regimen (n; %)	Birth outcome Definition	Birth outcome Distribution	Magnitude of risk: adjusted OR (95% CI); p-value
Congenital Abnormalities	Sibiude et al, 2014[71] France	Preferred initial treatment drugs in U.S.: A. ABC (1,104; 8%) B. 3TC (9,170; 70%) C. TDF (1,031; 8%) D. FTC (670; 5%) E. ATV (513; 4%) F. RTV (5,087; 39%) Alternative initial treatment drugs in U.S.: G. ZDV (10,760; 82%) H. LPV (3,704; 28%) I. EFV (389; 3%) J. Any NRTI (12,663; 96%) K. Any PI (7,235; 55%) L. Any NNRTI (1,504; 11%) Total N=13,124	Birth defects EUROCAT and MACDP classifications	EUROCAT 4.4%* MACDP 7.0%*	All vs. unexposed (EUROCAT): **ABC 1st T, 1.39 (1.06 to 1.83)** ABC 2-3 T, 1.16 (0.90 to 1.51) **3TC 1st T, 1.37 (1.06 to 1.73)** **3TC 2-3 T, 1.26 (1.01 to 1.57)** TDF 1st T, 0.75 (0.51 to 1.10) TDF 2-3 T, 0.82 (0.40 to 1.69) **FTC 1st T, 0.52 (0.30 to 0.90)** FTC 2-3 T, 1.38 (0.63 to 3.02) ATV 1st T, 0.58 (0.32 to 1.05) ATV 2-3 T, 1.23 (0.38 to 4.01) RTV 1st T, 0.86 (0.67 to 1.10) RTV 2-3 T, 0.92 (0.74 to 1.15) **ZDV 1st T, 1.39 (1.06 to 1.83)** ZDV 2-3 T, 1.16 (0.90 to 1.51) LPV 1st T, 0.92 (0.68 to 1.23) LPV 2-3 T, 1.13 (0.90 to 1.41) EFV 1st T, 1.16 (0.73 to 1.85) EFV 2-3 T, 1.83 (0.23 to 14.5) Any NRTI 1st T, 2.36 (0.86 to 6.47) Any NRTI 2-3 T, 2.04 (0.75 to 5.59) Any PI 1st T, 0.91 (0.73 to 1.13) Any PI 2-3 T, 0.94 (0.77 to 1.16) Any NNRTI 1st T, 1.02 (0.76 to 1.37) Any NNRTI 2-3 T, 1.21 (0.72 to 2.03)

Table 3. Studies Examining the Association Between Birth Outcomes and HIV Antiretroviral Therapy

Harm category	Study, year Country Study name	ART regimen (n; %)	Birth outcome Definition	Birth outcome Distribution	Magnitude of risk: adjusted OR (95% CI); p-value
Congenital Abnormalities	Williams et al, 2015[76] U.S. PHACS/SMARTT	Preferred initial treatment drugs in U.S.: A. ABC (222; 9%) B. 3TC (797; 32%) C. TDF (431; 17%) D. FTC (374; 15%) E. ATV (222; 9%) F. RTV (635; 25%) G. DRV (54; 2%) Alternative initial treatment drugs in U.S.: H. ZDV (726; 29%) I. LPV (341; 9%) J. EFV (94; 4%) K. Any NRTI (1,211; 48%) L. Any PI (887; 35%) M. Any NNRTI (214; 9%) Total N=2,580	Birth defects Antiretroviral Pregnancy Registry modification to MACDP classifications	6.8%	All vs. unexposed: A. 0.94 (0.53 to 1.65) B. 1.14 (0.81 to 1.60) C. 1.14 (0.76 to 1.71) D. 1.14 (0.74 to 1.74) E. **1.95 (1.24 to 3.05)** F. **1.56 (1.11 to 2.20)** G. 0.30 (0.04 to 2.21) H. 1.10 (0.78 to 1.56) I. 1.37 (0.90 to 2.09) J. 1.13 (0.51 to 2.50) K. 1.19 (0.86 to 1.65) L. **1.39 (1.00 to 1.92)** M. 0.97 (0.54 to 1.74)

Note: Studies that adjusted for confounders.
*Percent of study population.

Abbreviations: 3TC=lamivudine; ABC=abacavir; APGAR=appearance, pulse, grimace, activity, respiration; aRR=adjusted risk ratio; ART=antiretroviral therapy; ARV=antiretroviral; ATV=atazanavir; ATV/r=atazanavir/ritonavir; AZT=azidothymidine; CD4=cluster of differentiation 4; CI=confidence interval; D4T=stavudine; DRV=darunavir; EFV=efavirenz; EUROCAT=European Surveillance of Congenital Anomalies; FTC=emtricitabine; HAART=highly-active antiretroviral therapy; IMPAACT=International Maternal Pediatric Adolescents AIDS Clinical Trials Network; LPV=lopinavir; LPVr=lopinavir/ritonavir; MACDP=Metropolitan Atlanta Congenital Defects Program; NA=not assessed; NR=not reported; NNRTI=nonnucleoside reverse transcriptase inhibitor; NRTI=nucleoside reverse transcriptase inhibitor; NS=not significant; NVP=nevirapine; OR=odds ratio; PHACS=Pediatric HIV/AIDS Cohort Study; PI=protease inhibitor; RAL=raltegravir; RPV=rilpivirine; RR=relative risk; RTV=ritonavir; SGA=small size for gestational age; SMARTT=Surveillance Monitoring for ART Toxicities study; 1st T=first trimester; 2-3 T=second and third trimester; TDF=tenofovir disoproxil fumarate; TZV=abacavir/zidovudine/lamivudine; U.K.=United Kingdom; U.S.=United States; VSGA=very small size for gestational age; ZDV=zidovudine.

Table 4. Summary of Evidence

Key Question	No. of Studies (k) No. of Participants (n) Study Design	Summary of Findings by Outcome	Consistency/ Precision	Reporting Bias	Overall Risk of Bias/ Quality	Other Limitations	Strength of Evidence	Applicability
KQ 1. Benefits of screening	No studies	No studies	No studies	No studies	No studies	No studies	No studies	No studies
KQ 2. Yield of repeat HIV screening at different intervals	No studies	No studies	No studies	No studies	No studies	No studies	No studies	No studies
KQ 3. Harms of screening	No studies	No studies	No studies	No studies	No studies	No studies	No studies	No studies
KQ 4. Effectiveness of currently recommended ART regimens	2012 USPSTF review: 6 RCTs (N=3,534) and 8 cohort studies (N=27,776) New: 1 RCT (n=3,490), 4 cohort studies (N=14,344), and 1 individual patient data analysis of 7 cohorts (n=4,459)	Prior USPSTF review included 8 cohort studies that found full-course combination ART associated with mother-to-child transmission rates of <1% to 2.4%, compared with 9% to 22% with no ART. Five new cohort studies found full-course combination ART associated with risk of mother-to-child transmission of <1% to 2.8%. One African RCT reported a mother-to-child transmission rate of 0.5%.	Consistent No imprecision	No reporting bias detected	Moderate	Most evidence observational, with no RCT conducted in the U.S. or other high-income setting	High	Cohort studies conducted in high-income settings but RCT was conducted in Africa. Exact ART regimen not specified in most studies. Variability in timing of ART initiation.

Table 4. Summary of Evidence

Key Question	No. of Studies (k) No. of Participants (n) Study Design	Summary of Findings by Outcome	Consistency/ Precision	Reporting Bias	Overall Risk of Bias/ Quality	Other Limitations	Strength of Evidence	Applicability
KQ 5. Harms of currently recommended ART regimens	**Preterm Birth** 2012 USPSTF review: 1 RCT (n=560), 4 cohort studies (N=15,252) New: 1 RCT (n=3,490) and 17 cohort studies (N=48,452)	**Preterm Birth** Prior USPSTF review included 1 RCT and 4 cohort studies that found increased preterm birth associated with ART, 1 RCT and 3 cohort studies that found increased risk of preterm birth associated with ART that included a PI. One new RCT and 4 new cohort studies found increased risk of preterm birth with ART; 3 new cohort studies (all from Africa) found decreased risk of preterm birth with ART. One RCT and 3 cohort studies found ART that included a boosted PI associated with increased risk of preterm birth.	Inconsistent No imprecision	No reporting bias detected	Moderate	No U.S. RCTs or trials from nonresource-poor countries	Low	Cohort studies conducted in all settings; RCT was conducted primarily in Africa. Exact ART regimen not specified in most studies. Variability in timing of ART initiation.
	Overall Birth Defects 2012 USPSTF review: 4 cohort studies (N=21,113) New: 5 cohort studies (N=27,409)	**Overall Birth Defects** Prior USPSTF review found no association between ART and birth defects. Five new cohort studies found most currently recommended ART drugs not associated with increased risk of birth defects.	Consistent Precise	No reporting bias detected	Moderate	No RCTs	Moderate	Cohort studies conducted in high-resource settings. Individual ART drugs specified.

Table 4. Summary of Evidence

Key Question	No. of Studies (k) No. of Participants (n) Study Design	Summary of Findings by Outcome	Consistency/ Precision	Reporting Bias	Overall Risk of Bias/ Quality	Other Limitations	Strength of Evidence	Applicability
KQ 5 cont.	**Low Birth Weight** 2012 USPSTF review: 5 cohort studies (N=17,976) New: 1 RCT (n=3,490) and 5 cohort studies (N=11,213) **Small Size for Gestational Age** 2012 USPSTF review: 1 cohort study (n=7,635) New: 10 cohort studies (N=37,670) **Stillbirth** 2012 USPSTF review: None New: 6 cohort studies (N=30,417) **Neonatal Death** 2012 USPSTF review: None New: 1 RCT (n=3,490) and 3 cohort studies (N=7,038)	**Low Birth Weight** Prior evidence: No clear association between prenatal ART and low birth weight or intrauterine growth restriction. One new RCT and 4 cohort studies found no clear association between ART and low birth weight. **Small Size for Gestational Age** Nine new cohort studies found no clear association between ART and small size for gestational age. **Stillbirth** Three new cohort studies found no clear association between ART and stillbirth; 3 new cohort studies found mixed results for treatment with tenofovir disoproxil fumarate/emtricitabine vs. zidovudine/lamivudine. **Neonatal Death** One new RCT and 3 cohort studies found mixed results for neonatal death.	Consistent Imprecise	No reporting bias detected	Moderate	No U.S. RCTs or trials from nonresource-poor countries	Low	Cohort studies conducted in all settings; RCT was conducted in Africa. Exact ART regimen not specified in most studies. Variability in timing of ART initiation.

Table 4. Summary of Evidence

Key Question	No. of Studies (k) No. of Participants (n) Study Design	Summary of Findings by Outcome	Consistency/ Precision	Reporting Bias	Overall Risk of Bias/ Quality	Other Limitations	Strength of Evidence	Applicability
KQ 5 cont.	**Infant Cardiac Harms** 2012 USPSTF review: 2 cohort studies (N=734) New: 3 cohort studies (N=15,888)	**Infant Cardiac Harms** Prior USPSTF review included 1 cohort study that reported reduced left ventricular mass and increased left ventricular contractility at age 2 years with in utero ART exposure and 1 study found no association; no echocardiographic differences in children ages 2 to 5 years. Three new cohort studies found mixed evidence for zidovudine exposure in first trimester for increased congenital heart defects; mixed evidence for several ART drugs and echocardiographic changes but not clinical changes.	Consistent Imprecise	No reporting bias detected	Moderate	No RCTs; no studies of in utero exposed, HIV-uninfected children beyond age 7 years	Low	Cohort studies conducted in high-resource settings. Variability in timing of ART initiation.
	Infant Neurodevelopmental Harms 2012 USPSTF review: 3 cohort studies (N=2,590) New: SMARTT cohort (n=3,542)	**Infant Neurodevelopmental Harms** Prior USPSTF review found no association between in utero ART exposure and worse neurodevelopmental outcomes. New evidence from the SMARTT cohort found no positive association between ART and neurological development.	Consistent Precise	No reporting bias detected	Moderate	No RCT; drug regimens often not provided	Low	Cohort studies conducted in high-income settings. Variability in timing of ART initiation.

Table 4. Summary of Evidence

Key Question	No. of Studies (k) No. of Participants (n) Study Design	Summary of Findings by Outcome	Consistency/ Precision	Reporting Bias	Overall Risk of Bias/ Quality	Other Limitations	Strength of Evidence	Applicability
KQ 5 cont.	**Maternal Harms** 2012 USPSTF review: 1 meta-analysis (n=1,391) and 3 cohort studies (N=4,117) New: 2 RCTs (N=12,338)	**Maternal Harms** No association between zidovudine monotherapy and maternal death or long-term harms; possible association between increased risk for gestational diabetes; increased risk of anemia. Anemia in HIV-infected pregnant women improved with ART, iron, and folic acid; treatment with zidovudine-based or tenofovir-based ART resulted in increased risk for any grade 2 or higher maternal adverse event compared with zidovudine monotherapy, but few women left the study due to adverse events.	Inconsistent Precise	No reporting bias detected	Moderate	No U.S. RCTs or trials from nonresource-poor countries	Low	Cohort studies conducted in all settings; RCT conducted in Africa. Exact ART regimen not specified in most studies. Variability in timing of ART initiation.

Abbreviations: ART=antiretroviral therapy; KQ=key question; PI=protease inhibitor; RCT=randomized, controlled trial; SMARTT=Surveillance Monitoring for ART Toxicities Study; U.S.=United States; USPSTF=U.S. Preventive Services Task Force.

Appendix A1. Search Strategies

Screening

Database: Ovid MEDLINE(R) without Revisions

1 exp HIV/
2 HIV Antibodies/
3 HIV Antigens/
4 HIV Seroprevalence/
5 HIV Seropositivity/
6 HIV Seronegativity/
7 AIDS Serodiagnosis/
8 human immunodeficiency virus.ti,ab
9 hiv.ti,ab.
10 Mass Screening/
11 screen$.ti.
12 or/1-9
13 10 or 11
14 12 and 13
15 limit 14 to (english language and humans)
16 limit 15 to yr="2012 - 2018"
17 16 and pregnan*.ti,ab.
18 16 and mother*.ti,ab.
19 17 or 18

Database: EBM Reviews - Cochrane Central Register of Controlled Trials

1 exp HIV/
2 HIV Antibodies/
3 HIV Antigens/
4 HIV Seroprevalence/
5 HIV Seropositivity/
6 HIV Seronegativity/
7 AIDS Serodiagnosis/
8 human immunodeficiency virus.ti.
9 hiv.ti,ab.
10 Mass Screening/
11 screen$.ti.
12 or/1-9
13 10 or 11
14 12 and 13
15 limit 14 to yr="2012 - 2018"
16 limit 15 to english language
17 16 and (pregnan* or mother*).ti,ab.

Treatment

Database: Ovid MEDLINE(R) without Revisions and EBM Reviews - Cochrane Central Register of Controlled Trials

1 exp HIV Infections/dt, pc, th
2 exp Anti-Retroviral Agents/ad, tu
3 Antiretroviral Therapy, Highly Active/
4 or/1-3
5 Infectious Disease Transmission, Vertical/
6 ((mother* or child*) and transmission).mp.
7 5 or 6
8 4 and 7
9 limit 8 to yr="2012 - 2018"

10 limit 9 to (clinical trial, all or comparative study or meta analysis or randomized controlled trial or systematic reviews)
11 9 and (random* or control* or cohort).ti,ab.
12 10 or 11 (630)
13 12 and pregnan*.mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier] (450)

Treatment harms

Database: Ovid MEDLINE(R) without Revisions and EBM Reviews - Cochrane Central Register of Controlled Trials

1 exp HIV Infections/dt, pc, th [
2 exp Anti-Retroviral Agents/ad, tu
3 Antiretroviral Therapy, Highly Active/
4 or/1-3
5 4 and (harm* or safety or adverse).ti,ab.
6 limit 5 to yr="2012 - 2018"
7 6 and (pregnan* or mother*).mp.

Screening and treatment

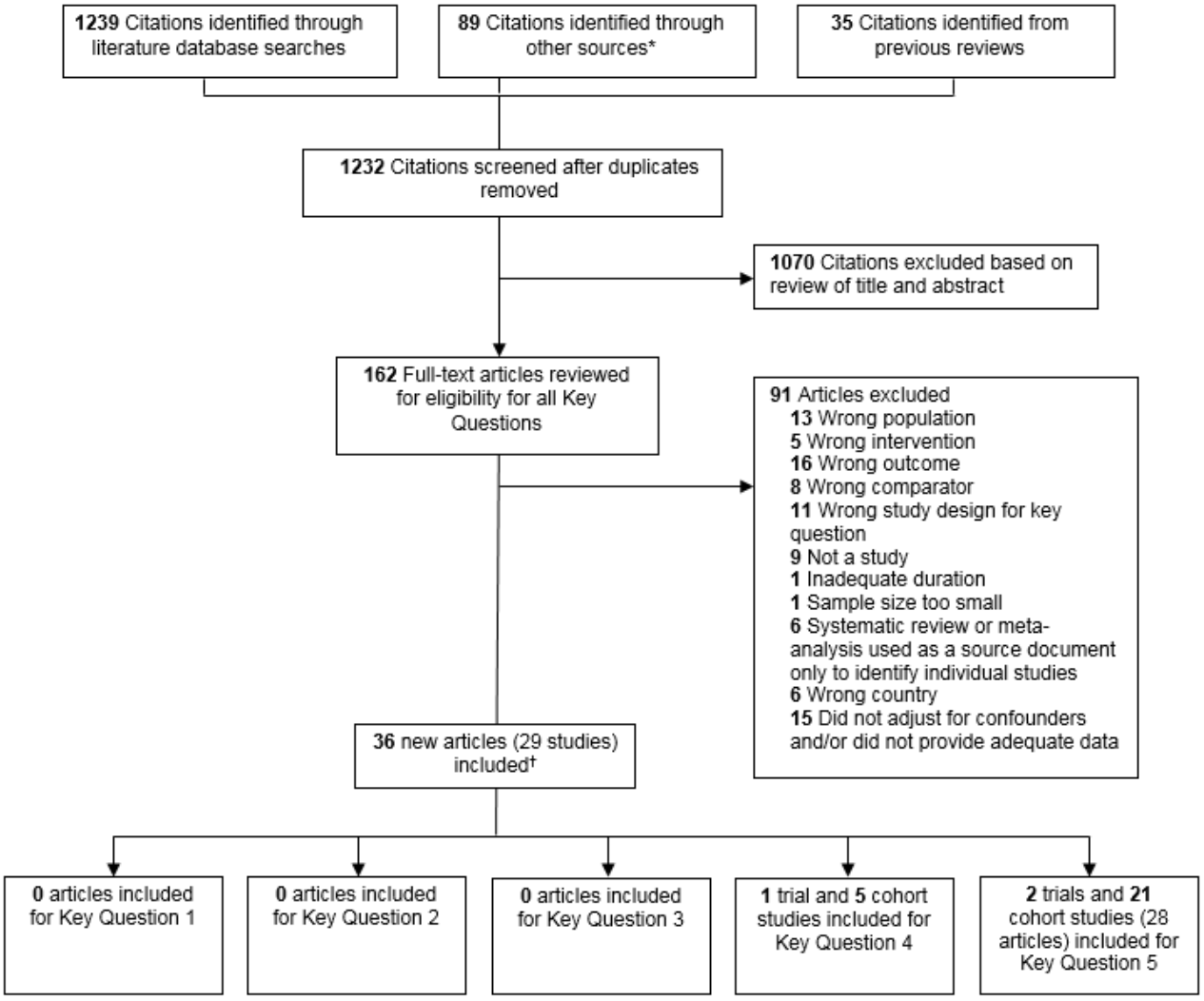
Database: EBM Reviews - Cochrane Database of Systematic Reviews
1 (hiv or "human immunodeficiency virus").ti.
2 1 and screen*.ti.
3 1 and (treatment or antiretroviral or therapy).ti.
4 2 or 3
5 4 and pregnan*.mp.

Appendix A2. Inclusion and Exclusion Criteria

Category	Include	Exclude
Settings	**KQs 1–3:** Primary care or other settings generalizable to primary care (e.g., prenatal, antenatal, and family planning clinics) and other health care settings in which screening is commonly performed (e.g., emergency room or urgent care) **KQs 4–5:** Focus on studies conducted in the United States and other high-income countries with low prevalence of HIV infection and in which management of HIV infection is similar to that in the United States, except for RCTs of ART and harms of treatment if currently recommended regimens or drugs are used	Studies of screening conducted in low- and middle-income countries, unless fair- or good-quality studies in the United States are not available
Populations	**KQs 1–3:** Asymptomatic pregnant women not known to be HIV positive, including adolescents (ages 13 to 18 years) **KQ 4:** Pregnant women living with HIV and their infants **KQ 5:** Women who received ART regimens while pregnant; neonates, infants, and children who were exposed to ART in utero	**KQs 1–3:** Women who have known HIV infection, are on dialysis, are posttransplant, or have occupational exposure (because of risk of needle stick or other parenteral exposure); women with known infection with hepatitis C virus, hepatitis B virus, or tuberculosis **KQs 4, 5:** Women who are already or were previously taking ART prior to pregnancy; women with acute HIV infection; studies limiting enrollment to persons with hepatitis C virus, hepatitis B virus, or tuberculosis coinfection
Interventions	**KQs 1–3:** Rapid or standard HIV antibody testing with confirmatory testing **KQs 4, 5:** Currently recommended ART regimens or drugs, or studies published since 2012 that reported outcomes for combination antiretroviral regimens and reported the categorizations for ART regimens used in the study	**KQs 4, 5:** Regimens that are clearly outside of current U.S. practice; Women who discontinued ART during pregnancy; women with treatment interruption
Comparisons	**KQs 1, 3:** HIV screening vs. no screening **KQ 2:** Repeat HIV screening during pregnancy vs. one-time screening; screening at one interval vs. another **KQs 4, 5:** Currently recommended ART regimens; full-course combination ART vs. no ART, abbreviated courses of ART, or one- or two-drug therapy	
Outcomes	**KQs 1, 4:** Mother-to-child HIV transmission rates **KQ 2:** Yield of screening (number of cases of HIV infection identified per number of tests performed) **KQ 3:** Harms of screening, including false-positive results, anxiety and effects of labeling, and partner discord, abuse, or violence **KQ 5:** Maternal and infant harms of treatment, including long-term harms following in utero exposure to ART	**KQs 1, 5:** Pharmacokinetic outcomes
Study designs/ countries	**KQs 1–3:** RCTs and controlled observational studies **KQ 4:** RCTs in any country as long as recommended ART regimens were evaluated, and observational studies in countries similar to the United States **KQ 5:** RCTs and observational studies that controlled for potential confounders; any countries as long as recommended ART regimens were evaluated	**KQs 1–4:** Modeling studies
Timing	**KQ 5:** Any timing	

Abbreviations: ART=antiretroviral therapy; KQ=key question; RCT=randomized, controlled trial.

Appendix A3. Literature Flow Diagram



*Other sources include reference lists of relevant articles, studies, and systematic reviews and suggestions from reviewers; also includes background articles.
†In addition, 33 studies (in 35 articles) were carried forward from the prior U.S. Preventive Services Task Force reviews.

Appendix A4. Included Studies List

Aaron E, Bonacquisti A, Mathew L, et al. Small-for-gestational-age births in pregnant women with HIV, due to severity of HIV disease, not antiretroviral therapy. Infect Dis Obstet Gynecol. 2012;2012:135030. doi: 10.1155/2012/135030. PMID: 22778533.

Antiretroviral Pregnancy Registry Steering Committee. Antiretroviral Pregnancy Registry Interim Report for 1 January 1989 through 31 January 2018. Wilmington, NC: Registry Coordinating Center; 2018. http://www.apregistry.com/forms/interim_report.pdf Accessed July 27, 2018.

Berard A, Sheehy O, Zhao JP, et al. Antiretroviral combination use during pregnancy and the risk of major congenital malformations. AIDS. 2017;31(16):2267-77. doi: 10.1097/QAD.0000000000001610. PMID: 28806195.

Chagomerana MB, Miller WC, Pence BW, et al. PMTCT option B+ does not increase preterm birth risk and may prevent extreme prematurity: A retrospective cohort study in Malawi. J Acquir Immune Defic Syndr. 2017;74(4):367-74. doi: 10.1097/QAI.0000000000001253. PMID: 27875363.

Chen JY, Ribaudo HJ, Souda S, et al. Highly active antiretroviral therapy and adverse birth outcomes among HIV-infected women in Botswana. J Infect Dis. 2012;206(11):1695-705. doi: 10.1093/infdis/jis553. PMID: 23066160.

Chiappini E, Galli L, Giaquinto C, et al. Use of combination neonatal prophylaxis for the prevention of mother-to-child transmission of HIV infection in European high-risk infants. AIDS. 2013;27(6):991-1000. doi: 10.1097/QAD.0b013e32835cffb1. PMID: 23211776.

Duryea E, Nicholson F, Cooper S, et al. The use of protease inhibitors in pregnancy: maternal and fetal considerations. Infect Dis Obstet Gynecol. 2015 doi: 10.1155/2015/563727. PMID: 26617456.

Floridia M, Mastroiacovo P, Tamburrini E, et al. Birth defects in a national cohort of pregnant women with HIV infection in Italy, 2001-2011. BJOG. 2013;120(12):1466-75. doi: 10.1111/1471-0528.12285. PMID: 23721372.

Fowler MG, Qin M, Fiscus SA, et al. Benefits and risks of antiretroviral therapy for perinatal HIV prevention. N Engl J Med. 2016;375(18):1726-37. doi: 10.1056/NEJMoa1511691. PMID: 27806243.

Kakkar F, Boucoiran I, Lamarre V, et al. Risk factors for pre-term birth in a Canadian cohort of HIV-positive women: role of ritonavir boosting? J Int AIDS Soc. 2015;18:19933. doi: 10.7448/IAS.18.1.19933. PMID: 26051165.

Knapp KM, Brogly SB, Muenz DG, et al. Prevalence of congenital anomalies in infants with in utero exposure to antiretrovirals. Pediatr Infect Dis J. 2012;31(2):164-70. doi: 10.1097/INF.0b013e318235c7aa. PMID: 21983213.

Kreitchmann R, Li SX, Melo VH, et al. Predictors of adverse pregnancy outcomes in women infected with HIV in Latin America and the Caribbean: a cohort study. BJOG. 2014;121(12):1501-8. doi: 10.1111/1471-0528.12680. PMID: 24602102.

Li N, Sando MM, Spiegelman D, et al. Antiretroviral therapy in relation to birth outcomes among HIV-infected women: a cohort study. J Infect Dis. 2016;213(7):1057-64. doi: 10.1093/infdis/jiv389. PMID: 26265780.

Lipshultz SE, Williams PL, Zeldow B, et al. Cardiac effects of in-utero exposure to antiretroviral therapy in HIV-uninfected children born to HIV-infected mothers. AIDS. 2015;29(1):91-100. doi: 10.1097/QAD.0000000000000499. PMID: 25562493.

Lopez M, Figueras F, Hernandez S, et al. Association of HIV infection with spontaneous and iatrogenic preterm delivery: effect of HAART. AIDS. 2012;26(1):37-43. doi: 10.1097/QAD.0b013e32834db300. PMID: 22008651.

Lu D, Liu J, Samson L, et al. Factors responsible for mother-to-child HIV transmission in Ontario, Canada, 1996-2008. Can J Public Health. 2014;105(1):e47-52. PMID: 24735697.

Mandelbrot L, Tubiana R, Le Chenadec J, et al. No perinatal HIV-1 transmission from women with effective antiretroviral therapy starting before conception. Clin Infect Dis. 2015;61(11):1715-25. doi: 10.1093/cid/civ578. PMID: 26197844.

Moodley T, Moodley D, Sebitloane M, et al. Improved pregnancy outcomes with increasing antiretroviral coverage in South Africa. BMC Pregnancy Childbirth. 2016;16:35. doi: 10.1186/s12884-016-0821-3. PMID: 26867536.

Mor Z, Sheffer R, Chemtob D. Mother-to-child HIV transmissions in Israel, 1985-2011. Epidemiol Infect. 2017;145(9):1913-21. doi: 10.1017/s0950268817000577. PMID: 28374653.

Nozyce ML, Huo Y, Williams PL, et al. Safety of in utero and neonatal antiretroviral exposure: cognitive and academic outcomes in HIV-exposed, uninfected children 5-13 years of age. Pediatr Infect Dis J. 2014;33(11):1128-33. doi: 10.1097/INF.0000000000000410. PMID: 25361407.

Pintye J, Baeten JM, Celum C, et al. Maternal tenofovir disoproxil fumarate use during pregnancy is not associated with adverse perinatal outcomes among HIV-infected East African women: A prospective study. J Infect Dis. 2017;216(12):1561-8. doi: 10.1093/infdis/jix542. PMID: 29040666.

Ramokolo V, Goga AE, Lombard C, et al. In utero ART exposure and birth and early growth outcomes among HIV-exposed uninfected infants attending immunization services: Results from National PMTCT Surveillance, South Africa. Open Forum Infect. 2017;4(4):ofx187. doi: 10.1093/ofid/ofx187. PMID: 29062860.

Appendix A4. Included Studies List

Rough K, Seage GR, 3rd, Williams PL, et al. Birth outcomes for pregnant women with HIV using tenofovir-emtricitabine. N Engl J Med. 2018;378(17):1593-603. doi: 10.1056/NEJMoa1701666. PMID: 29694825.

Sartorius BK, Chersich MF, Mwaura M, et al. Maternal anaemia and duration of zidovudine in antiretroviral regimens for preventing mother-to-child transmission: a randomized trial in three African countries. BMC Infect Dis. 2013;13:522. doi: 10.1186/1471-2334-13-522. PMID: 24192332.

Short CE, Douglas M, Smith JH, et al. Preterm delivery risk in women initiating antiretroviral therapy to prevent HIV mother-to-child transmission. HIV Med. 2014;15(4):233-8. doi: 10.1111/hiv.12083. PMID: 24025074.

Siberry GK, Williams PL, Mendez H, et al. Safety of tenofovir use during pregnancy: early growth outcomes in HIV-exposed uninfected infants. AIDS. 2012;26(9):1151-9. doi: 10.1097/QAD.0b013e328352d135. PMID: 22382151.

Sibiude J, Le Chenadec J, Bonnet D, et al. In utero exposure to zidovudine and heart anomalies in the ANRS French perinatal cohort and the nested PRIMEVA randomized trial. Clin Infect Dis. 2015;61(2):270-80. doi: 10.1093/cid/civ260. PMID: 25838291.

Sibiude J, Mandelbrot L, Blanche S, et al. Association between prenatal exposure to antiretroviral therapy and birth defects: an analysis of the French perinatal cohort study (ANRS CO1/CO11). PLoS Med. 2014;11(4):e1001635. doi: 10.1371/journal.pmed.1001635. PMID: 24781315.

Sibiude J, Warszawski J, Tubiana R, et al. Premature delivery in HIV-infected women starting protease inhibitor therapy during pregnancy: role of the ritonavir boost? Clin Infect Dis. 2012;54(9):1348-60. doi: 10.1093/cid/cis198. PMID: 22460969.

Snijdewind IJM, Smit C, Godfried MH, et al. Preconception use of cART by HIV-positive pregnant women increases the risk of infants being born small for gestational age. PLoS ONE. 2018;13(1):e0191389. doi: 10.1371/journal.pone.0191389. PMID: 29351561.

Tookey PA, Thorne C, van Wyk J, et al. Maternal and foetal outcomes among 4118 women with HIV infection treated with lopinavir/ritonavir during pregnancy: analysis of population-based surveillance data from the national study of HIV in pregnancy and childhood in the United Kingdom and Ireland. BMC Infect Dis. 2016;16:65. doi: 10.1186/s12879-016-1400-y. PMID: 26847625.

Watts DH, Williams PL, Kacanek D, et al. Combination antiretroviral use and preterm birth. J Infect Dis. 2013;207(4):612-21. doi: 10.1093/infdis/jis728. PMID: 23204173.

Williams PL, Crain MJ, Yildirim C, et al. Congenital anomalies and in utero antiretroviral exposure in human immunodeficiency virus-exposed uninfected infants. JAMA Pediatr. 2015;169(1):48-55. doi: 10.1001/jamapediatrics.2014.1889. PMID: 25383770.

Williams PL, Hazra R, Van Dyke RB, et al. Antiretroviral exposure during pregnancy and adverse outcomes in HIV-exposed uninfected infants and children using a trigger-based design. AIDS. 2016;30(1):133-44. doi: 10.1097/QAD.0000000000000916. PMID: 26731758.

Zash R, Jacobson DL, Diseko M, et al. Comparative safety of antiretroviral treatment regimens in pregnancy. JAMA Pediatr. 2017;171(10):e172222. doi: 10.1001/jamapediatrics.2017.2222. PMID: 28783807.

Zash R, Souda S, Chen JY, et al. Reassuring birth outcomes with tenofovir/emtricitabine/efavirenz used for prevention of mother-to-child transmission of HIV in Botswana. J Acquir Immune Defic Syndr. 2016;71(4):428-36. doi: 10.1097/QAI.0000000000000847. PMID: 26379069.

Appendix A5. Excluded Studies List

Abimpaye M, Kirk CM, Iyer HS, et al. The impact of "Option B" on HIV transmission from mother to child in Rwanda: An interrupted time series analysis. PLoS ONE. 2018;13(2):e0192910. doi: 10.1371/journal.pone.0192910. PMID: 29451925. Excluded: wrong population.

Ajibola G, Zash R, Shapiro RL, et al. Detecting congenital malformations - Lessons learned from the Mpepu study, Botswana. PLoS One. 2017;12(3):e0173800. doi: 10.1371/journal.pone.0173800. PMID: 28339500. Excluded: did not adjust for confounders and/or did not provide adequate data.

Ambia J, Mandala J. A systematic review of interventions to improve prevention of mother-to-child HIV transmission service delivery and promote retention. J Int AIDS Soc. 2016;19(1):20309. doi: 10.7448/IAS.19.1.20309. PMID: 27056361. Excluded: wrong outcome.

Association of Women's Health Obstetric Neonatal Nursing. HIV screening for pregnant women and infants. Nurs Womens Health. 2012 Feb-Mar;16(1):88-9. doi: 10.1111/j.1751-486X.2012.01711.x. PMID: 22900734. Excluded: wrong study design for Key Question.

Awodele O, Popoola D, Odunsi P, et al. Assessing the risk of birth defects associated with exposure to highly active anti-retroviral therapy during organogenesis in rats. Tokai J Exp Clin Med. 2013 Jul;38(2):82-92. PMID: 23868740. Excluded: wrong population.

Bera E, Mia R. Safety of nevirapine in HIV-infected pregnant women initiating antiretroviral therapy at higher CD4 counts: a systematic review and meta-analysis. S Afr Med J. 2012 Nov;102(11 Pt 1):855-9. doi: 10.7196/samj.5700. PMID: 23116743. Excluded: systematic review or meta-analysis used as a source document only to identify individual studies.

Bisio F, Nicco E, Calzi A, et al. Pregnancy outcomes following exposure to efavirenz-based antiretroviral therapy in the Republic of Congo. New Microbiol. 2015 Apr;38(2):185-92. PMID: 25938743. Excluded: did not adjust for confounders and/or did not provide adequate data.

Bispo S, Chikhungu L, Rollins N, et al. Postnatal HIV transmission in breastfed infants of HIV-infected women on ART: a systematic review and meta-analysis. J Int AIDS Soc. 2017 02 22;20(1):21251. doi: 10.7448/IAS.20.1.21251. PMID: 28362072. Excluded: wrong population.

Bokharaei-Salim F, Kalantari S, Gholamypour Z, et al. Investigation of the effects of a prevention of mother-to-child HIV transmission program among Iranian neonates. Arch Virol. 2018 May;163(5):1179-85. doi: 10.1007/s00705-017-3661-1. PMID: 29383588. Excluded: did not adjust for confounders and/or did not provide adequate data.

Bolduc P, Roder N, Colgate E, et al. Care of patients with HIV infection: diagnosis and monitoring. Fp Essent. 2016 Apr;443:11-5. PMID: 27092562. Excluded: not a study (letter, editorial, non-systematic review article, no original data).

Browne JL, Schrier VJ, Grobbee DE, et al. HIV, antiretroviral therapy, and hypertensive disorders in pregnancy: a systematic review and meta-analysis. J Acquir Immune Defic Syndr. 2015 Sep 1;70(1):91-8. doi: 10.1097/QAI.0000000000000686. PMID: 26322669. Excluded: systematic review or meta-analysis used as a source document only to identify individual studies.

Bunupuradah T, Phupitakphol T, Sophonphan J, et al. Prevalence of persistent renal dysfunction in perinatally HIV-infected Thai adolescents. Pediatr Infect Dis J. 2018 Jan;37(1):66-70. doi: 10.1097/INF.0000000000001684. PMID: 28719505. Excluded: wrong population.

Caniglia EC, Zash R, Jacobson DL, et al. Emulating a target trial of antiretroviral therapy regimens started before conception and risk of adverse birth outcomes. AIDS. 2018 Jan 02;32(1):113-20. doi: 10.1097/QAD.0000000000001673. PMID: 29112066. Excluded: wrong population.

Cecchini DM, Martinez MG, Morganti LM, et al. Antiretroviral therapy containing raltegravir to prevent mother-to-child transmission of HIV in infected pregnant women. Infect Dis Rep. 2017 May 31;9(2):7017. doi: 10.4081/idr.2017.7017. PMID: 28663779. Excluded: did not adjust for confounders and/or did not provide adequate data.

Centers for Disease Control and Prevention. HIV/AIDS HIV among pregnant women, infants, and children. 2016. http://www.cdc.gov/hiv/group/gender/pregnantwomen/index.html. Accessed October 28, 2016. Excluded: not a study (letter, editorial, non-systematic review article, no original data).

Cha S, Malik T, Abara WE, et al. Screening for syphilis and other sexually transmitted infections in pregnant women - Guam, 2014. MMWR Morb Mortal Wkly Rep. 2017 Jun 23;66(24):644-8. doi: 10.15585/mmwr.mm6624a4. PMID: 28640799. Excluded: wrong outcome.

Chaiyachati KH, Ogbuoji O, Price M, et al. Interventions to improve adherence to antiretroviral therapy: a rapid systematic review. AIDS. 2014 Mar;28 Suppl 2:S187-204. doi: 10.1097/QAD.0000000000000252. PMID: 24849479. Excluded: wrong outcome.

Chaudhury S, Williams PL, Mayondi GK, et al. Neurodevelopment of HIV-exposed and HIV-unexposed uninfected children at 24 months. Pediatrics. 2017 Oct;140(4)doi: 10.1542/peds.2017-0988. PMID: 28912368. Excluded: wrong comparator.

Appendix A5. Excluded Studies List

Colbers AP, Hawkins DA, Gingelmaier A, et al. The pharmacokinetics, safety and efficacy of tenofovir and emtricitabine in HIV-1-infected pregnant women. AIDS. 2013 Mar 13;27(5):739-48. doi: 10.1097/QAD.0b013e32835c208b. PMID: 23169329. Excluded: sample size too small.

Coovadia HM, Brown ER, Fowler MG, et al. Efficacy and safety of an extended nevirapine regimen in infant children of breastfeeding mothers with HIV-1 infection for prevention of postnatal HIV-1 transmission (HPTN 046): a randomised, double-blind, placebo-controlled trial. Lancet. 2012 Jan 21;379(9812):221-8. doi: 10.1016/S0140-6736(11)61653-X. PMID: 22196945. Excluded: wrong population.

Currier J, et al. Randomized trial of stopping or continuing ART among postpartum women with pre-ART CD4 ≥400 cells/mm^3 (PROMISE 1077HS). 21st International AIDS Conference (AIDS 2016). 2016. Excluded: not a study (letter, editorial, non-systematic review article, no original data).

da Silva KM, de Sa CD, Carvalho R. Evaluation of motor and cognitive development among infants exposed to HIV. Early Hum Dev. 2017 Feb;105:7-10. doi: 10.1016/j.earlhumdev.2016.12.013. PMID: 28088692. Excluded: wrong comparator.

d'Arminio Monforte A, Galli L, Lo Caputo S, et al. Pregnancy outcomes among ART-naive and ART-experienced HIV-positive women: data from the ICONA foundation study group, years 1997-2013. J Acquir Immune Defic Syndr. 2014 Nov 1;67(3):258-67. doi: 10.1097/QAI.0000000000000297. PMID: 25314248. Excluded: wrong outcome.

Davis NL, Miller WC, Hudgens MG, et al. Adherence to extended postpartum antiretrovirals is associated with decreased breast milk HIV-1 transmission. AIDS. 2014 Nov 28;28(18):2739-49. doi: 10.1097/QAD.0000000000000492. PMID: 25493600. Excluded: wrong intervention.

Decker S, Rempis E, Schnack A, et al. Prevention of mother-to-child transmission of HIV: Postpartum adherence to Option B+ until 18 months in Western Uganda. PLoS One. 2017;12(6):e0179448. doi: 10.1371/journal.pone.0179448. PMID: 28662036. Excluded: wrong outcome.

Del Bianco G, Bell CS, Benjamins LJ, et al. Persistently high perinatal transmission of HIV: assessment of risk factors. Pediatr Infect Dis J. 2014 Jun;33(6):e151-7. doi: 10.1097/INF.0000000000000199. PMID: 24836756. Excluded: did not adjust for confounders and/or did not provide adequate data.

Dinh TH, Delaney KP, Goga A, et al. Impact of maternal HIV seroconversion during pregnancy on early mother to child transmission of HIV (MTCT) measured at 4-8 weeks postpartum in South Africa 2011-2012: A national population-based evaluation. PLoS One. 2015;10(5):e0125525. doi: 10.1371/journal.pone.0125525. PMID: 25942423. Excluded: wrong country.

Domingues R, Saraceni V, Leal MDC. Mother to child transmission of HIV in Brazil: Data from the "Birth in Brazil study", a national hospital-based study. PLoS ONE. 2018;13(2):e0192985. doi: 10.1371/journal.pone.0192985. PMID: 29438439. Excluded: wrong country.

Downie J, Mactier H, Bland RM. Should pregnant women with unknown HIV status be offered rapid HIV testing in labour? Arch Dis Child Fetal Neonatal Ed. 2016 Jan;101(1):F79-84. doi: 10.1136/archdischild-2014-307226. PMID: 26668051. Excluded: wrong intervention.

Drake AL, Wagner A, Richardson B, et al. Incident HIV during pregnancy and postpartum and risk of mother-to-child HIV transmission: a systematic review and meta-analysis. PLoS Med. 2014 Feb;11(2):e1001608. doi: 10.1371/journal.pmed.1001608. PMID: 24586123. Excluded: wrong study design for Key Question.

Eleje GU, Edokwe ES, Ikechebelu JI, et al. Mother-to-child transmission of human immunodeficiency virus (HIV) among HIV-infected pregnant women on highly active anti-retroviral therapy with premature rupture of membranes at term. J Matern Fetal Neonatal Med. 2018 Jan;31(2):184-90. doi: 10.1080/14767058.2017.1279600. PMID: 28064549. Excluded: wrong population.

Faghih S, Secord E. Increased adolescent HIV infection during pregnancy leads to increase in perinatal transmission at urban referral center. J Int Assoc Physicians AIDS Care (Chic). 2012 Sep-Oct;11(5):293-5. doi: 10.1177/1545109712446175. PMID: 22628370. Excluded: wrong study design for Key Question.

Fitz Harris LF, Taylor AW, Zhang F, et al. Factors associated with human immunodeficiency virus screening of women during pregnancy, labor and delivery, United States, 2005-2006. Matern Child Health J. 2014 Apr;18(3):648-56. doi: 10.1007/s10995-013-1289-7. PMID: 23836013. Excluded: wrong outcome.

Frederick T, Homans J, Spencer L, et al. The effect of prenatal highly active antiretroviral therapy on the transmission of congenital and perinatal/early postnatal cytomegalovirus among HIV-infected and HIV-exposed infants. Clin Infect Dis. 2012 Sep;55(6):877-84. doi: 10.1093/cid/cis535. PMID: 22675157. Excluded: wrong study design for Key Question.

Gertsch A, Michel O, Locatelli I, et al. Adherence to antiretroviral treatment decreases during postpartum compared to pregnancy: a longitudinal electronic monitoring study. Aids Patient Care STDS. 2013 Apr;27(4):208-10. doi: 10.1089/apc.2013.0005. PMID: 23506310. Excluded: wrong outcome.

Appendix A5. Excluded Studies List

Gibb DM, Kizito H, Russell EC, et al. Pregnancy and infant outcomes among HIV-infected women taking long-term ART with and without tenofovir in the DART trial. PLoS Med. 2012;9(5):e1001217. doi: 10.1371/journal.pmed.1001217. PMID: 22615543. Excluded: wrong country.

Gill MM, Hoffman HJ, Ndatimana D, et al. 24-month HIV-free survival among infants born to HIV-positive women enrolled in Option B+ program in Kigali, Rwanda: The Kabeho Study. Medicine (Baltimore). 2017 Dec;96(51):e9445. doi: 10.1097/MD.0000000000009445. PMID: 29390577. Excluded: wrong population.

Gonzalez R, Ruperez M, Sevene E, et al. Effects of HIV infection on maternal and neonatal health in southern Mozambique: A prospective cohort study after a decade of antiretroviral drugs roll out. PLoS One. 2017;12(6):e0178134. doi: 10.1371/journal.pone.0178134. PMID: 28575010. Excluded: wrong comparator.

Harmsen MJ, Browne JL, Venter F, et al. The association between HIV (treatment), pregnancy serum lipid concentrations and pregnancy outcomes: a systematic review. BMC Infect Dis. 2017 Jul 11;17(1):489. doi: 10.1186/s12879-017-2581-8. PMID: 28697741. Excluded: wrong outcome.

Heemelaar S, Habets N, Makukula Z, et al. Repeat HIV testing during pregnancy and delivery: missed opportunities in a rural district hospital in Zambia. Trop Med Int Health. 2015 Mar;20(3):277-83. doi: 10.1111/tmi.12432. PMID: 25418130. Excluded: did not adjust for confounders and/or did not provide adequate data.

Hernandez S, Catalan-Garcia M, Moren C, et al. Placental mitochondrial toxicity, oxidative stress, apoptosis, and adverse perinatal outcomes in HIV pregnancies under antiretroviral treatment containing zidovudine. J Acquir Immune Defic Syndr. 2017 Aug 01;75(4):e113-e9. doi: 10.1097/QAI.0000000000001334. PMID: 28234688. Excluded: wrong comparator.

Huang X, Xu Y, Yang Q, et al. Efficacy and biological safety of lopinavir/ritonavir based anti-retroviral therapy in HIV-1-infected patients: a meta-analysis of randomized controlled trials. Sci Rep. 2015;5 PMID: 25704206. Excluded: wrong study design for Key Question.

Inzaule SC, Osi SJ, Akinbiyi G, et al. High prevalence of HIV drug resistance among newly diagnosed infants aged <18 months: results from a nationwide surveillance in Nigeria. J Acquir Immune Defic Syndr. 2018 01 01;77(1):e1-e7. doi: 10.1097/QAI.0000000000001553. PMID: 28961680. Excluded: wrong outcome.

Jao J, Abrams EJ. Metabolic complications of in utero maternal HIV and antiretroviral exposure in HIV-exposed infants. Pediatr Infect Dis J. 2014 Jul;33(7):734-40. doi: 10.1097/INF.0000000000000224. PMID: 24378947. Excluded: wrong study design for Key Question.

Johnson M, Afonina L, Haanyama O. The challenges of testing for HIV in women: experience from the UK and other European countries. Antivir Ther. 2013;18 Suppl 2:19-25. doi: 10.3851/IMP2637. PMID: 23784671. Excluded: not a study (letter, editorial, non-systematic review article, no original data).

Kakkar FW, Samson L, Vaudry W, et al. Safety of combination antiretroviral prophylaxis in high-risk HIV-exposed newborns: a retrospective review of the Canadian experience. J Int AIDS Soc. 2016;19(1):20520. doi: 10.7448/IAS.19.1.20520. PMID: 26880241. Excluded: wrong population.

Kim LH, Cohan DL, Sparks TN, et al. The cost-effectiveness of repeat HIV testing during pregnancy in a resource-limited setting. JAIDS. 2013 Jun 1;63(2):195-200. doi: 10.1097/QAI.0b013e3182895565. PMID: 23392461. Excluded: wrong country.

Koss CA, Natureeba P, Plenty A, et al. Risk factors for preterm birth among HIV-infected pregnant Ugandan women randomized to lopinavir/ritonavir- or efavirenz-based antiretroviral therapy. J Acquir Immune Defic Syndr. 2014 Oct 01;67(2):128-35. doi: 10.1097/qai.0000000000000281. PMID: 25072616. Excluded: did not adjust for confounders and/or did not provide adequate data.

Lassi ZS, Imam AM, Dean SV, et al. Preconception care: preventing and treating infections. Reprod Health. 2014 Sep 26;11 Suppl 3:S4. doi: 10.1186/1742-4755-11-S3-S4. PMID: 25415557. Excluded: wrong outcome.

le Roux SM, Jao J, Brittain K, et al. Tenofovir exposure in utero and linear growth in HIV-exposed, uninfected infants. AIDS. 2017 Jan 02;31(1):97-104. doi: 10.1097/QAD.0000000000001302. PMID: 27898591. Excluded: wrong outcome.

Liao C, Golden WC, Anderson JR, et al. Missed opportunities for repeat HIV testing in pregnancy: Implications for elimination of mother-to-child transmission in the United States. Aids Patient Care STDS. 2017 Jan;31(1):20-6. doi: 10.1089/apc.2016.0204. PMID: 27936863. Excluded: wrong study design for Key Question.

Lin AW, Wong KH, Chan K, et al. Accelerating prevention of mother-to-child transmission of HIV: ten-year experience of universal antenatal HIV testing programme in a low HIV prevalence setting in Hong Kong. AIDS Care. 2014 Feb;26(2):169-75. doi: 10.1080/09540121.2013.819402. PMID: 23869699. Excluded: wrong outcome.

Liotta G, Mancinelli S, Nielsen-Saines K, et al. Reduction of maternal mortality with highly active antiretroviral therapy in a large cohort of HIV-infected pregnant women in Malawi and Mozambique. PLoS One. 2013;8(8):e71653. doi: 10.1371/journal.pone.0071653. PMID: 23990966. Excluded: wrong comparator.

Appendix A5. Excluded Studies List

Little KM, Taylor AW, Borkowf CB, et al. Perinatal antiretroviral exposure and prevented mother-to-child HIV infections in the era of antiretroviral prophylaxis in the United States, 1994-2010. Pediatr Infect Dis J. 2017 Jan;36(1):66-71. doi: 10.1097/INF.0000000000001355. PMID: 27749662. Excluded: wrong study design for Key Question.

Liu KC, Chibwesha CJ. Intrapartum management for prevention of mother-to-child transmission of HIV in resource-limited settings: a review of the literature. Afr J Reprod Health. 2013 Dec;17(4 Spec No):107-17. PMID: 24689322. Excluded: not a study (letter, editorial, non-systematic review article, no original data).

Malaba TR, Phillips T, Le Roux S, et al. Antiretroviral therapy use during pregnancy and adverse birth outcomes in South African women. Int J Epidemiol. 2017 Oct 01;46(5):1678-89. doi: 10.1093/ije/dyx136. PMID: 29040569. Excluded: wrong comparator.

Mesfin YM, Kibret KT, Taye A. Is protease inhibitors based antiretroviral therapy during pregnancy associated with an increased risk of preterm birth? Systematic review and a meta-analysis. Reprod Health. 2016 Apr 5;13:30. doi: 10.1186/s12978-016-0149-5. PMID: 27048501. Excluded: systematic review or meta-analysis used as a source document only to identify individual studies.

Minniear TD, Girde S, Angira F, et al. Outcomes in a cohort of women who discontinued maternal triple-antiretroviral regimens initially used to prevent mother-to-child transmission during pregnancy and breastfeeding--Kenya, 2003-2009. PLoS One. 2014;9(4):e93556. doi: 10.1371/journal.pone.0093556. PMID: 24733021. Excluded: wrong study design for Key Question.

Moodley D, Esterhuizen TM, Pather T, et al. High HIV incidence during pregnancy: compelling reason for repeat HIV testing. AIDS. 2009 Jun 19;23(10):1255-9. doi: 10.1097/QAD.0b013e32832a5934. PMID: 19455017. Excluded: wrong country.

Mora S, Diceglie C, Vigano A, et al. Antiretroviral therapy and pregnancy: effect on cortical bone status of human immunodeficiency virus-infected Caucasian women as assessed by quantitative ultrasonography. Calcif Tissue Int. 2013 Apr;92(4):394-8. doi: 10.1007/s00223-013-9696-8. PMID: 23307187. Excluded: wrong comparator.

Mora S, Giacomet V, Vigano A, et al. Exposure to antiretroviral agents during pregnancy does not alter bone status in infants. Bone. 2012 Jan;50(1):255-8. doi: 10.1016/j.bone.2011.10.030. PMID: 22080170. Excluded: wrong comparator.

Myer L, Zulliger R, Bekker LG, et al. Systemic delays in the initiation of antiretroviral therapy during pregnancy do not improve outcomes of HIV-positive mothers: a cohort study. BMC Pregnancy Childbirth. 2012;12:94. doi: 10.1186/1471-2393-12-94. PMID: 22963318. Excluded: wrong country.

Nachega JB, Uthman OA, Mofenson LM, et al. Safety of tenofovir disoproxil fumarate-based antiretroviral therapy regimens in pregnancy for HIV-infected women and their Infants: a systematic review and meta-analysis. J Acquir Immune Defic Syndr. 2017 Sep 01;76(1):1-12. doi: 10.1097/QAI.0000000000001359. PMID: 28291053. Excluded: systematic review or meta-analysis used as a source document only to identify individual studies.

Nesheim SR, Wiener J, Fitz Harris LF, et al. Brief report: estimated incidence of perinatally acquired HIV infection in the United States, 1978-2013. J Acquir Immune Defic Syndr. 2017 Dec 15;76(5):461-4. doi: 10.1097/QAI.0000000000001552. PMID: 28991886. Excluded: wrong study design for Key Question.

Ngoma MS, Hunter JA, Harper JA, et al. Cognitive and language outcomes in HIV-uninfected infants exposed to combined antiretroviral therapy in utero and through extended breast-feeding. AIDS. 2014 Jul;28 Suppl 3:S323-30. doi: 10.1097/QAD.0000000000000357. PMID: 24991905. Excluded: wrong intervention.

Nielsen-Saines K, Watts DH, Veloso VG, et al. Three postpartum antiretroviral regimens to prevent intrapartum HIV infection. N Engl J Med. 2012;366(25):2368-79. PMID: 22716975. Excluded: wrong intervention.

Parekh N, Ribaudo H, Souda S, et al. Risk factors for very preterm delivery and delivery of very-small-for-gestational-age infants among HIV-exposed and HIV-unexposed infants in Botswana. Int J Gynaecol Obstet. 2011 Oct;115(1):20-5. doi: 10.1016/j.ijgo.2011.04.008. PMID: 21767835. Excluded: not a study (letter, editorial, non-systematic review article, no original data).

Patel K, Van Dyke RB, Mittleman MA, et al. The impact of HAART on cardiomyopathy among children and adolescents perinatally infected with HIV-1. AIDS. 2012 Oct 23;26(16):2027-37. doi: 10.1097/QAD.0b013e3283578bfa. PMID: 22781228. Excluded: wrong intervention.

Perry ME, Taylor GP, Sabin CA, et al. Lopinavir and atazanavir in pregnancy: comparable infant outcomes, virological efficacies and preterm delivery rates. HIV Med. 2016 Jan;17(1):28-35. doi: 10.1111/hiv.12277. PMID: 26200570. Excluded: did not adjust for confounders and/or did not provide adequate data.

Poliquin V, Yudin MH, Murphy KE, et al. Antepartum screening for maternal infection and immune status: is it time to broaden our routine? J Obstet Gynaecol Can. 2015 Dec;37(12):1118-21. PMID: 26637086. Excluded: not a study (letter, editorial, non-systematic review article, no original data).

Appendix A5. Excluded Studies List

Prieto LM, Fernandez McPhee C, Rojas P, et al. Pregnancy outcomes in perinatally HIV-infected young women in Madrid, Spain: 2000-2015. PLoS One. 2017;12(8):e0183558. doi: 10.1371/journal.pone.0183558. PMID: 28841701. Excluded: wrong population.

Prosperi MC, Fabbiani M, Fanti I, et al. Predictors of first-line antiretroviral therapy discontinuation due to drug-related adverse events in HIV-infected patients: a retrospective cohort study. BMC Infect Dis. 2012;12:296. doi: 10.1186/1471-2334-12-296. PMID: 23145925. Excluded: wrong outcome.

Radon-Pokracka M, Piasecki M, Lachowska A, et al. Assessment of the implementation of the infectious diseases screening programmes among pregnant women in the Lesser Poland region and comparison with similar programmes conducted in other European Union countries. Ginekol Pol. 2017;88(3):151-5. doi: 10.5603/GP.a2017.0029. PMID: 28397205. Excluded: wrong outcome.

Raffe SF, Savage C, Perry LA, et al. The management of HIV in pregnancy: A 10-year experience. Eur J Obstet Gynecol Reprod Biol. 2017 Mar;210:310-3. doi: 10.1016/j.ejogrb.2016.12.021. PMID: 28110176. Excluded: did not adjust for confounders and/or did not provide adequate data.

Ransom CE, Huo Y, Patel K, et al. Infant growth outcomes after maternal tenofovir disoproxil fumarate use during pregnancy. J Acquir Immune Defic Syndr. 2013 Dec 1;64(4):374-81. doi: 10.1097/QAI.0b013e3182a7adb2. PMID: 24169122. Excluded: wrong outcome.

Rawizza H. Triple-drug antiretroviral therapy results in lower HIV maternal-fetal transmission rates but increased adverse effects compared with zidovudine alone. J Pediatr. 2017 Mar;182:401-4. doi: 10.1016/j.jpeds.2016.12.068. PMID: 28237453. Excluded: did not adjust for confounders and/or did not provide adequate data.

Regan S, Losina E, Chetty S, et al. Factors associated with self-reported repeat HIV testing after a negative result in Durban, South Africa. PLoS One. 2013;8(4):e62362. doi: 10.1371/journal.pone.0062362. PMID: 23626808. Excluded: wrong population.

Rough K, Sun JW, Seage GR, 3rd, et al. Zidovudine use in pregnancy and congenital malformations. AIDS. 2017 Jul 31;31(12):1733-43. doi: 10.1097/QAD.0000000000001549. PMID: 28537936. Excluded: systematic review or meta-analysis used as a source document only to identify individual studies.

Scott RK, Chakhtoura N, Burke MM, et al. Delivery after 40 weeks of gestation in pregnant women with well-controlled human immunodeficiency virus. Obstet Gynecol. 2017 Sep;130(3):502-10. doi: 10.1097/AOG.0000000000002186. PMID: 28796679. Excluded: did not adjust for confounders and/or did not provide adequate data.

Siemieniuk RAC, Lytvyn L, Mah Ming J, et al. Antiretroviral therapy in pregnant women living with HIV: a clinical practice guideline. BMJ. 2017 09 11;358:j3961. doi: 10.1136/bmj.j3961. PMID: 28893728. Excluded: not a study (letter, editorial, non-systematic review article, no original data).

Sirois PA, Huo Y, Williams PL, et al. Safety of perinatal exposure to antiretroviral medications: developmental outcomes in infants. Pediatr Infect Dis J. 2013 Jun;32(6):648-55. doi: 10.1097/INF.0b013e318284129a. PMID: 23340561. Excluded: inadequate duration.

Smith C, Forster JE, Levin MJ, et al. Serious adverse events are uncommon with combination neonatal antiretroviral prophylaxis: a retrospective case review. PLoS One. 2015;10(5):e0127062. doi: 10.1371/journal.pone.0127062. PMID: 26000984. Excluded: wrong population.

Taron-Brocard C, Le Chenadec J, Faye A, et al. Increased risk of serious bacterial infections due to maternal immunosuppression in HIV-exposed uninfected infants in a European country. Clin Infect Dis. 2014 Nov 1;59(9):1332-45. doi: 10.1093/cid/ciu586. PMID: 25053719. Excluded: wrong outcome.

Thorne C, Semenenko I, Malyuta R, et al. Prevention of mother-to-child transmission of human immunodeficiency virus among pregnant women using injecting drugs in Ukraine, 2000-10. Addiction. 2012 Jan;107(1):118-28. doi: 10.1111/j.1360-0443.2011.03609.x. PMID: 21819473. Excluded: did not adjust for confounders and/or did not provide adequate data.

Tricco AC, Antony J, Angeliki VA, et al. Safety and effectiveness of antiretroviral therapies for HIV-infected women and their infants and children: protocol for a systematic review and network meta-analysis. Syst Rev. 2014;3:51. doi: 10.1186/2046-4053-3-51. PMID: 24887455. Excluded: not a study (letter, editorial, non-systematic review article, no original data).

Uthman OA, Nachega JB, Anderson J, et al. Timing of initiation of antiretroviral therapy and adverse pregnancy outcomes: a systematic review and meta-analysis. Lancet HIV. 2017 Jan;4(1):e21-e30. doi: 10.1016/S2352-3018(16)30195-3. PMID: 27864000. Excluded: systematic review or meta-analysis used as a source document only to identify individual studies.

Van Dyke RB, Chadwick EG, Hazra R, et al. The PHACS SMARTT study: Assessment of the safety of in utero exposure to antiretroviral drugs. Front Immunol. 2016;7:199. doi: 10.3389/fimmu.2016.00199. PMID: 27242802. Excluded: did not adjust for confounders and/or did not provide adequate data.

Appendix A5. Excluded Studies List

Vannappagari V, Koram N, Albano J, et al. Abacavir and lamivudine exposures during pregnancy and non-defect adverse pregnancy outcomes: data from the antiretroviral pregnancy registry. J Acquir Immune Defic Syndr. 2015 Mar 1;68(3):359-64. doi: 10.1097/QAI.0000000000000465. PMID: 25469525. Excluded: did not adjust for confounders and/or did not provide adequate data.

Villatoro CM, Luarte ME, Natareno GV, et al. Highly active antiretroviral treatment (HAART) for the prevention of HIV mother to child transmission (PMTCT) at Roosevelt Hospital's Infectious Diseases Clinic in Guatemala: the role of (LPV/r) standard dose. World J AIDS. 2012;2(03):259. Excluded: did not adjust for confounders and/or did not provide adequate data.

Whitehead N, Potterton J, Coovadia A. The neurodevelopment of HIV-infected infants on HAART compared to HIV-exposed but uninfected infants. AIDS Care. 2014 Apr;26(4):497-504. doi: 10.1080/09540121.2013.841828. PMID: 24125015. Excluded: wrong population.

Williams B, Costello M, McHugh E, et al. Repeat antenatal HIV testing in the third trimester: a study of feasibility and maternal uptake rates. HIV Med. 2014 Jul;15(6):362-6. doi: 10.1111/hiv.12110. PMID: 24215444. Excluded: wrong study design for Key Question.

Systematic Reviews

Criteria:

- Comprehensiveness of sources considered/search strategy used
- Standard appraisal of included studies
- Validity of conclusions
- Recency and relevance (especially important for systematic reviews)

Definition of ratings based on above criteria:

Good: Recent, relevant review with comprehensive sources and search strategies; explicit and relevant selection criteria; standard appraisal of included studies; and valid conclusions

Fair: Recent, relevant review that is not clearly biased but lacks comprehensive sources and search strategies

Poor: Outdated, irrelevant, or biased review without systematic search for studies, explicit selection criteria, or standard appraisal of studies

Case-Control Studies

Criteria:

- Accurate ascertainment of cases
- Nonbiased selection of cases/controls, with exclusion criteria applied equally to both
- Response rate
- Diagnostic testing procedures applied equally to each group
- Measurement of exposure accurate and applied equally to each group
- Appropriate attention to potential confounding variables

Definition of ratings based on above criteria:

Good: Appropriate ascertainment of cases and nonbiased selection of case and control participants; exclusion criteria applied equally to cases and controls; response rate equal to or greater than 80 percent; accurate diagnostic procedures and measurements applied equally to cases and controls; and appropriate attention to confounding variables

Fair: Recent, relevant, and without major apparent selection or diagnostic workup bias, but response rate less than 80 percent or attention to some but not all important confounding variables

Poor: Major selection or diagnostic workup bias, response rate less than 50 percent, or inattention to confounding variables

RCTs and Cohort Studies

Criteria:

- Initial assembly of comparable groups:
  - For RCTs: Adequate randomization, including first concealment and whether potential confounders were distributed equally among groups
  - For cohort studies: Consideration of potential confounders, with either restriction or measurement for adjustment in the analysis; consideration of inception cohorts

- Maintenance of comparable groups (includes attrition, cross-overs, adherence, contamination)
- Important differential loss to followup or overall high loss to followup
- Measurements: equal, reliable, and valid (includes masking of outcome assessment)
- Clear definition of interventions
- All important outcomes considered
- Analysis: adjustment for potential confounders for cohort studies or intention-to treat analysis for RCTs

Definition of ratings based on above criteria:

Good: Meets all criteria: Comparable groups are assembled initially and maintained throughout the study (followup ≥80%); reliable and valid measurement instruments are used and applied equally to all groups; interventions are spelled out clearly; all important outcomes are considered; and appropriate attention to confounders in analysis. In addition, intention-to-treat analysis is used for RCTs.

Fair: Studies are graded "fair" if any or all of the following problems occur, without the fatal flaws noted in the "poor" category below: Generally comparable groups are assembled initially, but some question remains whether some (although not major) differences occurred with followup; measurement instruments are acceptable (although not the best) and generally applied equally; some but not all important outcomes are considered; and some but not all potential confounders are accounted for. Intention-to-treat analysis is used for RCTs.

Poor: Studies are graded "poor" if any of the following fatal flaws exists: Groups assembled initially are not close to being comparable or maintained throughout the study; unreliable or invalid measurement instruments are used or not applied equally among groups (including not masking outcome assessment); and key confounders are given little or no attention. Intention-to-treat analysis is lacking for RCTs.

Diagnostic Accuracy Studies

Criteria:

- Screening test relevant, available for primary care, and adequately described
- Credible reference standard, performed regardless of test results
- Reference standard interpreted independently of screening test
- Indeterminate results handled in a reasonable manner
- Spectrum of patients included in study
- Sample size
- Reliable screening test

Definition of ratings based on above criteria:

Good: Evaluates relevant available screening test; uses a credible reference standard; interprets reference standard independently of screening test; assesses reliability of test; has few or handles indeterminate results in a reasonable manner; includes large number (>100) of broad-spectrum patients with and without disease

Fair: Evaluates relevant available screening test; uses reasonable although not best standard; interprets reference standard independent of screening test; has moderate sample size (50 to 100 subjects) and a "medium" spectrum of patients

Poor: Has a fatal flaw, such as: Uses inappropriate reference standard; improperly administers screening test; biased ascertainment of reference standard; has very small sample size or very narrow selected spectrum of patients

Source: U.S. Preventive Services Task Force Procedure Manual. Accessed at https://www.uspreventiveservicestaskforce.org/Page/Name/methods-and-processes

Appendix A7. Expert Reviewers of the Draft Report

- Maggie Czarnogorski, MD, MPH, Deputy Director, Comprehensive Women's Health, U.S. Department of Veterans Affairs
- Brenna Hughes, MD, MSc, Division of Maternal Fetal Medicine, Duke University
- Margaret Lampe, RN, MPH, Centers for Disease Control and Prevention
- Lynne Mofenson, MD, Elizabeth Glaser Pediatric AIDS Foundation
- Brandy Peaker, MD, MPH, Centers for Disease Control and Prevention
- George Siberry, MD, Pediatric Technical Advisor for the U.S. President's Emergency Plan for AIDS Relief, State Department

Note: Reviewers provided comments on a prior version of the draft report and may or may not agree with the report findings.

Appendix B Table 1. Currently Recommended Initial Regimens for Antiretroviral-Naive Pregnant Women With HIV

Preferred Regimens
Two-NRTI Backbones
ABC/3TC*
TDF/FTC or TDF/3TC†
INSTI Regimens
DTG/ABC/3TC or DTG plus a preferred 2-NRTI backbone (after the first trimester)‡
RAL plus a preferred 2-NRTI backbone
PI Regimens
ATV/r plus a preferred 2-NRTI backbone
DRV/r plus a preferred 2-NRTI backbone
Alternative Regimens
2-NRTI Backbones
ZDV/3TC§
PI Regimens
LPV/r plus a preferred 2-NRTI backbone
NNRTI Regimens
EFV/TDF/FTC or EFV/TDF/3TC or EFV plus a preferred 2-NRTI backbone‖
RPV/TDF/FTC or RPV plus a preferred 2-NRTI backbone¶

* ABC should not be used in patients who test positive for the HLA-B*5701 gene because of the risk of a hypersensitivity reaction.
† TDF has potential renal toxicity; thus, TDF-based dual-NRTI combinations should be used with caution in patients with renal insufficiency.
‡ Should not be initiated during the first trimester because of concerns about a possible increased risk of neural tube defects.
§ Increased potential for hematologic and other toxicities.
‖ Birth defects have been seen in primate studies of EFV, but there has been no evidence of an increased risk of birth defects in human studies and extensive experience in pregnancy; higher rate of adverse events than for other preferred drugs.
¶ RPV is not recommended in patients with pretreatment HIV RNA >100,000 copies/mL or CD4 cell counts <200 cells/mm^3; do not use with PPIs.

Source: U.S. Department of Health and Human Services. Recommendations for the Use of Antiretroviral Drugs in Pregnant Women with HIV Infection and Interventions to Reduce Perinatal HIV Transmission in the United States. Version December 7, 2018. https://aidsinfo.nih.gov/guidelines/html/3/perinatal/0 Accessed on 4/8/19.

Abbreviations: 3TC=lamivudine; ABC=abacavir; ATV/r=atazanavir/ritonavir; CD4=CD4 T lymphocyte cell; DRV/r=darunavir/ritonavir; DTG=dolutegravir; EFV=efavirenz; FTC=emtricitabine; INSTI=integrase strand transfer inhibitor; LPV/r=lopinavir/ritonavir; NNRTI=nonnucleoside reverse transcriptase inhibitor; NRTI=nucleoside reverse transcriptase inhibitor; PI=protease inhibitor; PPI=proton pump inhibitor; RAL=raltegravir; RNA=ribonucleic acid; RPV=rilpivirine; TDF=tenofovir disoproxil fumarate; ZDV=zidovudine.

Appendix B Table 2. Evidence Table of Included Studies: Study Characteristics

Author, year Study	Study design	Number of centers, Country	Study duration Followup	Intervention	Inclusion criteria	Patient characteristics	N	Quality rating	Funding source
Aaron, 2012[46]	Prospective cohort	1 site U.S. (Philadelphia, PA)	Through birth January 2000 through January 2011	A. Any ART initiation during pregnancy (n=137) B. NNRTI use (n=39) C. PI use (n=117)	HIV-infected, pregnant, and older than age 17 years	Maternal age: mean, 28 years Race/ethnicity: 74.7% African American; 25.3% other Started medication in pregnancy: 74.9%	183	Fair	NR
Antiretroviral Pregnancy Registry, 2018[47]	Cohort (≈1,000 women prospectively included)	Multinational (69 countries), 75% U.S. and its territories	January 1989 through January 2018	Preferred initial treatment drugs in U.S.: A. ABC (1,131; 12%) B. 3TC (5,008; 54%) C. TDF (3,535; 38%) D. FTC (2,785; 30%) E. ATV (1,279; 14%) F. RTV (3,155; 34%) G. DRV (456; 5%) H. RAL (291; 3%) Alternative initial treatment drugs in U.S.: I. ZDV (4,178; 45%) J. LPV (1,418; 15%) K. EFV (1,023; 11%) L. RPV (297; 3%)	Pregnant women exposed to antiretroviral drug for treatment of HIV and HBV infection and prevention of HIV infection (PrEP or postexposure prophylaxis)	Pregnancies enrolled in database (n=19,449): Maternal age: median 28 years Indication for ART at start of pregnancy: 89.4% HIV infected, 1.7% prophylaxis (HIV uninfected), 4.1% HBV monoinfected, 2.3% unknown, 2.4% missing CD4 count at start of pregnancy: 30.9% ≥500 cells/mm^3, 39.4% 200–499 cells/mm^3, 14.1% <200 cells/mm^3	9,336	Fair	Cosponsored and cofunded by 26 pharmaceutical companies that manufacture drugs used in ART
Berard, 2017[48] Quebec Pregnancy Cohort	Prospective cohort	Database study (Quebec Drug Plan) Canada	From birth in 1998 to 2015	A. No ART exposure (n=214,042) B. First-trimester ART exposure (n=198)	Age 15 and 45 years on the first day of gestation, continuously insured by the RAMQ drug plan for at least 6 months before the first day of gestation and during pregnancy, and have a singleton live birth	A vs. B Maternal age: 31.5 vs. 28.3 years (p<0.0001) Welfare recipient: 54% vs. 23% (p<0.0001) Infant gestational age: 38.2 vs. 38.8 weeks	214,240	Fair	Canadian Institutes of Health Research, Fonds de Antiretroviral la Recherche du Québec–Santé
Chagomerana, 2017[49]	Retrospective cohort	1 hospital Malawi	Through birth Period April 2012 to November 2015	A. ART (n=2,909) B. No ART (n=165)	HIV+ pregnant women who initiated ART before 27 weeks of gestation or did not receive ART and	A vs. B Maternal age: 27 to 30 vs. 26 years Gestation at delivery: 38 vs. 38 weeks	3,074	Fair	National Institutes of Health and a Gilead Training Fellowship

Appendix B Table 2. Evidence Table of Included Studies: Study Characteristics

Author, year Study	Study design	Number of centers, Country	Study duration Followup	Intervention	Inclusion criteria	Patient characteristics	N	Quality rating	Funding source
					delivered after 27 weeks				
Chen, 2012[50]	Prospective cohort	6 sites Botswana	May (1 site) or November (5 sites) 2009 through April 2011 28 days after delivery	A. Continued HAART during pregnancy (n=2,189) B. Initiated HAART during pregnancy (n=1,101) C. Initiated ZDV during pregnancy (n=4,625) D. No ART (n=1,234)	All women who delivered live births or stillbirths at a gestational age of ≥20 weeks at 6 government facilities in Botswana	A vs. B vs. C vs. D Maternal age: median 32 vs. 29 vs. 27 vs. 27 years Botswana nationality: 99% vs. 98% vs. 97% vs. 64% Received antenatal care: 97% vs. 99% vs. 99% vs. 78%	9,504	Fair	Centers for Disease Control and Prevention, National Institutes of Health, Harvard University, Doris Duke Charitable Research Foundation
Chiappini, 2013[51] EPPICC Study	Analysis from 8 cohort studies	8 cohorts from 7 countries in Europe: U.K. and Ireland's NSHPC and CHIPS; ITLR; Madrid Cohort of HIV-Infected Children; CoRISPE-Cat; "Victor Babes" Hospital Cohort, Bucharest, Romania; MoCHiV; ECS on HIV-Infected Pregnant Women and Their Children; ECS was considered as 2 studies	Up to 18 months Period 1996-2010	A. 3 or more drugs (n=2,355) B. 2 drugs (n=255) C. 1 drug (n=681) D. No therapy (n=1,933)	Children born to diagnosed HIV-infected mothers between January 1, 1996 and June 30, 2010 at high risk for acquiring HIV infection whose mothers received antenatal and intrapartum antiretroviral drugs but had suboptimal viral suppression at delivery (defined as a detectable viral load [>50 copies/mL] documented in the last 8 weeks of pregnancy and/or at delivery), received only intrapartum antiretroviral drugs, and received no antenatal or intrapartum antiretroviral drugs	Maternal age: mean NR; 70% age ≥20 years Race/ethnicity: 29% white; 40% black; 3% other Region or country: 37% Europe; 42% Africa Maternal CD4 count: mean NR; 53% ≥200 cells/mm^3 Maternal viral load: mean NR; 27% ≥1,000 copies/mL Gestational age: mean NR; 6% ≤32 weeks; 16% 33 to 36 weeks; 76% ≥37 weeks	5,285 mother-infant pairs	Fair	European Union Seventh Framework Programme; Pediatric European Network or Treatment of AIDS Foundation

Appendix B Table 2. Evidence Table of Included Studies: Study Characteristics

Author, year Study	Study design	Number of centers, Country	Study duration Followup	Intervention	Inclusion criteria	Patient characteristics	N	Quality rating	Funding source
Duryea, 2015[52]	Retrospective cohort	Single site Texas, U.S.	Through birth Period January 1984 to April 2014	A. ART with PI (n=597) B. ART without PI (n=230) C. No ART (n=177)	All HIV+ women who delivered at the institution (University of Texas Southwestern Medical Center, Dallas) during the study period	Maternal age at delivery: 25 to 28 years (p<0.001) Race/ethnicity: black 64% to 69%, Hispanic 19%, white 11% to 16% Gestational age at presentation for prenatal care: 12 to 24 weeks (p<0.001) CD4 count at presentation: 456 to 557 cells/mm^3 (p<0.001) CD4 count at delivery: 505 to 565 cells/mm^3 (p=0.349) Duration of diagnosis: 1 to 2 years (p<0.001)	1,004	Fair	NR
Floridia, 2013[53] Italian Group on Surveillance on Antiretroviral Treatment in Pregnancy	Prospective cohort	Unclear Italy	Through birth Period 2001 to 2011	Various cART regimens	HIV-positive pregnant women with data from the Italian National Programme on Surveillance on Antiretroviral Treatment in Pregnancy	Mean maternal age at conception: 32.3 years Ethnicity: 66% white, 29% African, 4% other CD4 count at first trimester: 464 cells/mm^3 HIV RNA at first trimester: 3.0 copies/mL, log_{10} HCV coinfection: 22% HBV coinfection: 11% Treatment-naive before pregnancy: 36% Diagnosis of HIV during current pregnancy: 24.6% Week of first ART in pregnancy: 10.4 Mode of HIV acquisition: 73.1% sexual, 13.6% PWID Maternal ART at first trimester: 55.3% NRTI, 20.4% NNRTI, 27.8% PI	1,257	Fair	Italian Medicines Agency

Appendix B Table 2. Evidence Table of Included Studies: Study Characteristics

French Perinatal Cohort Study ANRS-EPF Mandelbrot, 2015[61]	Prospective cohort, no control	90 sites France (but majority from sub-Saharan Africa)	Pre-conception to postpartum Period 2000 to 2011	cART comparing starting at different times and viral loads A. Preconception B. 1st trimester C. 2nd trimester D. 3rd trimester Other interventions: Intrapartum ZDV 96.0% Neonatal antiretroviral prophylaxis: 91.6% ZDV monotherapy, 7.5% other Neonatal single dose NVP: 4.2%	All HIV-1+ women enrolled in the French Perinatal Cohort delivering in metropolitan France between 2000 and 2011 that received HAART (regimen containing ≥3 drugs or 1 drug other than a NRTI) during pregnancy. Women who received only reverse-transcriptase inhibitor monotherapy or dual therapy were excluded. However, women who switched from a combination therapy to monotherapy or dual therapy were included, as were the small number of women who received monotherapy with RTV-boosted PIs. Breastfeeding women were excluded.	N=8,678 Age: <25 years 8.7%, 25 to 34 years 56.5%, >34 years 34.8% Geographic origin: metropolitan France 16.6%, sub-Saharan Africa 71.6%, other 11.8% HIV diagnosis before conception: 80.4% Timing of ART initiation: before conception 47.2% (n=4,095), 1st trimester 8.2% (n=713), 2nd trimester 32.3% (n=2,803), 3rd trimester 12.3% (n=1,067) Initial ART regimen during pregnancy: triple NRTI 5.9%, PI-based 76.1%, NNRTI-based 15.8%, 3 classes 1.2%, other 1.0% Last ART regimen during pregnancy: ZDV monotherapy 0.4%, dual NRTI 1.1%, triple NRTI 3.1%, PI-based 81.2%, NNRTI-based 10.9%, 3 classes 1.3%, other 2.0% Maintained initial ART regimen throughout pregnancy: 71.4% Last viral load before delivery (copies/mL): <50 68.0%, undetectable (50 to 400) 5.9%, 50 to 399 15.2%, ≥400 10.9% CD4 count before delivery (cells/mm^3): <200 9.0%, 200 to 349 21.0%, 350 to 499 28.0%, ≥500 42.0% Delivery mode: vaginal 42.7%, emergency	Eligible: 8,678 mother-infant pairs HIV status of child determ-ined: 8,075 mother-infant pairs	Fair	Agence Nationale de Recherche sur le SIDA et les Hepatites Virales

Appendix B Table 2. Evidence Table of Included Studies: Study Characteristics

Author, year Study	Study design	Number of centers, Country	Study duration Followup	Intervention	Inclusion criteria	Patient characteristics	N	Quality rating	Funding source
						Caesarean 22.0%, planned Caesarean 35.3%			
French Perinatal Cohort Study ANRS-EPF C01/C011 Sibiude, 2012[72]	See above	See above	See Period 1990 to 2009	A. ZDV monotherapy (n=2,975) B. NRTI dual therapy (n=1,664) C. cART therapy (n=6,738) Substudy: D. Boosted PI (n=1,066) E. Nonboosted PI (n=187)	All HIV-1+ women enrolled in the French Perinatal Cohort between 1990 and 2009 Substudy cohort: Singleton births from 2005 through 2009 for mothers enrolled in the CO1 component of the cohort, which recorded more detailed data	A vs. B vs. C Maternal age: median NR; 65% vs. 63% vs. 57% ages 25 to 34 years Maternal geographic origin France: 28% vs. 31% vs. 19% Africa: 51% vs. 53% vs. 63% Other: 21% vs. 16% vs. 17% D vs. E Maternal age: median NR; 83% vs. 84% ages 25 to 39 years Maternal geographic origin: Europe: 11% vs. 14% Africa or Caribbean: 88% vs. 83% Other: 1% vs. 3%	13,271	See above	French Agence Nationale de Recherche sur le SIDA
French Perinatal Cohort Study ANRS-EPF C01/C011 Sibiude, 2014[71]	Prospective cohort	90 centers France (but majority from sub-Saharan Africa)	2 years Period 1994 to 2010	cART	Same as Sibiude 2012	Same as Sibiude 2012 Median maternal age: 31 years Origin sub-Saharan Africa: 61% PWID: 2% Exposed to ART in the first trimester: 42% (5,388)	13,124	See above	See above
French Perinatal Cohort Study ANRS-EPF C01/C011 and nested PRIMEVA ANRS 135 RCT Sibiude, 2015[70]	Cohort combining prospectively collected observational data and retrospective analysis of data from an RCT	Same as Sibiude 2014	Up to 24 months Period 1994 to 2010	A. ZDV exposure (n=3,262) B. No ZDV exposure (n=9,626)	Same as Sibiude 2014	Maternal age: mean NR; 60% ages 25 to 34 years Race/ethnicity: NR Maternal geographic origin: 22% France; 61% Africa	12,888	See above	Agence Nationale de Recherche sur le SIDA et les Hepatites Virales

Appendix B Table 2. Evidence Table of Included Studies: Study Characteristics

Fowler, 2016[44] PROMISE trial	RCT, open label	14 sites in 7 countries (India, Malawi, South Africa, Tanzania, Uganda, Zambia, Zimbabwe)	Through 6 to 14 days postpartum (antepartum period) Period 2011 to 2014	A. ZDV-based ART (ZDV, 3TC, LPV/r) B. Tenofovir-based ART (tenofovir, FTC, LPV/r) C. ZDV alone (ZDV plus intrapartum single-dose NVP with 6 to 14 days of TDF-FTC postpartum) All infants received NVP from birth. During period 1 (April 2011 to September 2012), women without HBV were assigned only to ZDV alone or ZDV-based ART, but starting in October 2012 due to additional data on TDF, women were assigned to any regimen regardless of HBV status (period 2 = October 2012 to October 2014)	CD4 count of ≥350 cells/mm^3 (or a country-specific threshold for initiating triple-drug ART, if that threshold was higher), gestation of ≥14 weeks and not in labor, no previous use of triple-drug ART, no clinical or immune-related indication for triple-drug ART, a hemoglobin level of at least 7.5 g/dL, an absolute neutrophil count of at least 750 cells/mm^3, an ALT of <2.5 times the upper limit of the normal range, an estimated creatinine clearance of >60 mL/min, and no serious pregnancy complications. Receipt of 1 or 2 antiretroviral agents for the prevention of mother-to-child transmission in previous pregnancies and for ≤30 days during the current pregnancy before enrollment was permitted. Key exclusion criteria were active tuberculosis or receipt of tuberculosis treatment within 30 days before trial entry, HBV infection requiring HBV treatment (patients who did not require	Median age: 26 years Race/ethnic group: 97% black African, 3% Indian, <0.5% other Median CD4 count: 530 cells/mm^3 Median viral load: 3.9 $\log_{10}$ copies/mL WHO clinical stage 1: 97% Gestational age: 26 weeks Region or country: 47% East Africa, 33% South Africa, 17% Southern Africa, 3% India	Enrolled 3,529 mother-infant pairs Analyzed: 3,490 mother-infant pairs	Fair	The National Institute of Allergy and Infectious Diseases of the National Institutes of Health, the Eunice Kennedy Shriver National Institute of Child Health and Human Development, and the National Institute of Mental Health, and some study drugs were donated by pharmaceutical companies

Appendix B Table 2. Evidence Table of Included Studies: Study Characteristics

Author, year Study	Study design	Number of centers, Country	Study duration Followup	Intervention	Inclusion criteria	Patient characteristics	N	Quality rating	Funding source
					HBV treatment could enroll), a structural or conduction heart defect, or a fetus with a serious congenital malformation.				
Kakkar, 2015[54] CMIS Mother-Infant Cohort	Retrospective cohort	Canada (Montreal)	Period 1988 to 2011	A. Boosted PIs (n=144) B. Unboosted PI (n=220) C. Other treatment (n=166) D. No treatment (n=59)	CMIS mother-child cohort of all HIV-positive pregnant women presenting to Centre Hospitalier Universitaire Sainte-Justine with attendance for at least 2 antenatal obstetric visits and singleton live births, at gestational age of 24 weeks or older	A vs. B vs. C vs. D Maternal age: median NR; 60% vs. 63% vs. 66% vs. 62% ages 25 to 35 years Race/ethnicity: 79% vs. 63% vs. 66% vs. 64% black; 15% vs. 28% vs. 26% vs. 34% Caucasian; 5% vs. 9% vs. 9% vs. 2% other	525 mother-infant pairs	Fair	Fonds de Recherche du Quebec-Santé
Knapp, 2012[55] IMPAACT Groups Protocol P1025	Case-control	Multiple sites International	Through birth Period 2002 to 2007	Various cART regimens A. Congenital anomaly (n=61) B. No congenital anomaly (n=1,051)	Singleton children born to HIV-infected mothers enrolled in P1025 trial	Maternal age at enrollment, ≤24 years: 33% Maternal age at enrollment, 25 to 34 years: 53% Maternal age at enrollment, ≥35 years: 15% HIV diagnosis prior to pregnancy: 69% Earliest ART use during pregnancy: 47% first trimester, 52% second trimester HIV RNA near labor and delivery <400 copies/mL: 76%	1,112	Fair	National Institutes of Health, National Institute of Allergy and Infectious Diseases

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Author, year Study	Study design	Number of centers, Country	Study duration Followup	Intervention	Inclusion criteria	Patient characteristics	N	Quality rating	Funding source
Kreitchmann, 2014[56] LILAC Study	Prospective cohort	Multisite Latin America and Caribbean	Through birth Period 2002 to 2011	At least 28 days in 3rd trimester: A. HAART + PI (888; 59%) B. HAART no PI (410; 27%) C. Non-HAART (134; 9%) D. No ART (80; 5%) Total N=1,512	Pregnant women who were enrolled in the NISDI Perinatal and LILAC protocols with first pregnancy after study enrollment, and either a live birth or a stillbirth	Maternal age: mean 28.2 years Maternal education: mean 8.0 years Race/ethnicity: 91.4% Hispanic/Latino; 70% non-Hispanic/Latino; 58% white; 20.4% black; 21.6% other races	1,563	Fair	National Institute of Child Health and Human Development
Li, 2016[57]	Prospective cohort	10 sites Tanzania	18 months November 2004 to September 2011	A. Initiated ZDV during pregnancy (1,768; 53%) B. Initiated HAART during pregnancy (512; 15%) C. Continued HAART from before pregnancy (582; 18%) D. No ART (452; 14%)	HIV-infected pregnant women who had uninfected HIV-exposed infants at birth	Maternal age: median 30 years Race/ethnicity: NR	3,314	Fair	U.S. President's Emergency Plan for AIDS Relief
Lopez, 2012[59]	Retrospective cohort (case control)	1 site Spain (Barcelona)	January 1986 to June 2010 Through birth	A. HAART entire pregnancy (n=226) B. HAART 2nd half of pregnancy only (n=72) C. PI during pregnancy (n=178) D. No HAART (n=221)	HIV-infected pregnant women who consecutively attended and delivered in a university referral hospital in Barcelona, Spain, covering an urban area of about 1 million inhabitants between January 1986 and June 2010. Inclusion criteria were singleton pregnancy and delivery beyond 22 weeks. Women with active PWID during pregnancy	HIV infected only: Maternal age: mean 30 years 8% Black; other race/ethnicity NR Low education level: 50% Prior preterm delivery: 8%	519	Fair	NR

Appendix B Table 2. Evidence Table of Included Studies: Study Characteristics

Author, year Study	Study design	Number of centers, Country	Study duration Followup	Intervention	Inclusion criteria	Patient characteristics	N	Quality rating	Funding source
					were excluded				
Lu, 2014[60] CPHSP Study	Retrospective cohort, no control	Canada (Ontario)	Through birth Period 1996 to 2008	A. Complete antiretroviral prophylaxis (n=251) B. Incomplete antiretroviral prophylaxis (n=336) C. No antiretroviral prophylaxis (n=58)	Data from women delivering 1996 to 2008 in the Ontaria group of the CPHSP	Maternal age: NR Maternal race/ethnicity: 63% black; 26% white Maternal region or country: 52% Africa; 30% Canada Caesarean delivery: 43% Screen-detected HIV during pregnancy: NR; 13% were considered late diagnoses (diagnosed at or after delivery)	645 mother-child pairs	Fair	None reported
Moodley, 2016[62]	Retrospective cross sectional analysis	Single center South Africa	July to December 2011 and January to June 2014	A. Dual ART (AZT/NVP; n=974) B. Triple ART (D4T/3TC/NVP; n=907) C. Fixed-dose ART (EFV/TDF-FTC; n=1,666) D. No ART (n=148)	Women with viable pregnancies delivering a neonate weighing ≥500 g and whose birth outcomes were recorded in the maternity register	NR	3,695	Fair	NR
Mor, 2017[63]	Cohort	Multisite Israel	Through birth Period 1985 to 2011	A. Infants born before 1996 (n=80) B. Infant born after 1997 (HAART introduced; n=716)	All HIV-infected women who delivered in Israel and were local citizens between January 1988 and December 2011	A vs. B Maternal age: 27.6 vs. 30.4 years (p=0.001) Mother born in Ethiopia: 87.5% vs. 81.7% HIV transmission route: endemic country 88.6% vs. 82.6%, drug use 1.3% vs. 5.3%, heterosexual 10.1% vs. 12.1% Previous HIV-infected child(ren): 12.0% vs. 9.9% Mother did not receive HAART during pregnancy: 90.0% vs. 46.8% (p=0.001) Caesarian delivery: 11.2% vs. 44.4% (p=0.001) Mother did not receive ART during labor: 95.0% vs. 55.8%	796 infants born to HIV-infected mothers	Fair	No funding received

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Author, year Study	Study design	Number of centers, Country	Study duration Followup	Intervention	Inclusion criteria	Patient characteristics	N	Quality rating	Funding source
						Infant did not receive ART after birth: 80.0% vs. 19.9% (p=0.001) Breastfed: 1.3% vs. 1.0%			
Pintye, 2017[65] Partners PrEP Study and Partners Demonstration Project	Cohort	Kenya and Uganda	Partners PrEP: 2008 through 2012 Partners Demonstration Project: 2012–2016	A. TDF-containing 3-drug ART (n=208) B. Non-TDF–containing 3-drug ART (n=214)	Women who were HIV-infected at enrollment in Partners PrEP or Partners Demonstration Projects and became pregnant during the study period	A vs. B Maternal age 24.7 vs. 26.6 years Years of education: 8 vs. 7 years Timing of ART initiation: 39.2% vs. 26.4% before pregnancy; 20.6% vs. 13.0% first trimester; 40.2% vs. 60.6% second or third trimester	422 pregnancies	Fair	National Institutes of Health, University of Washington Center for AIDS Research, University of Washington Global Center for Integrated Health of Women, Adolescents, and Children
Ramokolo, 2017[66] PMTCT Program	Cross-sectional cohort	580 sites South Africa	Through 4–8 weeks postpartum Period October 2012 to May 2013	A. Postconception ART (n=780) B. Preconception ART (n=616) C. ZDV prophylaxis (n=873) D. No ART (n=330)	Mother-infant pairs attending immunization services at 1 of 580 primary health facilities offering immunization services consecutively or systematically enrolled, regardless of maternal HIV status	A vs. B vs. C vs. D Maternal age: 3.1% vs. 1.8% vs. 7.0% vs. 5.2% <20 years; 28.5% vs. 10.0% vs. 36.2% vs. 34.9% ages 20–25 years; 27.2% vs. 23.3% vs. 26.1% vs. 24.5% ages 26–29 years; 29.8% vs. 35.2% vs. 19.1% vs. 20.7% ages 30–35 years; 14.6% vs. 29.8% vs. 11.6% vs. 14.7% >35 years Education less than 7th grade: 15.1% vs. 16.9% vs. 21.8% vs. 22.1% Black race: 98.2% vs. 97.3% vs. 96.2% vs. 97.5%	2,599 (HIV exposed infants only)	Fair	Centers for Disease Control and Prevention; South African National Health Scholarship Programme

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Author, year Study	Study design	Number of centers, Country	Study duration Followup	Intervention	Inclusion criteria	Patient characteristics	N	Quality rating	Funding source
Sartorius, 2013[45] Kesho Bora Trial	RCT	Africa (3 countries)	January 2005 and August 2008 Duration: 28 weeks of pregnancy until 12 to 24 months after delivery	A. Triple ART, CD4 <200 (n=118) B. ZDV plus single-dose NVP, CD4 >500 cells/mm^3 (n=128) C. Triple ART, CD4 200 to 500 cells/mm^3 (n=412) D. ZDV plus single-dose NVP, CD4 200 to 500 cells/mm^3 (n=412) Note: >70% breastfed	HIV-infected women had to reside and plan to continue living in the study area until 2 years postdelivery, have no contraindication to receive ART, and no evidence of clinically significant conditions (obstetric, cardiac, respiratory including active tuberculosis, hepatic, gastrointestinal, endocrine, renal, hematologic, psychiatric, neurologic, or allergic) that may interfere with study interventions	A vs. B vs. C vs. D Maternal age: 28 vs. 26 vs. 27 vs. 27 years Secondary education or higher: 36% vs. 40% vs. 52% vs. 49%	1,072	Fair	NR
Short, 2013[68]	Retrospective analysis	1 site U.K. (London)	Period 1996 to 2010	A. ZDV (n=65) B. Dual NRTI (n=7) C. Triple NRTI (n=5) D. Short-term cART (n=59) E. Preconception cART (n=131) F. New continuous cART (n=56)	HIV-positive pregnant women managed by a single, multidisciplinary team at St Mary's Hospital	Maternal age: median 32 years Race: 78% black African; other races NR Maternal history of any AIDS-defining illness: 11.5% Median gestational age: 13 weeks	331	Fair	NR
SMARTT and PHACS Studies Nozyce, 2014[64]	Prospective cohort	Multisite U.S.	Up to 13 years Period 2007 to 2012	Any maternal cART regimen containing ≥3 antiretroviral drugs from ≥2 drug classes, analyzed by assessment scale: WPPSI-III (n=369) WASI (n=452) WIAT-II-A (n=451) Other intervention:	All children enrolled in the SMARTT Static cohort (HIV-exposed) who completed a valid, age-appropriate measure of cognition and/or academic achievement in English and had information regarding in utero and neonatal	Male: 49% to 52% Ethnicity: 75% to 77% black, 19% to 25% Hispanic Preterm birth (<37 weeks): 17% to 21% Low birth weight (<2,500 g): 18% to 20% Household annual income ≤$20,000: 59% to 69% Caregiver with less than a	739	Fair	Eunice Kennedy Shriver National Institute of Child Health and Human Development; National Institute on Drug Abuse;

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Author, year Study	Study design	Number of centers, Country	Study duration Followup	Intervention	Inclusion criteria	Patient characteristics	N	Quality rating	Funding source
				Neonatal prophylaxis defined as antiretroviral drugs used during the first 8 weeks of life	ART exposure	high school education: 32% to 34% First viral load during pregnancy >400 copies/mL: 60% to 72% Last viral load prior to delivery >400 copies/mL: 19% to 33%			National Institute of Allergy and Infectious Diseases; Office of AIDS Research; National Institute of Mental Health; National Institute of Neurological Disorders and Stroke; National Institute on Deafness and Other Communication Disorders; National Heart, Lung, and Blood Institute; National Institute of Dental and Craniofacial Research; and the National Institute on Alcohol Abuse and Alcoholism; Harvard University and Tulane University and National Institutes of Health

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Author, year Study	Study design	Number of centers, Country	Study duration Followup	Intervention	Inclusion criteria	Patient characteristics	N	Quality rating	Funding source
PHACS Study Lipshultz, 2015[58]	Same as Nozyce 2014	Same as Nozyce 2014	Mean 4 years Period 2007 to 2012	A. HIV-exposed uninfected (n=417) B. HIV-unexposed controls (n=98)	SMARTT enrolled children with echocardiography and unexposed controls	A vs. B Maternal age: 28 vs. 26 years Race: 62% vs. 70% black; 30% vs. 26% white; 9% vs. 4% other; 39% vs. 22% Hispanic Child age at time of echocardiography: 4.0 vs. 4.8 years	515	Same as Nozyce 2014	National Institutes of Health
SMARTT, study of the PHACS cohort and P1025 study of the IMPAACT cohort Rough, 2018[67]	Cohort	2 multisite cohorts U.S.	Period 2007 to 2016 for Dynamic cohort of the SMARTT study and 2002 to 2013 for the P1025 study	A. TDF-FTC + LPV/r (128; 8%) B. ZDV + 3TC + LPV/r (954; 59%) C. TDF-FTC + ATV/r (539; 33%)	All infants with an observed birth outcome in the SMARTT or P1025 study, when the first ART regimen that their mothers used during pregnancy was one of the following: TDF-FTC + LPV/r, ZDV + 3TC + LPV/r, or TDF-FTC + ATV/r	A vs. B vs. C Maternal age: 39.1% vs. 37.2% vs. 25.2% ≤24 years, 52.3% vs. 49.6% vs. 54.4% 25–34 years, 8.6% vs. 13.1% vs. 20.2% ≥35 years Race: 11.7% vs. 7.1% vs. 8.2% non-Hispanic white, 63.3% vs. 64.0% vs. 67.7% non-Hispanic black, 23.4% vs. 27.0% vs. 22.3% Hispanic, 0.8% vs. 1.2% vs. 1.7% other First CD4 count in pregnancy: 23.4% vs. 20.3% vs. 18.6% <250 cells/mm^3, 36.7% vs. 39.9% vs. 38.0% 250–500 cells/mm^3, 36.7% vs. 38.3% vs. 41.7% >500 cells/mm^3 First viral RNA in pregnancy: 47.7% vs. 29.5% vs. 51.4% <400 copies/mL, 25.8% vs. 37.8% vs. 25.4% 400–10,000 copies/mL, 25.8% vs. 32.0% vs. 22.6% >10,000 copies/mL Timing of regimen initiation: 45.3% vs. 11.6% vs. 49.2% before pregnancy, 14.1% vs. 12.1% vs. 15.2% first	1,621	Fair	Same as Nozyce 2014

Appendix B Table 2. Evidence Table of Included Studies: Study Characteristics

Author, year Study	Study design	Number of centers, Country	Study duration Followup	Intervention	Inclusion criteria	Patient characteristics	N	Quality rating	Funding source
						trimester, 40.6% vs. 76.3% vs. 35.6% second or third trimester			
SMARTT and PHACS Studies Siberry, 2012[69]	Prospective cohort	Multisite U.S.	Through infant growth at 1 year Period through January 2011	A. TDF-containing ART (n=449) B. non-TDF–containing ART (n=1,580)	Data collected in the SMARTT of the PHACS network, restricted primary models to consider only those exposed in utero to combination antiretroviral regimens with vs. without TDF	Race/ethnicity: black 66%, Latino 33% Caesarian delivery: 54% Gestational age: <32 weeks 3%, 32–37 weeks 17%, ≥37 weeks 76% Maternal CD4 count <250 cells/mm^3 at delivery: 15% HBV+: 2%	2,029	Same as Nozyce 2014	Same as Nozyce 2014
SMARTT and PHACS Studies Watts, 2013[75]	Prospective cohort	22 sites U.S.	Unclear Period 2007 to 2010	Various maternal cART regimens	HIV-infected mothers and their children enrolled in SMARTT of the PHACS network. This analysis limited to singleton gestations with maternal enrollment on or before October 2010.	Mean maternal age at delivery: 27 years Ethnicity: 65% black, 28% white, 7% other [34% Hispanic] Annual household income <$20,000: 63% CD4 count <200 cells/mm^3: 13% CD4 count 200 to 500 cells/mm^3: 46% CD4 count >500 cells/mm^3: 36% Antiretroviral regimen: 3% none, 7% monotherapy or dual therapy, 71% combination with PI (with or without NNRTI), 10% combination with ≥3 NRTIs, 9% combination with NNRTI (no PI) First trimester use of cART: 40% Second trimester use of cART: 63% Third trimester use of cART: 76%	1,869	Same as Nozyce 2014	Same as Nozyce 2014

Appendix B Table 2. Evidence Table of Included Studies: Study Characteristics

Author, year Study	Study design	Number of centers, Country	Study duration Followup	Intervention	Inclusion criteria	Patient characteristics	N	Quality rating	Funding source
SMARTT and PHACS Studies Williams, 2015[76]	Combined data from prospective and retrospective cohorts	Same as Nozyce 2014	Period 2007-2012	A. Any ART (n=1,219) B. Any HAART (n=1,025) C. NNTRI (n=214) D. NRTI (n=1,211) E. PI (n=887) F. No ART exposure of any kind (n=1,298 to 2,303 depending on comparison) All exposure was during first trimester	Static (retrospective) cohort: Mothers or caregivers and their children younger than age 12 years who had detailed information on ART use during pregnancy and pregnancy outcomes Dynamic (prospective) cohort: Pregnant women and their infants between 22 weeks of gestation and 1 week after delivery	Maternal age: mean NR; 13% >35 years Race/ethnicity: 66% black; 27% white; 0.5% other; 33% Latino/Hispanic Caregiver not a high school graduate: 5%	2,580	Same as Nozyce 2014	Same as Nozyce 2014
SMARTT and PHACS Studies Williams, 2016[77]	Same as Nozyce 2014	Same as Nozyce 2014	Period 2007 to 2012	A. Any HAART exposure (n=2,211) B. NNTRI exposed (n=395) C. NRTI (n=1,907) D. PI (n=NR) E. No ART exposure of any kind (n=469)	SMARTT cohort of children with adverse event trigger cases, defined as language impairment, metabolic abnormality, impaired growth, neurologic diagnosis, neurodevelopmental impairment, elevated blood lactate, chemistry or hematology toxicity, or hearing impairment	No adverse event vs. adverse event Maternal age: mean NR; 33% vs. 33% <25 years Infant characteristics 49% vs. 47% female Race/ethnicity: 68% vs. 61% black; 26% vs. 32% white; 4% vs. 4% Puerto Rican; 1% vs. 1% other; 32% vs. 37% Hispanic 17% vs. 25% low birth weight 19% vs. 24% preterm birth (<37 weeks of gestation) 55% vs. 56% Caesarean delivery	2,680	Same as Nozyce 2014	Same as Nozyce 2014

Appendix B Table 2. Evidence Table of Included Studies: Study Characteristics

Author, year Study	Study design	Number of centers, Country	Study duration Followup	Intervention	Inclusion criteria	Patient characteristics	N	Quality rating	Funding source
Snijdewind, 2018[73] ATHENA Cohort	Retrospective cohort	26 centers The Netherlands	Period 1997 to 2015	A. PI-based (928; 67%) B. NNRTI-based (438; 31%) C. Both or NRTI (12; 1%)	ATHENA cohort database; HIV-positive women age >18 years who gave birth to HIV- exposed and uninfected infants after a minimum 24 weeks of pregnancy; singleton births; includes women who started cART preconception as well as those who began postconception	Maternal age: median 29 years Region of origin: 61.3% sub-Saharan Africa, 20.7% Western Europe, 16.5% other Mode of delivery: 44.5% spontaneous labor, 13.6% elective Caesarean delivery, 6.8% emergency Caesarean delivery, 27.7% unknown CD4 count: median 520 cells/mm^3 HIV RNA: 79.1% ≤500 copies/mL Infant birth weight: median 3,090 kg Duration of pregnancy: 85.3% >37 weeks, 11.9% <37 weeks	1,378	Fair	Dutch Health Ministry
Tookey, 2016[74] NSHPC Study	Retrospective cohort, no control	U.K. and Ireland	Through birth Period 2003 to 2012	LPV/r	NSHPC participants with pregnancies who were due to deliver	Maternal age: median 30 years Maternal race/ethnicity: 15% white; 77% black; 8% other Maternal region/country: 14% U.K./Ireland; 77% Africa; 10% other	4,118 mothers, 4,864 pregnan-cies	Fair	Health Protection Agency, National Screening Committee and the Welton Foundation, Medical Research Council, National Institute for Health Research, Biomedical Research Centre at Great Ormond Street Hospital for

Appendix B Table 2. Evidence Table of Included Studies: Study Characteristics

Author, year Study	Study design	Number of centers, Country	Study duration Followup	Intervention	Inclusion criteria	Patient characteristics	N	Quality rating	Funding source
									Children, National Health Service Foundation Trust, and University College London
Zash, 2016[79]	Cohort	2 hospitals Botswana	Through birth Period May 2009 to April 2011 and April 2013 to April 2014	A. TDF-FTC and EFV at conception (n=165) B. Other 3-drug ART at conception (n=2,006) C. TDF-FTC and EFV during pregnancy (n=1,054) D. Other 3-drug ART during pregnancy (n=2,172)	All women who delivered live-born or stillborn infants at 8 government maternity wards in Botswana Excluded births that occurred before arrival at hospital and at gestational age <24 weeks	HIV infected, years 2009–2011 vs. 2013–2014: Maternal age: 28.9 vs. 30.2 years Any medical history: 17.4% vs. 19.5% Hypertension in pregnancy: 19.1% vs. 17.5% Anemia in pregnancy: 59.0% vs. 48.1% Primiparous 20.6% vs. 15.9% No prenatal care: 5.7% vs. 4.8% Unknown HIV status: 4.7% vs. 1.2% No ART during pregnancy: 16.1% vs. 12.3% Initiated ART <4 weeks prior to delivery: 24.7% vs. 17.0% Initiated ART <28 weeks gestational age: 22.0% vs. 59.8% Median CD4 count: 388 vs. 415 cells/mm^3	32,583 births, 9,445 HIV-infected women	Fair	CDC, National Institutes of Health/National Institute of Allergy and Infectious Diseases

Appendix B Table 2. Evidence Table of Included Studies: Study Characteristics

Author, year Study	Study design	Number of centers, Country	Study duration Followup	Intervention	Inclusion criteria	Patient characteristics	N	Quality rating	Funding source
Zash, 2017[78]	Surveillance cohort	8 government hospitals Botswana	Through birth Period August 2014 to August 2016	A. TDF-FTC-EFV (n=2,472) B. TDF-FTC-NVP (n=760) C. TDF-FTC-LPV/r (n=231) D. ZDV-3TC-NVP (n=1,365) E. ZDV-3TC-LPV/r (n=167)	All women who delivered live-born or stillborn infants at 8 government maternity wards in Botswana Excluded births that occurred before arrival at hospital and at gestational age <24 weeks, and HIV-positive mothers with no ART exposure, unknown ART timing, or unknown ART exposure	Maternal age: median 31 years Primiparous: 14.8% Gestational age at antenatal care presentation: median 17 weeks Received no prenatal care: 3.3% Alcohol consumption or smoking during pregnancy: 8.1% Caesarean delivery: 23.7% ART prior to conception: 5,780 infants, breakdown below: TDF-FTC-EFV: 2,503 ZDV-3TC-NVP: 1,403 TDF-FTC-NVP: 775 Unspecified ART: 547 TDF-FTC-LPV/r: 237 ZDV-3TC-LPV/r: 169 Other 3-drug ART: 104 Nonstandard ART: 21 Changed or terminated ART: 21 ART after conception: 4,812 infants, breakdown below: TDF-FTC-EFV: 4,569 Other ART regimen: 129 Unspecified ART: 94 Changed or terminated ART: 14 ZDV monotherapy: 3 Nonstandard ART: 3	47,124 total births 11,932 HIV-exposed births 10,592 included in analysis	Fair	National Institutes of Health

Abbreviations: 3TC=lamivudine; ABV=abacavir; ANRS-EPF=French Agence Nationale de Recherche sur le SIDA-Enquête Périnatale Française; ART=antiretroviral therapy; ATV=atazanavir; ATV/r=atazanavir/ritonavir; AZT=azidothymidine cART=combination antiretroviral therapy; CD4=cluster of differentiation 4; CDC=Centers for Disease Control and Prevention; CHIPs=Collaborative HIV Paediatric Study; CMIS=Centre Maternal et Infantile sur le SIDA; CPHSP=Canadian Perinatal HIV Surveillance Program; CoRISPE-Cat=Catalan Cohort of HIV-Infected Children; D4T=stavudine; DRV=darunavir; ECS=European Collaborative Study; EFV=efavirenz; EPPICC=European Pregnancy and Paediatric HIV Cohort Collaboration; FTC=emtricitabine; HAART=highly-active antiretroviral therapy; HBV=hepatitis B virus; HCV=hepatitis C virus; IMPAACT=International Maternal Pediatric Adolescent AIDS Clinical Trials; ITLR=Italian Register for HIV Infection in Children; LILAC=Perinatal and Longitudinal Study in Latin American Countries; LPV=lopinavir; LPV/r=lopinavir/ritonavir; MoCHiV=Swiss Mother and Child HIV Cohort Study; NIH=National Institutes of Health;

Appendix B Table 2. Evidence Table of Included Studies: Study Characteristics

NISDI=National Institute of Child Health and Human Development International Site Development Initiative; NNRTI=nonnucleoside reverse transcriptase inhibitors; NR=not reported; NRTI=nucleoside reverse transcriptase inhibitor; NSHPC=National Study of HIV in Pregnancy and Childhood; NVP=nevirapine; PHACS=Pediatric HIV/AIDS Cohort Study; PI=protease inhibitor; PrEP=pre-exposure prophylaxis; PROMISE=Promoting Maternal and Infant Survival Everywhere; PWID=persons who inject drugs; PWTCT=Prevention of Mother to Child Transmission Program; RAL=raltegravir; RAMQ=Régie de l'Assurance Maladie du Québec; RCT=randomized, controlled trial; RNA=ribonucleic acid; RPV=rilpivirine; RTV=ritonavir; SMARTT=Surveillance Monitoring for Antiretroviral Treatment Toxicities study; TDF=tenofovir disoproxil fumarate; U.K.=United Kingdom; U.S.=United States; WASI=Wechsler Abbreviated Scale of Intelligence; WHO=World Health Organization; WIAT-II-A=Wechsler Individual Achievement Test, 2nd Edition; WPPSI-III=Wechsler Preschool and Primary Scale of Intelligence, 3rd Edition; ZDV=zidovudine.

Appendix B Table 3. Evidence Table of Included Studies: Results

Study author, year	Intervention	HIV transmission	Adverse events
Aaron, 2012[46]	A. Any ART initiation during pregnancy (n=137) B. NNRTI use (n=39) C. PI use (n=117)	NR	A. SGA, 10th percentile: aOR, 1.47 (95% CI, 0.60 to 3.58); 3rd percentile: aOR, 4.64 (95% CI, 0.81 to 26) B. SGA, 10th percentile: aOR, 0.28 (95% CI, 0.10 to 0.75); 3rd percentile: 0.16 (95% CI, 0.03 to 0.91) C. SGA, 10th percentile: aOR, 1.68 (95% CI, 0.79 to 3.55); 3rd percentile: aOR, 2.73 (95% CI, 0.83 to 9.00)
Antiretroviral Pregnancy Registry, 2018[47]	Preferred initial treatment drugs in U.S.: A. ABC (1,131; 12%) B. 3TC (5,008; 54%) C. TDF (3,535; 38%) D. FTC (2,785; 30%) E. ATV (1,279; 14%) F. RTV (3,155; 34%) G. DRV (456; 5%) H. RAL (291; 3%) Alternative initial treatment drugs in U.S.: I. ZDV (4,178; 45%) J. LPV (1,418; 15%) K. EFV (1,023; 11%) L. RPV (297; 3%)	NR	Congenital abnormalities First-trimester exposed vs. unexposed, unadjusted OR (our analysis): A. 1.04 (0.72 to 1.52) B. 1.26 (0.98 to 1.63) C. 0.77 (0.59 to 1.01) D. 0.85 (0.64 to 1.13) E. 0.77 (0.52 to 1.15) F. 0.74 (0.56 to 0.97) G. 0.88 (0.48 to 1.61) H. 1.14 (0.58 to 2.24) I. 1.38 (1.08 to 1.77) J. 0.74 (0.50 to 1.09) K. 0.84 (0.55 to 1.29) L. 0.36 (0.11 to 1.12)
Berard, 2017[48] Quebec Pregnancy Cohort	A. No ART exposure (n=214,042) B. First-trimester ART exposure (n=198)	NR	A vs. B Any major congenital malformation: aOR, 0.59 (95% CI, 0.33 to 1.06) Nervous system major malformation: aOR, 0.21 (95% CI, 0.03 to 1.83) Circulatory system major malformation: aOR, 0.75 (95% CI, 0.31 to 1.85) Digestive system major malformation: aOR, 0.80 (95% CI, 0.14 to 4.40) Urinary system major malformation: aOR, 0.14 (95% CI, 0.02 to 1.12) Musculoskeletal major malformation: aOR, 0.59 (95% CI, 0.21 to 1.68) Specific malformations for which there was a statistically significant difference between groups: Small intestine: aOR, 10.32 (95% CI, 2.85 to 37.38) Other digestive congenital malformations (excluding tongue, mouth, pharynx, esophagus, intestines, gall bladder, bile ducts, liver): aOR, 6.83 (95% CI, 2.18 to 21.35) *OR adjusted for HIV diagnosis in the 6 months before and during pregnancy, maternal age, place of residence and welfare status, hospitalizations and emergency department visits, physician and specialist visits, number of other medication use and number of prescribers, maternal diabetes, hypertension, and asthma.*

Appendix B Table 3. Evidence Table of Included Studies: Results

Study author, year	Intervention	HIV transmission	Adverse events
Chagomerana, 2017[49]	A. ART (n=2,909) B. No ART (n=165)	NR	Overall preterm birth: 24% (731/3,074) A vs. B Preterm birth: 31% (690/2,219) vs. 33% (41/124); aRR, 1.14 (95% CI, 0.84 to 1.55) Extremely to very preterm (27–32 weeks) birth: 6% (133/2,219) vs. 13% (16/124); aRR, 2.33 (95% CI, 1.39 to 3.92)
Chen, 2012[50]	A. Continued HAART during pregnancy (n=2,189) B. Initiated HAART during pregnancy (n=1,101) C. Initiated ZDV during pregnancy (n=4,625) D. No ART (n=1,234)	NR	A vs. (B or C or D) Preterm delivery: 26.5% (543/2,050) vs. 22.7% (1,515/6,676); aOR, 1.2 (95% CI, 1.1 to 1.4) SGA: 26.1% (562/2,151) vs .15.6% (1,067/6,840); aOR, 1.8 (95% CI, 1.6 to 2.1) Stillbirth: 6.3% (1,38/2,189) vs. 4.1% (283/6,960); aOR, 1.5 (95% CI, 1.2 to 1.8) A vs. B SGA: 26.1% (562/2,151) vs. 21.6% (237/1,095); aOR, 1.3 (95% CI, 1.0 to 1.5) B vs. C Preterm delivery: 19.8% (177/892) vs. 14.2% (533/3,762); aOR, 1.4 (95% CI, 1.2 to 1.8) SGA: 21.5% (200/930) vs. 14.2% (542/3,811); aOR, 1.5 (95% CI, 1.2 to 1.9) Stillbirth: 4.7% (44/936) vs. 1.7% (64/3,827); aOR, 2.5 (95% CI, 1.6 to 3.9)
Chiappini, 2013[51] EPPICC Study	A. 3 or more drugs (n=2,355) B. 2 drugs (n=255) C. 1 drug (n=681) D. No therapy (n=1,933)	A. 2.8% (65/2,355); aOR, 0.36 (95% CI, 0.23 to 0.57); p<0.001 B. 1.2% (3/255); aOR, 0.12 (95% CI, 0.04 to 0.40); p<0.001 C. 3.1% (21/681); aOR, 0.33 (95% CI, 0.19 to 0.55); p<0.005 D. 14.3% (158/1,107); aOR, 1 reference	NR
Duryea, 2015[52]	A. ART with PI (n=597) B. ART without PI (n=230) C. No ART (n=177)	NR	Preterm birth (<37 weeks): A. 14% (82/597); 1 reference B. 13% (31/230); 0.9 (95% CI, 0.5 to 1.5) C. 21% (37/177); 1.0 (95% CI, 0.5 to 2.0) SGA (<10th percentile): 4% to 10% depending on ART regimen: A. 19% (116/597); 1 reference B. 23% (54/230); 1.3 (95% CI, 0.8 to 1.9) C. 22% (39/177); 1.1 (95% CI, 0.6 to 2.0)

Appendix B Table 3. Evidence Table of Included Studies: Results

Study author, year	Intervention	HIV transmission	Adverse events
Floridia, 2013[53] Italian Group on Surveillance on Antiretroviral Treatment in Pregnancy	Various cART regimens	Data on transmission available for 868 infants, of which 4 were HIV positive (0.5% [95% CI, 0.0 to 0.9])	Birth defects (Antiretroviral Pregnancy Registry criteria): Overall: 3.3% (42/1,257) for exposure at any time to ART during pregnancy Exposure to any ART during the first trimester: prevalence 3.2% (95% CI, 1.9 to 4.5) (23 cases with defects) vs. initial exposure to ART after the first trimester: prevalence 3.4% (95% CI, 1.9 to 4.9) (19 cases) By drug: No associations found between major birth defects and first-trimester exposure to any ART: OR, 0.94 (95% CI, 0.51 to 1.75) NRTI: OR, 0.95 (95% CI, 0.51 to 1.76) NNRTI: OR, 1.20 (95% CI, 0.56 to 2.55) PI: OR, 0.92 (95% CI, 0.43 to 1.95) Also, no associations found for individual drugs Stillbirth: 0.8% (10/1,257) Death within 2 weeks of delivery: 4 (different from the 4 infants with HIV, and none had birth defects). Reasons: 2 deaths from complications from prematurity and 2 deaths from neonatal sepsis Preterm delivery (<37 weeks): 20.9% Very preterm delivery (<32 weeks): 2.5% Low birth weight (<2,500 g): 22.1% Very low birth weight (<1,500 g): 2.5%
French Perinatal Cohort Study ANRS-EPF Mandelbrot, 2015[61]	ART comparing starting at different times and viral loads A. Preconception B. 1st trimester C. 2nd trimester D. 3rd trimester Other interventions: Intrapartum ZDV 96.0% Neonatal antiretroviral prophylaxis: 91.6% ZDV monotherapy, 7.5% other Neonatal single dose NVP: 4.2%	Overall mother-to-child HIV transmission: 0.7% (56/8,075) (95% CI, 0.5 to 0.9) A vs. B vs. C vs. D Mother-to-child HIV transmission based on timing of ART initiation: 0.2% (6/3,505) vs. 0.4% (3/709) vs. 0.9% (24/2,810) vs. 2.2% (23/1,051); p<0.001 Mother-to-child HIV transmission based on viral load (copies/mL) near delivery: <50, 0.3 (95% CI, 0.1 to 0.4); undetectable >50, 0.2 (95% CI <0.1 to 1.2); 50 to 399, 1.5 (95% CI, 0.9 to 2.4); ≥400, 2.8 (95% CI, 1.8 to 4.2), p<0.001; aOR, 4.0 (95% CI, 1.9 to 8.2)	A vs. B vs. C vs. D Live born: 99.1% (4,055/4,095) vs. 99.2% (707/713) vs. 99.1% (2,772/2,803) vs. 99.6% (1,062/1,067) Median birth weight (g): 3,020 vs. 3,065 vs. 3,018 vs. 3,040 Median length at birth (cm): 48.0 vs. 48.0 vs. 48.0 vs. 49.0 Median head circumference (cm): 34.0 vs. 34.0 vs. 34.0 vs. 34.0 5-Minute APGAR 8–10: 96.4% (3,776/4,095) vs. 97.3% (659/713) vs. 97.3% (2,618/2,803) vs. 97.7% (1,017/1,067) Gestational age at delivery: <32 weeks: 4.0% (164/4,095) vs. 3.2% (23/713) vs. 3.6% (100/2,803) vs. 0.7% (7/1,067) 32 to 36 weeks: 13.4% (549/4,095) vs. 12.8% (91/713) vs. 12.0% (336/2,803) vs. 11.6% (124/1,067) ≥37 weeks: 82.6% (3,382/4,095) vs. 84.0% (599/713) vs. 84.4% (2,367/2,803) vs. 87.7% (936/1,067) Stillbirth: 1.0% (38/4,095) vs. 0.8% (6/713) vs. 0.9% (25/2,803) vs. 0.4% (4/1,067) Death before HIV diagnosis: 0.5% (22/4,095) vs. 0.6% (4/713) vs. 0.5% (15/2,803) vs. 0.3% (3/1,067)

Appendix B Table 3. Evidence Table of Included Studies: Results

Study author, year	Intervention	HIV transmission	Adverse events
French Perinatal Cohort Study ANRS-EPF C01/C011 Sibiude, 2012[72]	A. ZDV monotherapy (n=2,975) B. NRTI dual therapy (n=1,664) C. cART therapy (n=6,738) Substudy: D. Boosted PI (n=1,066) E. Nonboosted PI (n=187)	NR	Full cohort, A vs. B vs. C Premature birth: 9.6% vs.11.3% vs. 14.7%; B vs. A: aOR, 1.24 (95% CI, 0.96 to 1.60); C vs. A: aOR, 1.69 (95% CI, 1.38 to 2.07) Substudy, D vs. E Premature birth: 14.4% vs. 9.1%; aHR, 2.03 (95% CI, 1.06 to 3.89) Gestational diabetes: 2.9% vs. 1.6%; p=0.46
French Perinatal Cohort Study ANRS-EPF C01/C011 Sibiude, 2014[71]	cART	NR	Overall birth defects prevalence (EUROCAT classification): .4% (575/13,124) (95% CI, 4.0 to 4.7) Overall birth defects prevalence (MACDP classification): 7.0% (914/13,124) (95% CI, 6.5 to 7.4) Premature delivery (<37 weeks): 14.5% (1,901/13,124) Low birth weight (<2,500 g): 16.2% (2,127/13,124) After adjustment for potential confounders, and by drug: Significant association found between exposure to ZDV in the first trimester and CHD: 2.3% (74/3,267); aOR, 2.2 (95% CI, 1.3 to 3.7) Significant association found between exposure to ddI and head and neck defects: 0.5%; aOR, 3.4 (95% CI, 1.1 to 10.4) Significant association found between exposure to IDV and head and neck defects: 0.9%; aOR, 3.8 (95% CI, 1.1 to 13.8) Significant association found between exposure to EFV and neurological defects (MACDP classification): n=4; aOR, 3.0 (95% CI, 1.1 to 8.5); but not significant using the EUROCAT classification: aOR, 2.1 (95% CI, 0.7 to 5.9) No association found between birth defects and LPV or RTV (with a power >85%) nor for NVP, tenofovir, D4T, ABC (with a power >70%)
French Perinatal Cohort Study ANRS-EPF C01/C011 and nested PRIMEVA ANRS 135 RCT Sibiude, 2015[70]	A. ZDV exposure (n=3,262) B. No ZDV exposure (n=9,626)	Overall mother-to-child HIV transmission: 1.3% (169/12,888)	A vs. B CHD: 1.5% vs. 0.77%; aOR, 2.2 (95% CI, 1.5 to 3.2) CHD, boys: aOR, 2.1 (95% CI, 1.2 to 3.7 CHD, girls: aOR, 2.0 (95% CI, 1.2 to 3.2); p=0.89 for interaction Echocardiography (based on RCT data only): girls more likely than boys to show LV shortening fraction at 1 month (p=0.3 for interaction); no significant differences for other measures at 1 month or 1 year
Fowler, 2016[44] PROMISE trial	A. ZDV-based ART (ZDV, 3TC, LPV/r) B. Tenofovir-based ART (tenofovir, FTC, LPV/r) C. ZVD alone (ZDV plus intrapartum single-dose NVP with 6 to 14 days of tenofovir and FTC postpartum)	Periods 1 and 2, A vs. B vs. C Rate of transmission: 0.5% (7/1,385) vs. 0.6% (2/325) vs. 1.8% (25/1,386), difference A and B vs. C: -1.3 percentage points (repeated CI, -2.1 to -0.4)	Periods 1 and 2 A vs. C Maternal any grade ≥2 adverse event: 21.1% (318/1,505) vs. 17.3% (261/1,510), p=0.008 Maternal grade ≥2 abnormal blood chemical value: 5.8% (88/1,505) vs. 1.3% (19/1,505), p<0.001 Any adverse pregnancy outcome: 40.0% (563/1,407) vs. 27.5% (389/1,414), p<0.001

Appendix B Table 3. Evidence Table of Included Studies: Results

Study author, year	Intervention	HIV transmission	Adverse events
	All infants received NVP from birth. During period 1 (April 2011 to September 2012), women without HBV were assigned only to ZDV alone or ZDV-based ART, but starting in October 2012, due to additional data on tenofovir, women were assigned to any regimen regardless of HBV status (period 2 = October 2012 to October 2014)	Gestational age at trial entry <34 weeks: 0.5% (6/1,230) vs. 0.4% (1/274) vs. 1.3% (16/1,229), difference A and B vs. C: -0.8 percentage points (repeated CI, -1.6 to -0.1) Gestational age at trial entry ≥34 weeks: 0.6% (1/154) vs. 2.0% (1/51) vs. 5.7% (9/157), difference A and B vs. C: -4.8 percentage points (repeated CI, -8.9 to -0.6) CD4 count at trial entry, 350–499 cells/mm^3: 0.7% (4/592) vs. 0.7% (1/136) vs. 2.8% (16/577), difference A and B vs. C: -2.1 percentage points (repeated CI, -3.7 to -0.5) CD4 count at trial entry, ≥500 cells/mm^3: 0.4% (3/793) vs. 0.5% (1/189) vs. 1.1% (9/809), difference A and B vs. C: -0.7 percentage points (repeated CI, -1.6 to 0.2) Viral load at trial entry, <1,000 copies/mL: 0.4% (1/253) vs. 0% (0/57) vs. 0% (0/299), difference A and B vs. C: 0.3 percentage points (repeated CI, -0.4 to 1.0) Viral load at trial entry, ≥1,000 copies/mL: 0.5% (6/1,129) vs. 0.7% (2/268) vs. 2.3% (25/1,083), difference A and B vs. C: -1.7 percentage points (repeated CI, -2.8 to -0.7)	Low birth weight, <2,500 g: 23.0% (306/1,332) vs. 12.0% (161/1,347); p<0.001 Preterm delivery, <37 weeks: 20.5% (288/1,406) vs. 13.1% (185/1,411); p<0.001 Any severe adverse pregnancy outcome: 7.1% (99/1,385) vs. 5.9% (83/1,399); p=0.22 Very preterm delivery, <34 weeks: 3.1% (44/1,406) vs. 2.6% (37/1,411); p=0.43 Infant death through week 1: 1.2% (17/1,419) vs. 2.0% (28/1,532); p=0.13 Period 2 A vs. B Maternal any grade adverse event: 15.8% (61/385) vs. 15.8% (60/380); p>0.99 Maternal abnormal blood chemistry value: 4.7% (18/385) vs. 2.9% (11/380); p=0.26 Any adverse pregnancy outcome: 37.5% (123/328) vs. 34.7% (111/320), p=0.46 Low birth weight, <2,500 g: 20.4% (65/319) vs. 16.9% (51/301); p=0.30 Preterm delivery, <37 weeks: 19.7% (68/346) vs. 18.5% (62/335); p=0.77 Any severe adverse pregnancy outcome: 4.3% (14/322) vs. 9.2% (29/314); p=0.02 Very preterm delivery, <34 weeks: 2.6% (9/346) vs. 6.0% (20/335); p=0.04 Infant death through week 1: 0.6% (2/346) vs. 4.4% (15/341); p=0.001 Period 2 B vs. C Maternal any grade adverse event: 15.8% (60/380) vs. 15.0% (59/393); p=0.77 Maternal abnormal blood chemistry value: 2.9% (11/380) vs. 0.8% (3/392); p=0.03 Any adverse pregnancy outcome: 34.7% (111/320) vs. 27.2% (91/334); p=0.04 Low birth weight, <2,500 g: 16.9% (51/301) vs. 8.9% (28/315); p=0.004 Preterm delivery, <37 weeks: 18.5% (62/335) vs. 13.5% (46/341); p=0.09 Any severe adverse pregnancy outcome: 9.2% (29/314) vs. 6.7% (22/329); p=0.25 Very preterm delivery, <34 weeks: 6.0% (20/335) vs. 3.2% (11/341); p=0.10 Infant death through week 1: 4.4% (15/341) vs. 3.2% (11/349); p=0.43

Appendix B Table 3. Evidence Table of Included Studies: Results

Study author, year	Intervention	HIV transmission	Adverse events
Kakkar, 2015[54] CMIS Mother-Infant cohort	A. Boosted PI (n=144) B. Unboosted PI (n=220) C. Other treatment (n=166) D. No treatment (n=59)	NR	A vs. B Preterm delivery: 19.3% vs. 10.8%; aOR, 2.17 (95% CI, 1.05 to 4.51) C vs. B Preterm delivery: 8.8% vs. 10.8%; aOR, 0.67 (95% CI, 0.27 to 1.63) D vs. B Preterm delivery: 25% vs. 10.8%; aOR, 1.50 (95% CI, 0.33 to 6.78)
Knapp, 2012[55] IMPAACT Groups Protocol P1025	Various cART regimens A. Congenital anomaly (n=61) B. No congenital anomaly (n=1,051)	0.63% (7/1,112)	Congenital anomalies (MACDP guidelines): Overall: 5.5% (61/1,112 infants), prevalence 5.49/100 live births (95% CI, 4.22 to 6.99), including 80 anomalies: cardiovascular (n=33), musculoskeletal (n=15), renal (n=9), genitourinary (n=6), craniofacial (n-4), and central nervous system (n=2) Preterm birth (<37 weeks): 17% (191/1,112) Low birth weight (<2,500 g): 14% (153/1,112) EFV, 1st-trimester exposure: OR, 2.84 (95% CI, 1.13 to 7.16) No other significant aORs for other drugs or timing of exposure
Kreitchmann, 2014[56] LILAC Study	At least 28 days in 3rd trimester: A. HAART + PI (888; 59%) B. HAART no PI (410; 27%) C. Non-HAART (134; 9%) D. No ARV (80; 5%) Total N=1,512	NR	Receiving ART at conception vs. no ART at conception, preterm delivery <37 weeks: 1.53 (95% CI, 1.11 to 2.09)
Li, 2016[57]	A. Initiated ZDV during pregnancy (1,768; 53%) B. Initiated HAART during pregnancy (512; 15%) C. Continued HAART from before pregnancy (582; 18%) D. No ART (452; 14%)	NR	HAART vs. ZDV started during pregnancy, preterm delivery: 34 to 37 weeks: 0.85 (95% CI, 0.70 to 1.02); p=0.14 <34 weeks: 0.87 (95% CI, 0.60 to 1.25); p=0.45
Lopez, 2012[59]	A. HAART entire pregnancy (n=226) B. HAART 2nd half of pregnancy only (n=72) C. PI during pregnancy (n=178) D. No HAART (n=221)	NR	Spontaneous preterm birth: A vs. D: aOR, 0.55 (95% CI, 0.20 to 1.51) B vs. D: aOR, 0.55 (95% CI, 0.18 to 1.68) C vs. D: aOR, 1.95 (95% CI, 0.87 to 4.38) Iatrogenic preterm birth: A vs. D: aOR, 3.42 (95% CI, 0.80 to 14.63) B vs. D: aOR, 6.16 (95% CI, 1.42 to 26.8) C vs. D: aOR, 0.44 (95% CI, 0.18 to 1.10)
Lu, 2014[60] CPHSP Study	A. Complete antiretroviral prophylaxis (n=251) B. Incomplete antiretroviral prophylaxis (n=336) C. No antiretroviral prophylaxis (n=58)	A. 1% (3/251) B. 2% (8/336) C. 67% (39/58)	NR

Appendix B Table 3. Evidence Table of Included Studies: Results

Study author, year	Intervention	HIV transmission	Adverse events
Moodley, 2016[62]	A. Dual ART (AZT/NVP; n=974) B. Triple ART (D4T/3TC/NVP; n=907) C. Fixed-dose ART (EFV/TDF-FTC; n=1,666) D. No ART (n=148)	NR	Stillbirth: A vs. D: aOR, 0.08 (95% CI, 0.04 to 0.16) B vs. D: aOR, 0.20 (95% CI, 0.11 to 0.38) C vs. D: aOR, 0.18 (95% CI, 0.10 to 0.34) Preterm birth: A vs. D: aOR, 0.20 (95% CI, 0.08 to 0.51) B vs. D: aOR, 0.21 (95% CI, 0.08 to 0.55) C vs. D: aOR, 0.31 (95% CI, 0.11 to 0.90) Low birth weight: A vs. D: aOR, 0.06 (95% CI, 0.02 to 0.18) B vs. D: aOR, 0.09 (95% CI, 0.03 to 0.24) C vs. D: aOR, 0.12 (95% CI, 0.04 to 0.37) SGA: A vs. D: aOR, 0.37 (95% CI, 0.10 to 1.45) B vs. D: aOR, 0.29 (95% CI, 0.08 to 1.07) C vs. D: aOR, 0.35 (95% CI, 0.07 to 0.87)
Mor, 2017[63]	A. Infants born before 1996 (n=80) B. Infant born after 1997 (HAART introduced; n=716)	Mother-to-child HIV transmission: Overall: 3.1% (25/796) A vs. B: 16.3% (13/80) vs. 1.7% (12/716); p<0.01 Transmission with HAART and vaginal delivery: 1.5% Transmission with HAART and Caesarean delivery: 0.6% Variables on mother-to-child HIV transmission HAART vs. no HAART during pregnancy: aOR, 0.4 (95% CI, 0.1 to 0.8) Infant ART prophylaxis: aOR, 0.2 (95% CI, 0.1 to 0.5)	NR
Pintye, 2017[65] Partners PrEP Study and Partners Demonstration Project	A. TDF-containing 3-drug ART (n=208) B. Non-TDF–containing 3-drug ART (n=214)	NR	A vs. B Pregnancy loss: 14% (17/208) vs. 9% (7/214); aOR, 1.05 (95% CI, 0.75 to 1.46) Pregnancy loss, <20 weeks: 11% (13/208) vs. 7% (6/214); aOR, 1.02 (95% CI, 0.73 to 1.40) Pregnancy loss, >20 weeks: 2% (4/208) vs. 1% (1/214); aOR, 1.04 (95% CI, 0.95 to 1.13) Neonatal death: 1% (3/208) vs. 2% (4/214); aOR, 1.01 (95% CI, 0.96 to 1.06) Preterm birth: 6% (10/208) vs. 10% (20/214); aOR, 0.85 (95% CI, 0.74 to

Appendix B Table 3. Evidence Table of Included Studies: Results

Study author, year	Intervention	HIV transmission	Adverse events
			1.02) *OR adjusted for study cohort, maternal age, time since HIV diagnosis, HIV RNA at first pregnancy visit, and year pregnancy occurred*
Ramokolo, 2017[66] PWTCT Study	A. Postconception ART (n=780) B. Preconception ART (n=616) C. ZDV prophylaxis (n=873) D. No ART (n=330)	NR	A vs. B vs. C vs. D Preterm delivery: A vs. B: aOR, 1.7 (95% CI, 1.1 to 2.5); A vs. C: aOR, 1.4 (95% CI, 0.9 to 2.0); A vs. D: aOR, 1.9 (95% CI, 1.1 to 3.1) Low birth weight: A vs. B: aOR, 0.9 (95% CI, 0.6 to 1.3); A vs. C: aOR, 0.8 (95% CI, 0.6 to 1.1); A vs. D: aOR, 1.1 (95% CI, 0.8 to 1.6) SGA: A vs. B: aOR, 0.9 (95% CI, 0.6 to 1.3); A vs. C: aOR, 0.7 (95% CI, 0.5 to 1.0); A vs. D: 0.7 (95% CI, 0.4 to 1.1) Underweight for age: A vs. B: aOR, 1.1 (95% CI, 0.7 to 1.6); A vs. C: aOR, 1.1 (95% CI, 0.8 to 1.6); A vs. D: aOR, 1.4 (95% CI, 0.9 to 2.2)
Sartorius, 2013[45] Kesho Bora Trial	A. Triple ART, CD4 <200 cells/mm^3 (n=118) B. ZDV plus single-dose NVP, CD4 >500 cells/mm^3 (n=128) C. Triple ART, CD4 200 to 500 cells/mm^3 (n=412) D. ZDV plus single-dose NVP, CD4 200 to 500 cells/mm^3 (n=412) Note: >70% breastfed	NR	A vs. B vs. C vs. D Severe maternal anemia (hemoglobin <8 g/dL), cumulative incidence: At delivery: 0.14 (95% CI, 0.09 to 0.22) vs. 0.05 (95% CI, 0.03 to 0.11) vs. 0.09 (95% CI, 0.06 to 0.12) vs. 0.08 (95% CI, 0.06 to 0.11); p=0.51 6 months postpartum: 0.30 (95% CI, 0.23 to 0.39) vs. 0.10 (95% CI, 0.06 to 0.16) vs. 0.16 (95% CI, 0.13 to 0.20) vs. 0.17 (95% CI, 0.14 to 0.21); p=0.44 12 months postpartum: 0.33 (95% CI, 0.26 to 0.41) vs. 0.11 (95% CI, 0.06 to 0.17) vs. 0.18 (95% CI, 0.14 to 0.21) vs. 0.19 (95% CI, 0.16 to 0.23); p=0.71 18 months postpartum: 0.34 (95% CI, 0.27 to 0.42) vs. 0.11 (95% CI, 0.06 to 0.17) vs. 0.18 (95% CI, 0.15 to 0.22) vs. 0.21 (95% CI, 0.17 to 0.25); p=0.36 C vs. D: aHR, 0.78 (95% CI, 0.54 to 1.11)
Short, 2013[68]	A. ZDV (n=65) B. Dual NRTI (n=7) C. Triple NRTI (n=5) D. Short-term cART (n=59) E. Preconception cART (n=131) F. New continuous cART (n=56)	NR	A vs. B vs. C vs. D vs. E vs. F Preterm delivery rate: 6.2% vs. 0% vs. 0% vs. 25.4% vs. 9.9% vs. 17.9% D vs. A: aOR, 5.00 (95% CI, 1.49 to 16.79)

Appendix B Table 3. Evidence Table of Included Studies: Results

Study author, year	Intervention	HIV transmission	Adverse events
SMARTT and PHACS Studies Nozyce, 2014[64]	Any maternal cART regimen containing at least 3 antiretroviral drugs from at least 2 drug classes, analyzed by assessment scale: WPPSI-III (n=369) WASI (n=452) WIAT-II-A (n=451) Other intervention: Neonatal prophylaxis defined as antiretroviral drugs used during the first 8 weeks of life	NR	Mean cognitive and academic scores were significantly below population norms (p=0.01 to p<0.001), with the exception of the WASI VIQ (p=0.48); data from figure There were no significant differences in adjusted mean scores for any cognitive or academic outcome when comparing different cART regimens or specific drugs or cumulative duration of prenatal cART exposure
PHACS Study Lipshultz, 2015[58]	A. HIV-exposed uninfected (n=417) B. HIV unexposed controls (n=98)	NR	A vs. B, adjusted mean difference z-score LV ejection fraction: 0.04 (95% CI, 0.14 to 0.21) LV M-mode shortening fraction: 0.06 (95% CI, 0.26 to 0.15) LV stress–velocity index: 0.12 (95% CI, 0.11 to 0.35) LV M-mode end diastolic short axis dimension: 0.07 (95% CI, 0.15 to 0.29) LV M-mode end diastolic postwall thickness: 0.05 (95% CI, 0.25 to 0.15) LV M-mode end diastolic septal thickness: 0.06 (95% CI, 0.25 to 0.13) LV M-mode mass: 0.02 (95% CI, 0.23 to 0.19) LV M-mode end systolic wall stress: 0.02 (95% CI, 0.29 to 0.25) LV M-mode thickness-to-dimension ratio: 0.07 (95% CI, 0.26 to 0.12)
SMARTT study of the and PHACS cohort and P1025 study of the IMPAACT cohort Rough, 2018[67]	A. TDF-FTC + LPV/r (128; 8%) B. ZDV + 3TC + LPV/r (954; 59%) C. TDF-FTC + ATV/r (539; 33%)	NR	Preterm delivery, aOR: A vs. B: 0.90 (95% CI, 0.60 to 1.33) C vs. B: 0.69 (95% CI, 0.51 to 0.94) A vs. C: 1.14 (95% CI, 0.75 to 1.72) Very preterm delivery, unadjusted OR: A vs. B: 0.85 (95% CI, 0.34 to 2.13) C vs. B: 1.04 (95% CI, 0.60 to 1.83) A vs. C: 0.82 (95% CI, 0.31 to 2.17) Low birth weight, aOR: A vs. B: 1.13 (95% CI, 0.78 to 1.64) C vs. B: 0.80 (95% CI, 0.60 to 1.09) A vs. C: 1.45 (95% CI, 0.96 to 2.17) Very low birth weight, unadjusted OR: A vs. B: 0.41 (95% CI, 0.06 to 3.06) C vs. B: 0.89 (95% CI, 0.40 to 2.00) A vs. C: 0.49 (95% CI, 0.07 to 3.57) Stillbirth—Fetal loss was undefined, included stillbirth (likely also included spontaneous abortion and fetal demise)

Appendix B Table 3. Evidence Table of Included Studies: Results

Study author, year	Intervention	HIV transmission	Adverse events
			Unadjusted OR (our analysis) for initial drug regimen: A vs. B: 2.51 (95% CI, 0.50 to 13) A vs. C: 4.26 (95% CI, 0.60 to 31) B vs. C: 1.70 (95% CI, 0.34 to 8.45) Neonatal death—within 14 days of live birth Unadjusted OR (our analysis) for initial drug regimen: A vs. B. 2.47 (95% CI, 0.10 to 61) A vs. C: 1.40 (95% CI, 0.06 to 34) B vs. C: 0.56 (95% CI, 0.04 to 9.04)
SMARTT and PHACS Studies Siberry, 2012[69]	A. TDF-containing ART (n=449) B. non-TDF–containing ART (n=1,580)	NR	A vs. B Low birth weight (n=1,302): 19.5% vs. 19,1%; aOR, 0.73 (95% CI, 0.48 to 1.11) SGA (n=1,148): 8.3% vs. 8.6%; aOR, 0.96 (95% CI, 0.60 to 1.52)
SMARTT and PHACS Studies Watts, 2013[75]	Various maternal cART regimens	NR	Overall: Preterm birth (<37 weeks): 18.6% (346/1,869) Spontaneous preterm birth (occurred after preterm labor or membrane rupture, without other complications): 10.2% (191/1,869) Very preterm delivery: 2.1% (37/1,799) SGA (birth weight <10% for gestational age): 7.3% (135/1,861) First trimester exposure: Association of first-trimester exposure to PI-based cART and preterm birth: aOR, 1.55 (95% CI, 1.16 to 2.07) Association of first-trimester exposure to PI-based cART and spontaneous preterm birth: aOR, 1.59 (95% CI, 1.10 to 2.30) No association of first-trimester exposure to PI-based cART and SGA: aOR, 0.79 (95% CI, 0.49 to 1.26) No associations for regimens containing NNRTI or ≥3 NRTIs during the first trimester Exposure overall (no significant associations): PI-based cART and preterm birth: aOR, 1.49 (95% CI, 0.83 to 2.67) PI-based cART and spontaneous preterm birth: aOR, 1.41 (95% CI, 0.66 to 2.99) NNRTI-based cART and preterm birth: aOR, 1.28 (95% CI, 0.62 to 2.66) NNRTI-based cART and spontaneous preterm birth: aOR, 1.53 (95% CI, 0.62 to 3.81) ≥3 NRTI-based cART and preterm birth: aOR, 1.04 (95% CI, 0.50 to 2.14) ≥3 NRTI-based cART and spontaneous preterm birth: aOR, 0.88 (95% CI, 0.34 to 2.29)

Appendix B Table 3. Evidence Table of Included Studies: Results

Study author, year	Intervention	HIV transmission	Adverse events
SMARTT and PHACS Studies Williams, 2015[76]	A. Any ART (n=1,219) B. Any HAART (n=1,025) C. NNTRI (n=214) D. NRTI (n=1,211) E. PI (n=887) F. No ART exposure of any kind (n=1,298 to 2,303 depending on comparison) All exposure was during first trimester	NR	Any CA: A vs. F: aOR, 1.20 (95% CI, 087 to 1.67) B vs. F: aOR, 1.35 (95% CI, 0.98 to 1.87) C vs. F: aOR, 0.97 (95% CI, 0.54 to 1.74) D vs. F: 1.19 (95% CI, 0.86 to 1.65) E vs. F: 1.39 (95% CI, 1.00 to 1.92) For specific drugs, there was no significant difference in risk of CA for exposed vs. unexposed except: ddl plus D4T: aOR, 8.19 (95% CI, 1.53 to 43) ATV sulfate: aOR, 1.95 (95% CI, 1.24 to 3.05) RTV when used as a booster: aOR, 1.56 (95% CI, 1.11 to 2.20)
SMARTT and PHACS Studies Williams, 2016[77]	A. Any HAART exposure (n=2,211) B. NNTRI exposed (n=395) C. NRTI (n=1,907) D. PI (n NR) E. No ART exposure of any kind (n=469)	NR	Adverse event cases: A vs. E: aRR, 0.98 (95% CI, 0.82 to 1.16) B vs. E: aRR, 0.98 (95% CI, 0.81 to 1.18) C vs. E: aRR, 1.15 (95% CI, 0.73 to 1.82) D vs. E: aRR, 1.01 (95% CI, 0.86 to 1.17) Differences for specific drug/event combinations: HAART, metabolic cases: aRR, 0.60 (95% CI, 0.44 to 0.82) PIs, metabolic cases: aRR, 0.69 (95% CI, 0.52 to 0.92) ZDV exposure, metabolic cases: aRR, 1.61 (95% CI, 1.01 to 2.58) LPV exposure, metabolic cases: aRR, 0.46 (95% CI, 0.31 to 0.69) LPV (1st trimester), metabolic cases: aRR, 0.39 (95% CI, 0.20 to 0.78) RTV (as booster), metabolic cases: aRR, 0.59 (95% CI, 0.43 to 0.81) RTV (1st trimester), metabolic cases: aRR, 0.61 (95% CI, 0.40 to 0.95) NRTIs, impaired growth: aRR, 0.48 (95% CI, 0.24 to 0.96) Neurodevelopmental impairment: HAART: aRR, 0.47 (95% CI, 0.27 to 0.83) NNRTIs: aRR, 0.38 (95% CI, 0.14 to 1.04) 3TC: aRR, 0.36 (95% CI, 0.36 to 1.02) ZVD + 3TC: aRR, 0.71 (95% CI, 0.41 to 1.17) 3TC (1st trimester): aRR, 0.64 (95% CI, 0.35 to 1.18)
Snijdewind, 2018[73] ATHENA cohort	A. PI-based (928; 67%) B. NNRTI-based (438; 31%) C. Both or NRTI (12; 1%)	NR	Preterm delivery Unadjusted OR: A. 1 (reference) B. 1.30 (95% CI, 0.95 to 1.77); p=0.11 C. 1.15 (95% CI, 0.41 to 3.19); p=0.78 Low birth weight Unadjusted OR: A. 1 (reference) B. 1.19 (95% CI, 0.88 to 3.97); p=0.26 C. 1.47 (95% CI, 0.54 to 3.97); p=0.45 SGA

Appendix B Table 3. Evidence Table of Included Studies: Results

Study author, year	Intervention	HIV transmission	Adverse events
			Unadjusted OR: A. 1 (reference) B. 1.04 (95% CI, 0.80 to 1.16); p=0.76 C. 2.51 (95% CI, 1.16 to 5.53); p=0.02 aOR: A. 1 (reference) B. 0.95 (95% CI, 0.71 to 1.27); p=0.73 C. 2.11 (95% CI, 0.98 to 4.57); p=0.06
Tookey, 2016[74] NSHPC Study	LPV/r	2003 to 2007 Overall: 18/1,633 (1.1% [95% CI, 0.6 to 1.6]) LPV/r initiation: Before conception: 2/6,333 (0.6% [95% CI, 0.2% to 2.2%]) 1st trimester: 0/33 (0%) 2nd trimester: 8/858 (0.9% [95% CI, 0.5% to 4.1%]) 3rd trimester: 8/376 (2.1% [95% CI, 1.1% to 4.1%]) 2008 to 2012 Overall: 12/2,406 (0.5% [95% CI, 0.2% to 0.8%]) LPV/r initiation: Before conception: 2/635 (0.3% [95% CI, 0.1% to 1.1%]) 1st trimester: 0/77 (0%) 2nd trimester: 5/1,397 (0.4% [95% CI, 0.2% to 0.8%]) 3rd trimester: 5/264 (1.9% [95% CI, 0.8% to 4.4%])	Infant mortality: 0.5% (24/4,762) Gestational age: <32 weeks: 2.5% (112/4,762) 32 to 36 weeks: 10.4% (473/4,762) ≥37 weeks: 87% (3971/4,762) Birth weight: <1,500 g: 2.3% (101/4,762) 1,500 to 2,499 g: 12.4% (545/4,762) ≥2,500 g: 85.3% (3,749/4,762) Any CA: 2.9%
Zash, 2016[79]	A. TDF-FTC-EFV at conception (n=165) B. Other 3-drug ART at conception (n=2,006) C. TDF-FTC-EFV during pregnancy (n=1,054) D. Other 3-drug ART during pregnancy (n=2,172)	NR	Initiated ART at conception A vs. B Stillbirth: 4.9% (8/165) vs. 6.4% (128/2,006); aOR, 0.4 (95% CI, 0.1 to 2.9) Preterm birth: 28% (47/165) vs. 31% (631/2,006); aOR, 0.9 (95% CI, 0.3 to 2.9) Very preterm birth: 10% (17/165) vs. 12% (236/2,006); aOR, 0.9 (95% CI, 0.1 to 8.0) SGA, Botswana norms: 8% (14/165) vs. 24% (476/2,006); aOR, 0.4 (95% CI, 0.1 to 1.4) SGA, WHO norms: 13% (22/165) vs. 32% (636/2,006); aOR, 0.3 (95% CI, 0.1 to 1.0)

Appendix B Table 3. Evidence Table of Included Studies: Results

Study author, year	Intervention	HIV transmission	Adverse events
			Any adverse outcome (any stillbirth, preterm birth, and/or SGA): 33% (55/165) vs. 51% (1,030/2,006); aOR, 0.5 (95% CI, 0.1 to 1.2) Initiated ART during pregnancy C vs. D Stillbirth: 1.7% (18/1,054) vs. 3.2% (70/2,172); aOR, 0.6 (95% CI, 0.3 to 1.3) Preterm birth: 18.2% (192/1,054) vs. 20.7% (450/2,172); aOR, 0.7 (95% CI, 0.5 to 1.1) SGA, Botswana norms: 11.9% (125/1,054) vs. 21.1% (459/2,172); aOR, 0.4 (95% CI, 0.3 to 0.6) SGA, WHO norms: 19.2% (202/1,054) vs. 27.7% (602/2,172); aOR, 0.5 (95% CI, 0.4 to 0.7) Any adverse outcome (any stillbirth, preterm birth, and/or SGA): 27% (287/1,054) vs. 41% (880/2,172); aOR, 0.4 (95% CI, 0.3 to 0.6)
Zash, 2017[78]	A. TDF-FTC-EFV (n=2,472) B. TDF-FTC-NVP (n=760) C. TDF-FTC-LPV/r (n=231) D. ZDV-3TC-NVP (n=1,365) E. ZDV-3TC-LPV/r (n=167)	NR	Preterm birth A. 21.4% (529/2,472), reference B. 19.1% (145/760); RR, 0.88 (95% CI, 0.75 to 1.04); aRR, 0.88 (95% CI, 0.75 to 1.05) C. 23.8% (55/231); RR, 1.11 (95% CI, 0.87 to 1.41); aRR, 1.12 (95% CI, 0.88 to 1.43) D. 24.8% (338/1,365); RR, 1.15 (95% CI, 1.02 to 1.30); aRR, 1.14 (95% CI, 1.01 to 1.29) E. 29.3% (49/167); RR, 1.36 (95% CI, 1.07 to 1.74); aRR, 1.36 (95% CI, 1.06 to 1.75) Very preterm birth (<32 weeks) A. 4.1% (101/2,472), reference B. 5.1% (39/760); RR, 1.25 (95% CI, 0.87 to 1.79); aRR, 1.23 (95% CI, 0.84 to 1.80) C. 5.2% (12/231); RR, 1.26 (95% CI, 0.71 to 2.27); aRR, 1.36 (95% CI, 0.76 to 2.45) D. 5.9% (80/1,365); RR, 1.43 (95% CI, 1.07 to 1.90); aRR, 1.44 (95% CI, 1.07 to 1.95) E. 9.0% (15/167); RR, 2.19 (95% CI, 1.30 to 3.67); aRR, 2.21 (95% CI, 1.29 to 3.79) SGA (<10th percentile) A. 16.9% (419/2,472), reference B. 24.9% (189/760); RR, 1.44 (95% CI, 1.24 to 1.68); aRR, 1.44 (95% CI, 1.24 to 1.68) C. 27.7% (64/231); RR, 1.62 (95% CI, 1.29 to 2.03); aRR, 1.56 (95% CI, 1.25 to 1.97) D. 28.2% (385/1,365); RR, 1.65 (95% CI, 1.46 to 1.86); aRR, 1.66 (95% CI, 1.46 to 1.87) E. 20.4% (34/167); RR, 1.19 (95% CI, 0.87 to 1.63); aRR, 1.13 (95% CI,

Appendix B Table 3. Evidence Table of Included Studies: Results

Study author, year	Intervention	HIV transmission	Adverse events
			0.82 to 1.56) Very SGA (<3rd percentile) A. 7.1% (176/2472), reference B. 11.2% (85/760); RR, 1.55 (95% CI, 1.21 to 1.98); aRR, 1.52 (95% CI, 1.18 to 1.94) C. 13.4% (31/231); RR, 1.87 (95% CI, 1.31 to 2.67); aRR, 1.81 (95% CI, 1.26 to 2.59) D. 12.9% (176/1,365); RR, 1.80 (95% CI, 1.47 to 2.19); aRR, 1.76 (95% CI, 1.44 to 2.16) E. 12.6% (21/167); RR, 1.75 (95% CI, 1.15 to 2.67); aRR, 1.70 (95% CI, 1.10 to 2.62) Stillbirth A. 2.4% (59/2,472), reference B. 2.9% (22/760); RR, 1.21 (95% CI, 0.75 to 1.97); aRR, 1.15 (95% CI, 0.70 to 1.89) C. 4.3% (10/231); RR, 1.81 (95% CI, 0.94 to 3.50); aRR, 1.81 (95% CI, 0.94 to 3.50) D. 6.1% (83/1,365); RR, 2.55 (95% CI, 1.84 to 3.53); aRR, 2.31 (95% CI, 1.64 to 3.26) E. 3.6% (6/167); RR, 1.51 (95% CI, 0.66 to 3.44); aRR, 1.53 (95% CI, 0.67 to 3.49) Neonatal death A. 1.2% (29/2,472), reference B. 1.7% (13/760); RR, 1.46 (95% CI, 0.77 to 2.80); aRR, 1.57 (95% CI, 0.81 to 3.06) C. 1.7% (4/231); RR, 1.50 (95% CI, 0.53 to 4.24); aRR, 1.60 (95% CI, 0.56 to 4.76) D. 2.1% (28/1,365); RR, 1.82 (95% CI, 1.09 to 3.04); aRR, 1.94 (95% CI, 1.13 to 3.33) E. 4.2% (7/167); RR, 3.64 (95% CI, 1.62 to 8.17); aRR, 4.01 (95% CI, 1.78 to 9.11)

Abbreviations: 3TC=lamivudine; ABC=abacavir; aHR=adjusted hazard ratio; ANRS-EPF=French Agence Nationale de Recherche sur le SIDA-Enquête Périnatale Française; aOR=adjusted odds ratio; APGAR=Appearance, Pulse, Grimace, Activity, Respiration; aRR=adjusted risk ratio; ART=antiretroviral therapy; ATV=atazanavir; CA=congenital abnormality; cART=combination antiretroviral therapy; CD4=cluster of differentiation 4; CHD=congenital heart defect; CI=confidence interval; CMIS=Centre Maternel et Infantile sur le SIDA; CPHSP=Canadian Perinatal HIV Surveillance Program; D4T=stavudine; ddl=didanosine; DRV=darunavir; EFV=efavirenz; EPPICC=European Pregnancy and Paediatic HIV Cohort Collaboration; EUROCAT=European Surveillance of Congenital Anomalies; FTC=emtricitabine; HAART=highly-active antiretroviral therapy; HBV=hepatitis B virus; IMPAACT=International Maternal Pediatric Adolescent AIDS Clinical Trials; IND=indinavir; LILAC=Perinatal and Longitudinal Study in Latin American Countries; LPV=lopinavir; LPV/r=lopinavir/ritonavir; LV=left ventricle; MACDP=Metropolitan Atlanta Congenital Defects Program; NNRTI=nonnucleoside reverse transcriptase inhibitors; NR=not reported; NRTI=nucleoside reverse transcriptase inhibitor; NSHPC=National Study of HIV in Pregnancy and Childhood; NVP=nevirapine; OR=odds ratio; PHACS=Pediatric HIV/AIDS Cohort Study; PI=protease inhibitor; PRIMEVA-ANRS=Protease Inhibitor Monotherapy Evaluation-French Agence Nationale de Recherche sur le SIDA; PROMISE=Promoting Maternal and Infant Survival Everywhere; PWTCT=Prevention of Mother to Child Transmission Program; RAL=raltegravir; RCT=randomized, controlled trial; RNA=ribonucleic acid; RTV=ritonavir; SGA=small size for gestational age; SMARTT=Surveillance Monitoring for Antiretroviral Treatment

Toxicities; TDF=tenofovir disoproxil fumarate; U.S.=United States; VIQ=verbal intelligence quotient; WASI=Wechsler Abbreviated Scale of Intelligence; WHO=World Health Organization; WIAT-II-A=Wechsler Individual Achievement Test, 2nd Edition; WPPSI-III=Wechsler Preschool and Primary Scale of Intelligence, 3rd Edition; ZDV=zidovudine.

Appendix B Table 4. Quality Assessment of Cohort Studies

Author, Year	Did the study attempt to enroll all (or a random sample of) patients meeting inclusion criteria, or a random sample (inception cohort)?	Were the groups comparable at baseline on key prognostic factors (e.g., by restriction or matching)?	Did the study maintain groups through the study period?	Did the study use accurate methods for ascertaining exposures and potential confounders?	Were outcome assessors and/or data analysts blinded to the exposure being studied?	Did the article report attrition?	Is there high attrition?	Were outcomes prespecified and defined, and ascertained using accurate methods?	Quality rating
Aaron, 2012[46]	Yes	Not relevant	Not relevant	Yes	Unclear	No	Unclear	Yes	Fair
Anteretroviral Pregnancy Registry Interim Report[47]	Not relevant (volunteer database); encourages participating MDs to enter all cases	Not relevant	Not relevant	Yes, but no adjustment for confounding	Unclear	No	No	Yes	Fair
Berard, 2017[48]	Yes	No	Yes	Yes	Unclear	No	Unclear	Yes	Fair
Chagomerana, 2017[49]	Yes	No	Yes	Yes	Unclear	Yes	No	Yes	Fair
Chen, 2012[50]	Yes	Differences in age, past adverse pregnancy outcome, receipt of antenatal care, CD4 count, parity	Unclear	Yes	Unclear	No	Unclear	Yes	Fair
Chiappini, 2013[51]	Yes	Not relevant	Not relevant	Yes	Unclear	No	Unclear	Yes	Fair
Duryea, 2015[52]	Yes	No	Yes	Yes	Unclear	No	Unclear	Yes	Fair
Floridia, 2013[53]	Yes	Not relevant	Not relevant	Yes	Unclear	No	Unclear	Yes	Fair
French Perinatal Cohort ANRS-EPF study Mandelbrot, 2015[61] Sibiude, 2012[72] Sibiude, 2014[68] Sibiude, 2015[70]	Yes	Not relevant	Not relevant	Yes	Unclear	No	Unclear	Yes	Fair
Kakkar, 2015[54]	Yes	Differences in study time period, parity, ethnicity	Unclear	Yes	Unclear	No	Unclear	Yes	Fair
Knapp, 2012[55]	Yes	Not relevant	Not relevant	Yes	Yes	No	Unclear	Yes	Fair
Kreitchmann, 2014[56]	Yes	Not relevant	Not relevant	Yes	Unclear	No	Unclear	Yes	Fair

Appendix B Table 4. Quality Assessment of Cohort Studies

Author, Year	Did the study attempt to enroll all (or a random sample of) patients meeting inclusion criteria, or a random sample (inception cohort)?	Were the groups comparable at baseline on key prognostic factors (e.g., by restriction or matching)?	Did the study maintain groups through the study period?	Did the study use accurate methods for ascertaining exposures and potential confounders?	Were outcome assessors and/or data analysts blinded to the exposure being studied?	Did the article report attrition?	Is there high attrition?	Were outcomes prespecified and defined, and ascertained using accurate methods?	Quality rating
Li, 2016[57]	Yes	Differences in delivering prior to year 2007, CD4 count, nutritional status, and other diseases and symptoms	Unclear	Yes	Unclear	No	Unclear	Yes	Fair
Lopez, 2012[59]	Yes	Differences in nulliparity and prior preterm birth for case-control analysis	Unclear	Yes	Unclear	No	Unclear	Yes	Fair
Lu, 2014[60]	Yes	Not relevant	Not relevant	Yes	Unclear	Yes	No	Yes	Fair
Mor, 2017[63]	Yes	No	Yes	Yes	Unclear	No	Unclear	Yes	Fair
Moodley, 2016[62]	Yes	Unclear	Unclear	Yes	Unclear	No	Unclear	Yes	Fair
Pintye, 2017[65]	Yes	No	Yes	Yes	Unclear	Yes	No	Yes	Fair
Ramokolo, 2017[66]	Yes	No	Yes	Yes	Unclear	No	Unclear	Yes	Fair
Rough, 2018[67] PHACS and IMPAACT P1025	Yes	Differences in age, timing of regimen initiation, viral load, and timing of HIV diagnosis	Yes	Yes	Unclear	No	Unclear	Yes	Fair
Short, 2013[68]	Yes	Not relevant	Not relevant	Yes	Unclear	No	Unclear	Yes	Fair
SMARTT/ PHACS studies Nozyce, 2014[64] Lipshultz, 2015[58] Siberry, 2012[69] Watts, 2013[75] Williams, 2015[76] Williams, 2016[77]	Yes	Not relevant	Not relevant	Yes	Unclear	No	Unclear	Yes	Fair
Snijdewind, 2018[73]	Yes	Not relevant	Not relevant	Yes	Unclear	No	Unclear	Yes	Fair
Tookey, 2016[74]	Yes	Not relevant	Not relevant	Yes	Unclear	No	Unclear	Yes	Fair
Zash, 2016[79]	Yes	Yes	Yes	Yes	Unclear	No	Unclear	Yes	Fair
Zash, 2017[78]	Yes	No	Yes	Yes	Unclear	No	Unclear	Yes	Fair

Appendix B Table 4. Quality Assessment of Cohort Studies

Author, Year	Did the study attempt to enroll all (or a random sample of) patients meeting inclusion criteria, or a random sample (inception cohort)?	Were the groups comparable at baseline on key prognostic factors (e.g., by restriction or matching)?	Did the study maintain groups through the study period?	Did the study use accurate methods for ascertaining exposures and potential confounders?	Were outcome assessors and/or data analysts blinded to the exposure being studied?	Did the article report attrition?	Is there high attrition?	Were outcomes prespecified and defined, and ascertained using accurate methods?	Quality rating

Abbreviations: ANRS-EPF=French Agence Nationale de Recherche sur le SIDA-Enquête Périnatale Française; CD4=cluster of differentiation 4; IMPAACT=International Maternal Pediatric Adolescent AIDS Clinical Trials; PHACS=Pediatric HIV/AIDS Cohort Study; SMARTT=Surveillance Monitoring for Antiretroviral Treatment Toxicities.

Appendix B Table 5. Quality Assessment of Randomized Trials

Author, year	Randomization adequate?	Allocation concealment adequate?	Groups similar at baseline?	Eligibility criteria specified?	Outcome assessors masked?	Care provider masked?	Patient masked?	Attrition and withdrawals reported?	Loss to followup: differential (>10%)/high (>20%)?	Analyze persons in the groups in which they were randomized?	Quality rating
Fowler, 2016[44]	Yes	Unclear	Yes	Yes	Unclear	Unclear	Unclear	Yes	No, No	Yes	Fair
Sartorius, 2013[45]	Unclear	Unclear	Yes	Yes	Unclear	Unclear	Unclear	Yes	No, No	Unclear	Fair