



Consolidated guideline on sexual and reproductive health and rights of women living with HIV

Web annex: GRADE tables and systematic review search strategies



Consolidated guideline on sexual and reproductive health and rights of women living with HIV.*

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* The full guideline is available at: www.who.int/reproductivehealth/publications/gender_rights/srhr-women-hiv/en/

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GRADE tables

1. Empowerment and self-efficacy interventions for women living with HIV

Date: 4 April 2016

PICO question: What interventions improve self-efficacy and empowerment around safer sex and reproductive decision-making for women living with HIV?

Systematic review: Robinson JL, Narasimhan M, Amin A, Morse S, Beres LK, Yeh PT, Kennedy CE. Interventions to address unequal gender and power relations and improve self efficacy and empowerment around sexual and reproductive health decision-making for women living with HIV: a systematic review. PLoS One. 2017 (under review).

1a. Should SISTA (Sisters Informing Sisters About Topics on AIDS) adaptations (Women Involved in Life Learning from Other Women [WILLOW], Peers Undertaking Reproductive and Sexual Health Education [PURSE]) be used in women living with HIV?

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	SISTA adaptations (WILLOW, PURSE)	Control	Relative (95% CI)	Absolute		
STIs: incident bacterial STI (chlamydia and gonorrhoea) (follow-up mean 12 months)												
1 ¹	Randomized trials	No serious risk of bias	No serious inconsistency ²	No serious indirectness	Serious ³	None	–	–	OR 0.1 (0.01 to 0.7) ⁴	–	⊕⊕⊕○ MODERATE	CRITICAL
STIs: incident bacterial vaginosis (BV) (follow-up mean 3 months)												
1 ⁵	Randomized trials	No serious risk of bias	No serious inconsistency ²	No serious indirectness	Serious ³	None	22/49 (44.9%)	18/48 (37.5%)	OR 1.23 (0.53 to 2.85) ⁶	50 more per 1000 (134 fewer to 256 more)	⊕⊕⊕○ MODERATE	CRITICAL
STIs: incident <i>Trichomonas vaginalis</i> (TV) (follow-up mean 3 months)												
1 ^{5,7}	Randomized trials	No serious risk of bias	No serious inconsistency ²	No serious indirectness	Serious ³	None	3/49 (6.1%)	13/48 (27.1%)	OR 0.06 (0.01 to 0.46) ⁶	249 fewer per 1000 (125 to 267 fewer)	⊕⊕⊕○ MODERATE	CRITICAL
STIs: incident <i>Neisseria gonorrhoeae</i> (NG) (follow-up mean 3 months)												
1 ⁵	Randomized trials	No serious risk of bias	No serious inconsistency ²	No serious indirectness	Serious ³	None	2/49 (4.1%)	14/48 (29.2%)	OR 0.10 (0.02 to 0.49) ⁶	252 fewer per 1000 (124 to 283 fewer)	⊕⊕⊕○ MODERATE	CRITICAL
STIs: incident <i>Chlamydia trachomatis</i> (CT) (follow-up mean 3 months)												
1 ⁵	Randomized trials	No serious risk of bias	No serious inconsistency ²	No serious indirectness	Serious ³	None	7/49 (14.3%)	19/48 (39.6%)	OR 0.21 (0.07 to 0.59) ⁶	275 fewer per 1000 (117 to 352 fewer)	⊕⊕⊕○ MODERATE	CRITICAL

1. Empowerment and self-efficacy interventions for women living with HIV

1a: Should SISTA (Sisters Informing Sisters About Topics on AIDS) adaptations (Women Involved in Life Learning from Other Women [WILLOW], Peers Undertaking Reproductive and Sexual Health Education [PURSE]) be used in women living with HIV? (continued)

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	SISTA adaptations (WILLOW, PURSE)	Control	Relative (95% CI)	Absolute		
Condom use: number of acts of unprotected vaginal sex in the past 30 days (follow-up mean 12 months; better indicated by lower values)												
1 ¹	Randomized trials	No serious risk of bias	No serious inconsistency ²	No serious indirectness	Serious ³	None	162	159	–	MD 0.7 lower (1.8 to 0.4 lower) ⁸	⊕⊕⊕○ MODERATE	IMPORTANT
Condom use: number of acts of unprotected vaginal/anal sex in past 30 days (follow-up mean 3 months; better indicated by lower values)												
1 ⁹	Randomized trials	No serious risk of bias	No serious inconsistency ²	No serious indirectness	Serious ³	None	87	88	–	MD 3.41 lower (5.54 to 1.29 lower) ¹⁰	⊕⊕⊕○ MODERATE	IMPORTANT
Condom use: proportion of acts of unprotected vaginal/anal sex in the past 30 days (follow-up mean 3 months; better indicated by lower values)												
1 ⁹	Randomized trials	No serious risk of bias	No serious inconsistency ²	No serious indirectness	Serious ³	None	87	88	–	MD 0.33 higher (0.13 to 0.52 higher) ¹¹	⊕⊕⊕○ MODERATE	IMPORTANT
Condom use: 100% condom use during vaginal/anal sex in the past 30 days (follow-up mean 3 months)												
1 ⁹	Randomized trials	No serious risk of bias	No serious inconsistency ²	No serious indirectness	Serious ³	None	87/87 (100%)	88/88 (100%)	OR 9.67 (1.25 to 74.97) ¹¹	–	⊕⊕⊕○ MODERATE	IMPORTANT
Condom use: never used condoms in the past 30 days (follow-up mean 12 months)												
1 ¹	Randomized trials	No serious risk of bias	No serious inconsistency ²	No serious indirectness	Serious ³	None	–	–	Not estimable	–	⊕⊕⊕○ MODERATE	IMPORTANT
Condom use: condom use at last sex (follow-up mean 3 months)												
1 ⁵	Randomized trials	No serious risk of bias	No serious inconsistency ²	No serious indirectness	Serious ³	None	–	–	Not estimable	–	⊕○○○ VERY LOW	IMPORTANT
Contraceptive use: long-acting reversible contraception (LARC) (follow-up mean 3 months ¹²)												
3 ^{1,5,13}	Randomized trials ¹⁷	No serious risk of bias	Serious ¹⁸	No serious indirectness	No serious imprecision	None	0	–	–	Mean ranged from 0 to 0 higher	⊕⊕⊕○ MODERATE	IMPORTANT

1. Empowerment and self-efficacy interventions for women living with HIV

1a: Should SISTA (Sisters Informing Sisters About Topics on AIDS) adaptations (Women Involved in Life Learning from Other Women [WILLOW], Peers Undertaking Reproductive and Sexual Health Education [PURSE]) be used in women living with HIV? (continued)

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	SISTA adaptations (WILLOW, PURSE)	Control	Relative (95% CI)	Absolute		
Relationship power (follow-up mean 3 months; measured with: control in relationships/relationship power; better indicated by higher values)												
2 ^{5,13}	Randomized trials ¹⁹	No serious risk of bias	Serious ¹⁸	No serious indirectness	No serious imprecision	None	0	–	–	Mean 0 higher (0 to 0 higher) ²⁰	⊕⊕⊕○ MODERATE	IMPORTANT
Sexual communication self-efficacy (follow-up mean 3 months; better indicated by higher values)												
1 ⁹	Randomized trials	No serious risk of bias	No serious inconsistency ²	No serious indirectness	Serious ³	None	0	–	–	MD 3.40 higher (1.12 to 5.65 higher) ²¹	⊕⊕⊕○ MODERATE	IMPORTANT

- Wingood GM, DiClemente RJ, Mikhail I, Lang DL, McCree DH, Davies SL et al. A randomized controlled trial to reduce HIV transmission risk behaviors and sexually transmitted diseases among women living with HIV: the WILLOW Program. *J Acquir Immune Defic Syndr.* 2004;37(Suppl 2):S58–67.
- Inconsistency cannot be assessed with a single study.
- Downgraded for imprecision for a small number of events (< 300).
- Data reported for generalized estimating equation (GEE) model over entire 12-month assessment period. At the 6-month assessment, the OR comparing intervention to control groups was 0.3 (95% CI: 0.1, 1.3, $P = 0.11$) and at 12-month assessment the OR was 0.1 (95% CI: 0.01, 0.7, $P = 0.023$).
- Saleh-Onoya D, Reddy PS, Ruiter RA, Sifunda S, Wingood G, van den Borne B. Condom use promotion among isiXhosa speaking women living with HIV in the Western Cape Province, South Africa: a pilot study. *AIDS Care.* 2009;21(7):817–25. doi:10.1080/09540120802537823.
- Controlling for baseline.
- Also measured in Wingood et al. (2004), but non-significant and data not reported: "No differences were observed for incident trichomonas infections at the 12-month assessment, or over the entire 12-month period."
- Over the entire 12-month follow-up period, the mean number of episodes was 1.8 in the intervention group vs 2.5 in the control group, $P = 0.029$.
- Klein CH, Lomonaco CG, Pavlescak R, Card JJ. WILLOW: reaching HIV-positive African-American women through a computer-delivered intervention. *AIDS Behav.* 2013;17(9):3013-23. doi:10.1007/s10461-013-0479-z.
- At 3-month follow-up, the mean number of episodes was 0.24 in the intervention group and 3.00 in the control group ($P = 0.002$).
- At 3-month follow-up, the proportion of episodes was 0.89 in the intervention group and 0.73 in the control group ($P = 0.002$). Analyses were also stratified by partner type. With HIV-negative partners: I: 0.89, C: 0.79, adjusted mean difference 0.31 (95% CI: 0.02, 0.61, $P = 0.040$). With HIV-positive partners: I: 1.0, C: 0.72, adjusted mean difference 0.48 (95% CI: 0.02, 0.75, $P = 0.003$).
- 3 months postpartum.
- Sarnquist CC, Moyo P, Stranix-Chibanda L, Chipato T, Kang JL, Maldonado YA. Integrating family planning and prevention of mother to child HIV transmission in Zimbabwe. *Contraception.* 2014;89(3):209–14. doi:10.1016/j.contraception.2013.11.003.
- Non-randomized trial ("quasi-experimental, prospective intervention trial"). Participants enrolled in intervention and control groups based on study entry date.
- Pregnant women living with HIV.
- I: 87.1%, C: 81.8%, $P = 0.34$.
- 2 randomized controlled trials (RCTs); 1 observational study.
- Studies showed differing effects (some statistically significant improvement, some no improvement), although no formal tests of heterogeneity were conducted.
- 1 RCT; 1 observational study.
- Saleh-Onoya et al. (2009): At 3-month follow-up, mean: I: 1.74, C: 1.91, $F = 0.77$, $P = 0.38$; Sarnquist et al. (2014): At 3-month follow-up postpartum, mean sexual relationship power scale: I: 2.5, C: 2.1, $P = 0.01$.
- $F = 9.12$, $P = 0.004$.

MD: mean difference.

1. Empowerment and self-efficacy interventions for women living with HIV

1b. Should “Stress Management And Relaxation Training/Expressive-Supportive Therapy (SMART/EST) Women’s Project”, “Now/Now2” and the “Partner Project” be used in women living with HIV?

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	SMART/EST Women’s Project, Now/ Now2 and the Partner Project	Control	Relative (95% CI)	Absolute		
Condom use: “all the time” (follow-up 9–12 months)												
3 ¹	Randomized trials	No serious risk of bias	No serious inconsistency ²	No serious indirectness	Serious ³	None	–	0%	F 0.24 (0 to 0) ^{4,5}	–	⊕⊕⊕○ MODERATE	IMPORTANT

- Jones DL, Weiss SM, Malow R, Ishii M, Devieux J, Stanley H et al. A brief sexual barrier intervention for women living with AIDS: acceptability, use, and ethnicity. *J Urban Health*. 2001;78(4):593–604. doi:10.1093/jurban/78.4.593. Jones DL, Ross D, Weiss SM, Bhat G, Chitalu N. Influence of partner participation on sexual risk behavior reduction among HIV-positive Zambian women. *J Urban Health*. 2005;82(3 Suppl 4):iv92-100. doi:10.1093/jurban/jti111. Jones DL, Weiss SM, Bhat GJ, Bwalya V. Influencing sexual practices among HIV-positive Zambian women. *AIDS Care*. 2006;18(6):629–34. doi:10.1080/09540120500415371.
- Meta-analysis not conducted to test for heterogeneity, but all 3 studies found sustained high levels of condom use.
- Downgraded for imprecision for a small number of events (< 300).
- 95% CI: 0.62.
- Data presented from Jones et al. (2006). Jones et al. (2001) reported “no change in male condom use” (98% at baseline, 100% at 3-month follow-up, and 100% at 9-month follow-up). Jones et al. (2005) reported that female participants maintained high levels of protected sex at the 12-month follow-up (X²: 4.83, *P* = 0.003; 94% reported using sexual protection “all of the time”).

1c. Should “Mothers 2 Mothers” (M2M) and “Mamekhaya” be used in women living with HIV?

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	M2M and Mamekhaya	Control	Relative (95% CI)	Absolute		
Condom use: abstinent or always uses condom (follow-up mean 6 months ¹)												
1 ²	Observational studies ³	Serious ⁴	No serious inconsistency ⁵	No serious indirectness ⁶	Serious ⁷	None	38/40 (95%)	30/31 (96.8%)	B 0.24 (0 to 0) ⁸	735 fewer per 1000 (968 to 968 fewer)	⊕○○○ VERY LOW	IMPORTANT

- Follow-up was 6 months after delivery.
- Futterman D, Shea J, Besser M, Stafford S, Desmond K, Comulada WS et al. Mamekhaya: a pilot study combining a cognitive-behavioral intervention and mentor mothers with PMTCT services in South Africa. *AIDS Care*. 2010;22(9):1093–100. doi:10.1080/09540121003600352.
- Group non-randomized trial; intervention and control sites not randomly allocated.
- High loss to follow-up (only 44% completion).
- Inconsistency cannot be assessed with a single study.
- Pregnant women living with HIV.
- Downgraded for imprecision for a small number of events (< 300).
- B = estimated effect of intervention (intervention × follow-up interaction term in Logit model, controlling for housing, education, employment and marital/living status. SE = 1.44; *P* > 0.05).

1. Empowerment and self-efficacy interventions for women living with HIV

1d. Should “Healthy Relationships” be used in women living with HIV?

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Healthy Relationships	Control	Relative (95% CI)	Absolute		
Condom use: no episodes of unprotected sex in the past 3 months (follow-up mean 6 months)												
1 ¹	Randomized trials	No serious risk of bias	No serious inconsistency ²	No serious indirectness	Serious ³	None	–	–	Not estimable ⁴	–	⊕⊕⊕⊖ MODERATE	IMPORTANT

1. Marhefka SL, Buhi ER, Baldwin J, Chen H, Johnson A, Lynn V et al. Effectiveness of healthy relationships video-group: a videoconferencing group intervention for women living with HIV: preliminary findings from a randomized controlled trial. *Telemed J E Health*. 2014;20(2):128–34. doi:10.1089/tmj.2013.0072.

2. Inconsistency cannot be assessed with a single study.

3. Downgraded for imprecision for a small number of events (< 300).

4. Odds ratio compares control group to intervention group.

1e. Should “Keeping Healthy and Active with Risk Reduction and Medication Adherence” (KHARMA) be used in women living with HIV?

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	KHARMA	Control	Relative (95% CI)	Absolute		
Condom use: always use condoms in the past 3 months (follow-up 6–9 months)												
2 ¹	Randomized trials ²	No serious risk of bias	No serious inconsistency	No serious indirectness	No serious imprecision	None	–	–	Not estimable ³	–	⊕⊕⊕⊕ HIGH	IMPORTANT
Condom use: at last sexual encounter (follow-up mean 6 months)												
1 ⁴	Observational studies ⁵	No serious risk of bias	No serious inconsistency ⁶	No serious indirectness	Serious ⁷	None	24/27 (88.9%)	10/19 (52.6%)	– ⁸	526 fewer per 1000 (526 to 526 fewer)	⊕⊖⊖⊖ VERY LOW	IMPORTANT

1. Holstad MM, Dilorio C, Kelley ME, Resnicow K, Sharma S. Group motivational interviewing to promote adherence to antiretroviral medications and risk reduction behaviors in HIV infected women. *AIDS Behav*. 2011;15(5):885–96. doi:10.1007/s10461-010-9865-y. Holstad MM, Essien JE, Ekong E, Higgins M, Teplinskiy I, Adewuyi MF. Motivational groups support adherence to antiretroviral therapy and use of risk reduction behaviors in HIV positive Nigerian women: a pilot study. *Afr J Reprod Health*. 2012;16(3):14–27.

2. 1 RCT; 1 quasi-experimental, two-group post-test only design.

3. Holstad et al. (2011): A greater proportion of intervention participants reported always using condoms in the past 3 months at all time points (2 weeks; 3, 6 and 9 months), but was only significant at the 6-month ($Z = 2.10$, $P = 0.036$) and borderline significant at the 9-month time periods ($Z = 1.91$, $P = 0.056$). Data for the 2-week and 3-month follow-up not shown. Holstad et al. (2012) (observational study): A significantly greater proportion of women in the intervention group reported always using condoms in the past 3 months at 3-month follow-up: I: 84.6%, C: 43.8%, $P = 0.014$.

4. Holstad et al. (2012).

5. Quasi-experimental, two-group post-test only design.

6. Inconsistency cannot be assessed with a single study.

7. Downgraded for imprecision for a small number of events (< 300).

8. $P = 0.015$.

1. Empowerment and self-efficacy interventions for women living with HIV

1f. Should “Project ROADMAP” (“Reeducating Older Adults in Maintaining AIDS Prevention”) be used in women living with HIV?

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Project ROADMAP (Reeducating Older Adults in Maintaining AIDS Prevention)	Control	Relative (95% CI)	Absolute		
Condom use: inconsistent condom use with all partners in the last 6 months (follow-up median 6 months)												
1 ¹	Randomized trials	Serious ²	No serious inconsistency ³	No serious indirectness	No serious imprecision ⁴	None	— ⁵	—	—	—	⊕⊕⊕○ MODERATE	IMPORTANT
Condom use: inconsistent condom use with HIV-negative/unknown serostatus partners in the last 6 months (follow-up median 6 months)												
1 ¹	Randomized trials	Serious ²	No serious inconsistency ³	No serious indirectness	Serious ⁴	None	— ⁶	—	—	—	⊕⊕○○ LOW	IMPORTANT
Condom use: inconsistent condom use with HIV-positive partners in the last 6 months (follow-up median 6 months)												
1 ¹	Randomized trials	Serious ²	No serious inconsistency ³	No serious indirectness	Serious ⁴	None	— ⁷	—	—	—	⊕⊕○○ LOW	IMPORTANT

- Echenique M, Illa L, Saint-Jean G, Avellaneda VB, Sanchez-Martinez M, Eisdorfer C. Impact of a secondary prevention intervention among HIV-positive older women. *AIDS Care*. 2013;25(4):443–6. doi:10.1080/09540121.2012.712666.
- High loss to follow-up: only 35% of participants (106/300) completed the 6-month follow-up.
- Inconsistency cannot be assessed with a single study.
- Downgraded for imprecision for a small number of events (< 300).
- I: Baseline (BL): 20%, Follow-up (FU): 9.2% (BL vs FU: $P < 0.05$). C: BL: 12.2%, FU: 9.8% (BL vs FU: $P = 0.42$); numbers (Ns) by group and time period not shown.
- I: BL: 12.3%, FU: 3.1% (BL vs FU: $P < 0.10$). C: BL: 2.4%, FU: 4.9% (BL vs FU: $P = 0.51$); Ns by group and time period not shown.
- I: BL: 7.7%, FU: 6.2% (BL vs FU: $P > 0.99$). C: BL: 9.8%, FU: 9.8% (BL vs FU: $P > 0.99$); Ns by group and time period not shown.

1. Empowerment and self-efficacy interventions for women living with HIV

1g. Should “Women and Infants Demonstration Project” (WIDP) be used in women living with HIV?

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Women and Infants Demonstration Project (WIDP)	Control	Relative (95% CI)	Absolute		
Condom use: progress in stage of always condom use with main partner (follow-up mean 18 months ¹ ; assessed with: moving up one or more stages or remaining in maintenance ²)												
1 ³	Randomized trials	No serious risk of bias	No serious inconsistency ⁴	No serious indirectness	No serious imprecision ⁵	None	–	–	Not estimable ⁶	–	⊕⊕⊕⊕ HIGH	IMPORTANT
Contraceptive use: progress in stage of always contraceptive use (follow-up mean 18 months ¹ ; assessed with: moving up one or more stages or remaining in maintenance ²)												
1 ³	Randomized trials	No serious risk of bias	No serious inconsistency ⁴	No serious indirectness	Serious ⁵	None	–	–	Not estimable ⁷	–	⊕⊕⊕○ MODERATE	IMPORTANT
Self-efficacy for condom use with main partner (follow-up mean 18 months ¹)												
1 ³	Randomized trials	No serious risk of bias	No serious inconsistency ⁴	No serious indirectness	Serious ⁵	None	–	–	Not estimable ⁸	–	⊕⊕⊕○ MODERATE	IMPORTANT

1. Follow-ups at 6, 12 and 18 months.

2. Stages of change measured through Prochaska's theory of 5 stages of change. "Maintenance" was practising the behaviour consistently for more than 6 months, "Action" was practising the behaviour consistently for less than 6 months, "Ready for action" was intending to be consistent within the next month, "Contemplation" was intending to be consistent within the next six months, "Pre-contemplation" was those who did not intend to perform the behaviour consistently.

3. Fogarty LA, Heilig CM, Armstrong K, Cabral R, Galavotti C, Gielen AC et al. Long-term effectiveness of a peer-based intervention to promote condom and contraceptive use among HIV-positive and at-risk women. Public Health Rep. 2001;116(Suppl 1):103–19.

4. Inconsistency cannot be assessed with a single study.

5. Downgraded for imprecision for a small number of events (< 300).

6. $P = 0.02$.

7. $P = 0.08$.

8. $P = 0.01$.

1. Empowerment and self-efficacy interventions for women living with HIV

1h. Should “Protect and Respect” be used in women living with HIV?

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Protect and Respect	Control	Relative (95% CI)	Absolute		
Condom use: proportion of vaginal and anal sex episodes during which a condom was used in the past 6 months (follow-up mean 18 months)												
1 ¹	Randomized trials	Serious ²	No serious inconsistency ³	No serious indirectness	Serious ⁴	None	–	–	Not estimable ⁵	–	⊕⊕⊕⊖ LOW	IMPORTANT

1. Teti M, Bowleg L, Cole R, Lloyd L, Rubinstein S, Spencer S et al. A mixed methods evaluation of the effect of the protect and respect intervention on the condom use and disclosure practices of women living with HIV/AIDS. *AIDS Behav.* 2010;14(3):567–79
2. High loss to follow-up (71% at 6 months but just 30% at 18 months).
3. Inconsistency cannot be assessed with a single study.
4. Downgraded for imprecision for a small number of events (< 300).
5. $P > 0.01$. At 6-month follow-up, adjusted difference in OR: 17.13 (95% CI: 2.96–99.1), $P < 0.01$. Adjusted for ethnicity, infection route, relationship status, age, months since HIV+ diagnosis.

1i. Should “Women’s CoOp” be used in women living with HIV?

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Women’s CoOp	Control	Relative (95% CI)	Absolute		
Condom use: condom use at last sex (follow-up mean 6 months)												
1 ¹	Randomized trials	No serious risk of bias	No serious inconsistency ²	No serious indirectness ³	Serious ⁴	None	–	–	Not estimable ⁵	–	⊕⊕⊕○ MODERATE	IMPORTANT

1. Wechsberg WM, Luseno WK, Kline TL, Browne FA, Zule WA. Preliminary findings of an adapted evidence-based woman-focused HIV intervention on condom use and negotiation among at-risk women in Pretoria, South Africa. *J Prev Interv Community.* 2010;38(2):132-46. doi:10.1080/10852351003640799.
2. Inconsistency cannot be assessed with a single study.
3. High-risk women who use alcohol and other drugs; includes both sex workers and non-sex workers.
4. Downgraded for imprecision for a small number of events (< 300).
5. $P < 0.05$.

1. Empowerment and self-efficacy interventions for women living with HIV

1j. Should “Enhanced Sexual Health Intervention” (ESHI) be used in women living with HIV?

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Enhanced Sexual Health Intervention (ESHI)	Control	Relative (95% CI)	Absolute		
Condom use: increase in percentage of episodes of sex in which a condom was used with main partner in the last 3 months (or maintenance at 100%) (follow-up mean 6 months)												
1 ¹	Randomized trials	No serious risk of bias	No serious inconsistency ²	No serious indirectness ³	Serious ⁴	None	–	–	Not estimable ⁵	–	⊕⊕⊕○ MODERATE	IMPORTANT

1. Wyatt GE, Longshore D, Chin D, Carmona JV, Loeb TB, Myers HF et al. The efficacy of an integrated risk reduction intervention for HIV-positive women with child sexual abuse histories. *AIDS Behav.* 2004;8(4):453–62. doi:10.1007/s10461-004-7329-y.
2. Inconsistency cannot be assessed with a single study.
3. Women with a history of childhood sexual abuse.
4. Downgraded for imprecision for a small number of events (< 300).
5. $P = 0.039$.

2. Safer disclosure for women living with HIV

Date: 8 January 2016

PICO question: What interventions facilitate safe disclosure of HIV status for women living with HIV who fear violence or who disclose that they are currently experiencing violence?

Systematic review: Kennedy C, Haberlen S, Amin A, Baggaley R, Narasimhan M. Safer disclosure of HIV serostatus for women living with HIV who experience or fear violence: a systematic review. *J Int AIDS Soc.* 2015;18(6 Suppl 5):20292. doi:10.7448/IAS.18.6.20292.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Safer disclosure	Control	Relative (95% CI)	Absolute		
Disclosure (follow-up 14 weeks to 35 months ¹ ; assessed with: self-disclosure of HIV status to sexual partner in the past year)												
1 ²	Randomized trials	No serious risk of bias	No serious inconsistency	Serious ³	No serious imprecision	Serious ²	131/402 (33%) ⁴	165/567 (29%)	PRR: 1.08 (0.82 to 1.43)	23 more per 1000 (52 fewer to 125 more)	⊕⊕⊕⊖ LOW	CRITICAL
Physical violence (follow-up 14 weeks to 35 months ¹ ; assessed with: adapted conflict tactics scale)												
1 ²	Randomized trials	No serious risk of bias	Serious ⁵	Very serious ^{3,6}	No serious imprecision	Serious ²	217/1812 (12%) ⁷	346/2127 (16%)	aPRR ⁸ : 0.79 (0.67 to 0.92)	34 fewer per 1000 (13 to 54 fewer)	⊕⊖⊖⊖ VERY LOW	CRITICAL
Sexual violence (follow-up 14 weeks to 35 months ¹ ; assessed with: adapted conflict tactics scale)												
1 ²	Randomized trials	No serious risk of bias	Serious ⁵	Very serious ^{3,6}	No serious imprecision	Serious ²	167/1737 (10%) ⁷	261/2038 (13%)	aPRR ⁸ : 0.80 (0.67 to 0.97)	26 fewer per 1000 (4 to 42 fewer)	⊕⊖⊖⊖ VERY LOW	CRITICAL
Emotional violence (follow-up 14 weeks to 35 months ¹ ; assessed with: adapted conflict tactics scale)												
1 ²	Randomized trials	No serious risk of bias	No serious inconsistency	Very serious ^{3,6}	No serious imprecision	Serious ²	409/2039 (20%) ⁷	311/1737 (18%)	aPRR ⁸ : 0.91 (0.79 to 1.04)	16 fewer per 1000 (38 fewer to 7 more)	⊕⊖⊖⊖ VERY LOW	CRITICAL
Fear of violence – not measured												
0	–	–	–	–	–	None	–	–	–	–		IMPORTANT
Positive outcomes – not measured												
0	–	–	–	–	–	None	–	–	–	–		IMPORTANT
Sexual communication self-efficacy (follow-up mean 3 months; better indicated by higher values)												
0	–	–	–	–	–	None	–	–	–	–		IMPORTANT

2. Safer disclosure for women living with HIV

2. Safer disclosure for women living with HIV (continued)

1. Follow-up: 14 weeks postpartum in SAHAPS study; 16 and 35 months post-intervention in SHARE study; longest follow-up (35 months) reported for SHARE study.
2. One study with data provided: Wagman JA, Gray RH, Campbell JC, Thoma M, Ndyanabo A, Ssekasanvu J et al. Effectiveness of an integrated intimate partner violence and HIV prevention intervention in Rakai, Uganda: analysis of an intervention in an existing cluster randomised cohort. *Lancet Glob Health*. 2015;3(1):e23–33. A second study provided information on statistical significance of findings for these outcomes but did not provide actual data: Maman S, Moodley D, McNaughton-Reyes HL, Groves AK, Kagee A, Moodley P. Efficacy of enhanced HIV counseling for risk reduction during pregnancy and in the postpartum period: a randomized controlled trial. *PLoS One*. 2014;9(5):e97092. We therefore downgraded due to having data for only one trial available.
3. Indirectness: Downgraded because outcome measured among all HIV-positive women in intervention and control groups, not just those who had received the safer disclosure intervention.
4. Measured among women living with HIV; unpublished data provided from authors.
5. Inconsistency: One study showed a statistically significant positive effect, the other showed no effect (although data were not provided).
6. Indirectness: Downgraded because outcome measured among all women (HIV-positive and HIV-negative); data from women living with HIV only not available.
7. Effect size calculated from Wagman et al. (2016); the other study reported no significant difference across arms, but did not provide data.
8. Adjusted for baseline age, baseline education, baseline marital status, and baseline experience of IPV victimization, according to type measured.

aPRR: adjusted prevalence rate ratio; PRR: prevalence rate ratio.

3. Mode of delivery for women living with HIV

Date: 12 April 2016

PICO question: What modes of delivery result in the best maternal and perinatal outcomes for women living with HIV?

Systematic review: Kennedy CE, Yeh PT, Pandey S, Betran AP, Narasimhan M. Elective caesarean section for women living with HIV: a systematic review of risks and benefits. AIDS. 2017 (under review).

3a. Infant HIV outcomes (elective caesarean section [C-section] vs vaginal birth)

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Elective C-section	Vaginal birth	Relative (95% CI)	Absolute		
HIV infection among infants (assessed with: randomized controlled trials)												
1 ¹	Randomized trials	No serious risk of bias	No serious inconsistency	No serious indirectness	Serious ²	Serious ⁵	3/190 (1.6%)	22/224 (9.8%)	OR 0.2 (0.0 to 0.5)	77 fewer per 1000 (47 to 98 fewer)	⊕⊕⊕⊖ LOW	CRITICAL
HIV infection among infants (assessed with: observational studies)												
16	Observational studies	Serious ³	No serious inconsistency	No serious indirectness	No serious imprecision	None	–	–	OR 0.35 (0.27 to 0.46) ⁴	–	⊕⊕⊕⊖ VERY LOW	CRITICAL
HIV infection among infants (assessed with: studies during the HAART era [after 1996 or ART use in country])												
7	Observational studies	Serious ³	No serious inconsistency	No serious indirectness	No serious imprecision	None	–	–	OR 0.33 (0.24 to 0.46)	–	⊕⊕⊕⊖ VERY LOW	CRITICAL
HIV infection among infants (assessed with: combination ART patients only)												
3	Observational studies	Serious ³	No serious inconsistency	No serious indirectness	Serious ²	None	–	–	OR 0.61 (0.31 to 1.2)	–	⊕⊕⊕⊖ VERY LOW	CRITICAL
HIV infection among infants (assessed with: combination ART patients at term only)												
3	Observational studies	Serious ³	No serious inconsistency	No serious indirectness	Serious ²	None	–	–	OR 0.65 (0.3 to 1.41)	–	⊕⊕⊕⊖ VERY LOW	CRITICAL
HIV infection among infants (assessed with: women with CD4 > 200 or viral load [VL] < 400 only)												
2	Observational studies	Serious ³	No serious inconsistency	No serious indirectness	Serious ²	None	–	–	OR 0.38 (0.18 to 0.79)	–	⊕⊕⊕⊖ VERY LOW	CRITICAL

3. Mode of delivery for women living with HIV

3a. Infant HIV outcomes (elective caesarean section [C-section] vs vaginal birth) (continued)

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Elective C-section	Vaginal birth	Relative (95% CI)	Absolute		
HIV infection among infants (assessed with: women with CD4 > 200 or VL < 400 at term only)												
2	Observational studies	Serious ³	No serious inconsistency	No serious indirectness	Serious ²	None	–	–	OR 0.37 (0.14 to 1.02)	–	⊕⊕⊕⊕ VERY LOW	CRITICAL

1. European Mode of Delivery Collaboration. Elective caesarean-section versus vaginal delivery in prevention of vertical HIV-1 transmission: a randomised clinical trial. *Lancet*. 1999;353(9158):1035–9.
2. Downgraded for imprecision for a small number of events (< 300).
3. High likelihood of other important confounders.
4. Unadjusted odds ratios. Using adjusted odds ratios instead from the same studies where available yields OR: 0.40 (95% CI: 0.32, 0.50).
5. Downgraded for being a single trial.

3. Mode of delivery for women living with HIV

3b. Infant HIV outcomes (elective C-section vs all other modes of delivery)¹

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Elective C-section	All other modes of delivery	Relative (95% CI)	Absolute		
HIV infection among infants (assessed with: observational studies)												
13	Observational studies	Serious ²	No serious inconsistency	No serious indirectness	No serious imprecision	None	–	–	OR 0.38 (0.31 to 0.46)	–	⊕⊕⊕⊕ VERY LOW	CRITICAL
HIV infection among infants (assessed with: studies during the HAART era [after 1996 or ART use in country])												
5	Observational studies	Serious ²	No serious inconsistency	No serious indirectness	No serious imprecision	None	–	–	OR 0.35 (0.25 to 0.49)	–	⊕⊕⊕⊕ VERY LOW	CRITICAL
HIV infection among infants (assessed with: combination ART patients only)												
2	Observational studies	Serious ²	No serious inconsistency	No serious indirectness	Serious ³	None	–	–	OR 0.70 (0.39 to 1.27)	–	⊕⊕⊕⊕ VERY LOW	CRITICAL
HIV infection among infants (assessed with: combination ART patients at term only)												
2	Observational studies	Serious ²	No serious inconsistency	No serious indirectness	Serious ³	None	–	–	OR 0.69 (0.35 to 1.36)	–	⊕⊕⊕⊕ VERY LOW	CRITICAL
HIV infection among infants (assessed with: women with CD4 > 200 or viral load [VL] < 400 only)												
2	Observational studies	Serious ²	No serious inconsistency	No serious indirectness	Serious ³	None	–	–	OR 0.45 (0.24 to 0.88)	–	⊕⊕⊕⊕ VERY LOW	CRITICAL
HIV infection among infants (assessed with: women with CD4 > 200 or VL < 400 at term only)												
2	Observational studies	Serious ²	No serious inconsistency	No serious indirectness	Serious ³	None	–	–	OR 0.45 (0.19 to 1.08)	–	⊕⊕⊕⊕ VERY LOW	CRITICAL

1. All other modes of delivery: vaginal birth, non-elective C-section or forceps/vacuum-assisted delivery.

2. High likelihood of other important confounders.

3. Downgraded for imprecision for a small number of events (< 300).

ART: antiretroviral therapy; HAART: highly active antiretroviral therapy.

3. Mode of delivery for women living with HIV

3c. Maternal health outcomes (elective C-section vs vaginal birth)

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Elective C-section	Vaginal birth	Relative (95% CI)	Absolute		
Any morbidity												
3	Observational studies	Serious ¹	Serious ²	No serious indirectness	Serious ³	None	–	–	OR 2.79 (1.33 to 5.82)	–	⊕⊕⊕⊕ VERY LOW	IMPORTANT
Urinary tract infection (UTI) / febrile UTI												
4	Observational studies	Serious ¹	No serious inconsistency	No serious indirectness	Serious ³	None	–	–	OR 2.56 (1.12 to 5.83)	–	⊕⊕⊕⊕ VERY LOW	IMPORTANT
Endometritis / febrile endometritis / amnionitis or endometritis												
4	Observational studies	Serious ¹	No serious inconsistency	No serious indirectness	Serious ³	None	–	–	OR 2.10 (1.04 to 4.24)	–	⊕⊕⊕⊕ VERY LOW	IMPORTANT
Haemorrhage / transfusion / severe anaemia or haemorrhage												
4	Observational studies	Serious ¹	No serious inconsistency	No serious indirectness	Serious ³	None	–	–	OR 1.67 (1.03 to 2.7)	–	⊕⊕⊕⊕ VERY LOW	CRITICAL

1. High likelihood of other important confounders.
2. Downgraded for inconsistency ($Q = 6.30$, $P = 0.01$, $I^2 = 84.13$).
3. Downgraded for imprecision for a small number of events (< 300).

3. Mode of delivery for women living with HIV

3d. Maternal health outcomes (elective C-section vs all other modes of delivery)¹

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Elective C-section	All other modes of delivery	Relative (95% CI)	Absolute		
Any morbidity												
2	Observational studies	Serious ²	Serious ³	No serious indirectness	Serious ⁴	None	–	–	OR 1.28 (0.39 to 4.24)	–	⊕⊕⊕⊕ VERY LOW	IMPORTANT
Urinary tract infection (UTI) / febrile UTI												
4	Observational studies	Serious ²	No serious inconsistency	No serious indirectness	Serious ⁴	None	–	–	OR 1.22 (0.61 to 2.41)	–	⊕⊕⊕⊕ VERY LOW	IMPORTANT
Endometritis / febrile endometritis / amnionitis or endometritis												
4	Observational studies	Serious ²	No serious inconsistency	No serious indirectness	Serious ⁴	None	–	–	OR 1.13 (0.62 to 2.04)	–	⊕⊕⊕⊕ VERY LOW	IMPORTANT
Haemorrhage / transfusion / severe anaemia or haemorrhage												
4	Observational studies	Serious ²	No serious inconsistency	No serious indirectness	Serious ⁴	None	–	–	OR 1.39 (0.91 to 2.11)	–	⊕⊕⊕⊕ VERY LOW	CRITICAL

1. All other modes of delivery: vaginal birth, non-elective C-section or forceps/vacuum-assisted delivery.
2. High likelihood of other important confounders.
3. Downgraded for inconsistency: $Q = 6.30$, $P = 0.01$, $I^2 = 84.13$.
4. Downgraded for imprecision for a small number of events (< 300).

3. Mode of delivery for women living with HIV

3e. Infant health outcomes (elective C-section vs vaginal birth)

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Elective C-section	Vaginal birth	Relative (95% CI)	Absolute		
Infant respiratory distress syndrome, scheduled C-section for other reasons												
1 ¹	Observational studies	Serious ²	No serious inconsistency ³	No serious indirectness	Serious ⁴	None	–	–	OR 3.67 (1.57 to 8.6)	–	⊕○○○ VERY LOW	IMPORTANT
Infant respiratory distress syndrome, scheduled C-section for prevention of mother-to-child transmission (PMTCT)												
1 ¹	Observational studies	Serious ²	No serious inconsistency ³	No serious indirectness	Serious ⁴	None	–	–	OR 1.88 (0.72 to 4.93)	–	⊕○○○ VERY LOW	IMPORTANT
Transient tachypnea of the newborn, scheduled C-section for other reasons												
1 ¹	Observational studies	Serious ²	No serious inconsistency ³	No serious indirectness	Serious ⁴	None	–	–	OR 9.46 (2.64 to 33.82)	–	⊕○○○ VERY LOW	IMPORTANT
Transient tachypnea of the newborn, scheduled C-section for PMTCT												
1 ¹	Observational studies	Serious ²	No serious inconsistency ³	No serious indirectness	Serious ⁴	None	–	–	OR 4.97 (1.27 to 19.37)	–	⊕○○○ VERY LOW	IMPORTANT

1. Kreitchmann R, Cohen RA, Stoszek SK, Pinto JA, Losso M, Pierre R et al. Mode of delivery and neonatal respiratory morbidity among HIV-exposed newborns in Latin America and the Caribbean: NISDI Perinatal-LILAC Studies. *Int J Gynaecol Obstet.* 2011;114(2):91–6. doi:10.1016/j.ijgo.2011.02.008.
2. High likelihood of other important confounders.
3. Inconsistency cannot be assessed with a single study.
4. Downgraded for imprecision for a small number of events (< 300).

4. Medical and surgical abortion for women living with HIV

Date: 16 December 2015

PICO question: Do outcomes of medical and surgical abortion among women living with HIV differ from outcomes among HIV-uninfected women?

Systematic review: Saleem H, Kennedy CE, Ganatra B, Narasimhan M. Medical and surgical abortion outcomes among women living with HIV: a systematic review. Cochrane Database Syst Rev. 2017 (in press).

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Medical abortion	Control	Relative (95% CI)	Absolute		
Efficacy (complete abortion)												
1 ¹	Observational studies	No serious risk of bias	No serious inconsistency ²	Very serious ³	No serious imprecision	None	65/68 (96%) ⁴	–	–	–	⊕⊕⊕⊕ VERY LOW	CRITICAL
Serious adverse events (assessed with: serious infections ⁵)												
1 ¹	Observational studies	No serious risk of bias	No serious inconsistency ²	Very serious ³	No serious imprecision	None	1/68 (2%)	–	–	–	⊕⊕⊕⊕ VERY LOW	CRITICAL
Other adverse events and side-effects (assessed with: heavy bleeding ⁵)												
1 ¹	Observational studies	No serious risk of bias	No serious inconsistency ²	Very serious ³	No serious imprecision	None	1/68 (2%)	–	–	–	⊕⊕⊕⊕ VERY LOW	IMPORTANT
Patient satisfaction												
0	No evidence available					None	–	–	–	–		IMPORTANT

1. Posokhova S, Shevchenko S, Gumenyuk L, Nikolaeva S, Popova T et al. The experience of use of medical abortion for HIV-positive women at home in Ukraine. In: 19th International AIDS Conference; 2010. Abstract no. MOPE675.
2. Inconsistency: This was not applicable as there was only a single study.
3. Indirectness: Downgraded twice. No comparison of women living with HIV vs HIV-uninfected women, or of medical vs surgical abortion among women living with HIV.
4. Three failures were incomplete abortion (1 case), heavy bleeding (1 case), continuing pregnancy (1 case).
5. Not further defined.

Systematic review search strategies and flowcharts

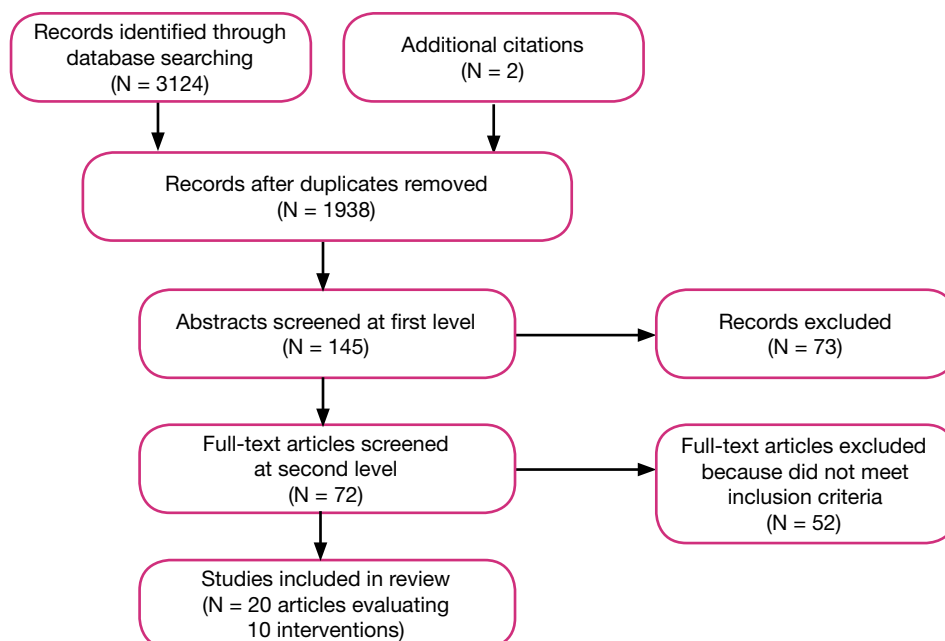
1. Empowerment and self-efficacy interventions for women living with HIV

PICO question: What interventions improve self-efficacy and empowerment around safer sex and reproductive decision-making for women living with HIV?

Systematic review: Robinson JL, Narasimhan M, Amin A, Morse S, Beres LK, Yeh PT, Kennedy CE. Interventions to address unequal gender and power relations and improve self-efficacy and empowerment around sexual and reproductive health decision-making for women living with HIV: a systematic review. PLoS One. 2017 (under review).

The following electronic databases were searched for articles up to a cut-off date of 12 November 2015: PubMed, CINAHL, Embase, PsycINFO and SCOPUS. A full set of search terms for all databases is given below. Secondary reference searching was also conducted on all studies included in the review. Further, selected experts in the field were contacted to identify additional articles not identified through other search methods.

The following search terms were adapted for each database: (“HIV positive” [tiab] OR “living with HIV” [tiab] OR “HIV infected” [tiab]) AND (Women’s Health [MeSH] OR women [tiab] OR woman [tiab] OR female* [tiab] OR gender [tiab]) AND (Intervention studies [MeSH] OR case control studies [MeSH] OR case-control stud* [tiab] OR intervention* [tiab] OR evaluat* [tiab] OR evaluation studies as topic [MeSH] OR assess* [tiab] OR program evaluation [MeSH] OR randomized controlled trial [pt] OR controlled clinical trial [pt] OR randomized [tiab] OR random* [tiab] OR clinical trials as topic [MeSH:noexp] OR “non-randomized trial” [tiab] OR “pre post study” [tiab] OR “before after study” [tiab] OR “time series study” [tiab] OR “cross-sectional”[tiab] OR “double-blind procedure” [tiab] OR “single-blind procedure” [tiab] OR “retrospective cohort”[tiab] OR randomly [tiab] OR trial [ti] NOT (animals[mh] NOT humans[mh])) AND (Self Efficacy [MeSH] OR self concept [MeSH] OR empower* [tiab] OR “self-efficacy”[tiab] OR “self esteem” [tiab] OR self perception* [tiab] OR “decision-making” [tiab] OR power [tiab] OR risk reduction behavior [MeSH] OR “risk reduction” [tiab]).



2. Safer disclosure for women living with HIV

PICO question: What interventions facilitate safe disclosure of HIV status for women living with HIV who fear violence or who disclose that they are currently experiencing violence?

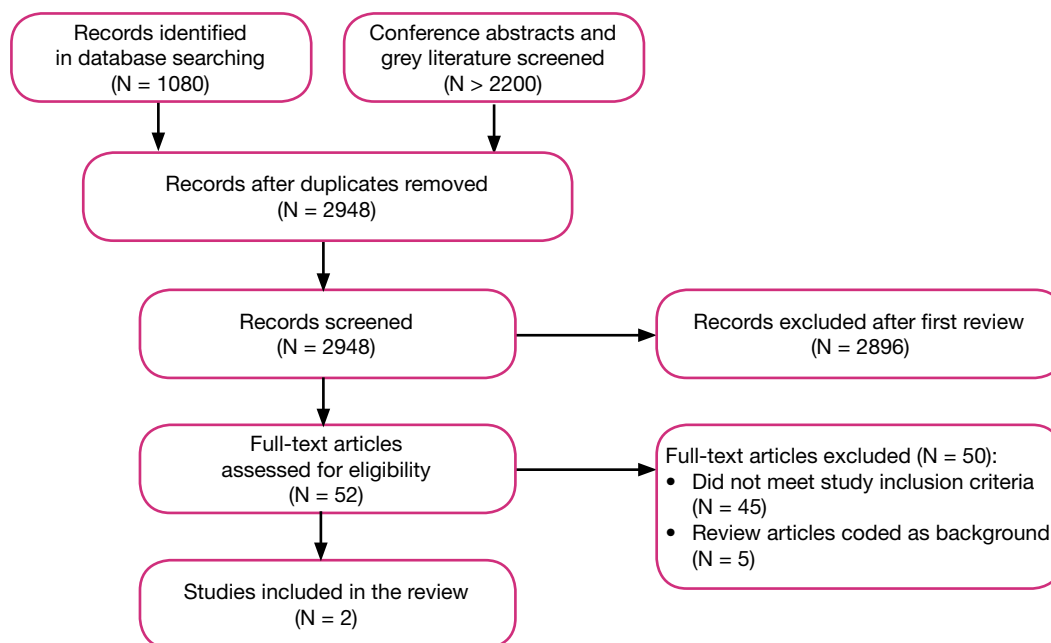
Systematic review: Kennedy CE, Haberlen S, Amin A, Baggaley R, Narasimhan M. Safer disclosure of HIV serostatus for women living with HIV who experience or fear violence: a systematic review. *J Int AIDS Soc.* 2015;18(6 Suppl 5):20292. doi:10.7448/IAS.18.6.20292.

The following electronic databases were searched for articles up to a cut-off date of 1 April 2015: PubMed, CINAHL and Embase. Secondary reference searching was also conducted on all studies included in the review. We used Google Scholar to review articles that cite key documents, such as the 2006 WHO meeting report *Addressing violence against women in HIV testing and counselling*.¹ Further, selected experts in the field were contacted to identify additional articles not identified through other search methods.

Abstracts from the following conferences were searched up to 1 April 2015: IAC, IAS, CROI, International Conference on AIDS and STIs in Africa (ICASA), Sexual Violence Research Initiative (SVRI) conference, the International Conference on Sexual Assault, Domestic Violence and Trafficking, and the World Association for Sexual Health (WAS) Conference on Sexual Health.

To search for other grey literature, the websites of the following organizations were reviewed: Sexual Violence Research Initiative (SVRI), STRIVE, London School of Hygiene and Tropical Medicine – Center for Gender Violence, International Planned Parenthood Federation (IPPF), FHI360, MenEngage and Population Council.

The following terms were entered into all computer databases: (disclos*) AND (violence OR abuse OR rape OR “forced sex” OR “coerced sex”) AND (HIV OR AIDS).



1. Maman S, King EM. Addressing violence against women in HIV testing and counselling: a meeting report, Geneva, 16–18 January 2006. Geneva: World Health Organization; 2006 (http://www.who.int/gender/documents/VCT_addressing_violence.pdf, accessed 31 January 2017).

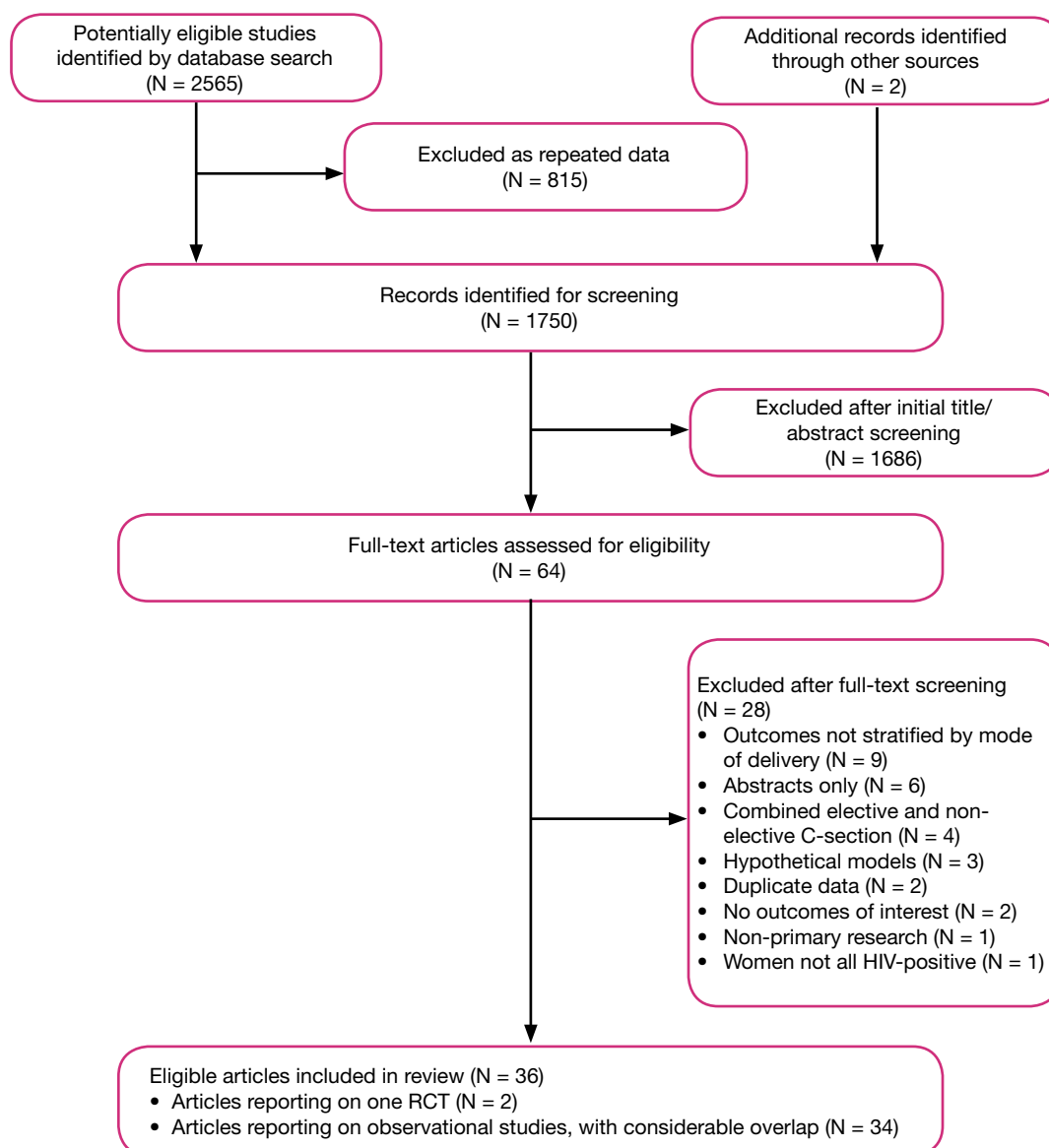
3. Mode of delivery for women living with HIV

PICO question: What modes of delivery result in the best maternal and perinatal outcomes for women living with HIV?

Systematic review: Kennedy CE, Yeh PT, Pandey S, Betran AP, Narasimhan M. Elective caesarean section for women living with HIV: a systematic review of risks and benefits. AIDS. 2017 (under review).

The following electronic databases were searched for articles up to a cut-off date of 1 October 2015: PubMed, CINAHL, Embase and the Cochrane Central Register of Controlled Trials. Secondary reference searching was conducted on all studies included in the review as well as other relevant review articles identified in the search. Further, selected experts in the field were contacted to identify additional articles not identified through other search methods.

The following search terms were used for each online database: (HIV OR AIDS) AND (“mode of delivery” or “caesarean section” or “cesarean section” or “c-section”).



4. Medical and surgical abortion for women living with HIV

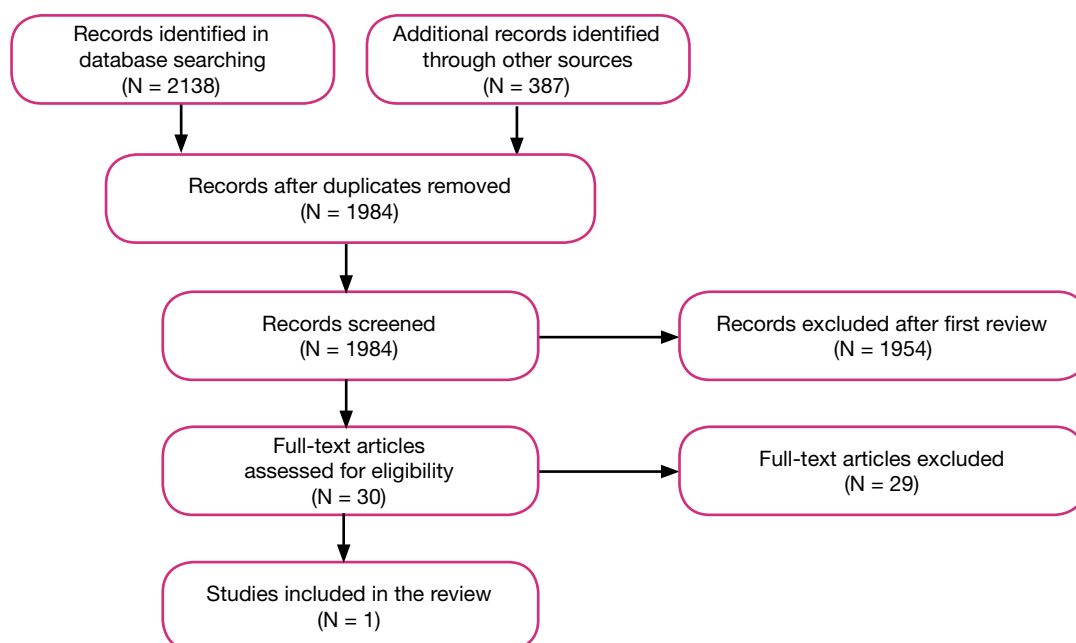
PICO question: Do outcomes of medical and surgical abortion among women living with HIV differ from outcomes among HIV-uninfected women?

Systematic review: Saleem H, Kennedy CE, Ganatra B, Narasimhan M. Medical and surgical abortion for women living with HIV: a systematic review. *Cochrane Database Syst Rev.* 2017 (in press).

The following electronic databases were searched for articles up to a cut-off date of 1 April 2015: PubMed, CINAHL (Cumulative Index to Nursing and Allied Health Literature), Embase and the Cochrane Central Register of Controlled Trials. Secondary reference searching was also conducted on all studies included in the review as well as other relevant review articles identified in the search. Further, selected experts in the field were contacted to identify additional articles not identified through other search methods.

Abstracts from the following conferences were searched up to 1 April 2015: International AIDS Conference (IAC), IAS Conference on HIV Pathogenesis, Treatment, and Prevention (IAS), the Conference on Retroviruses and Opportunistic Infections (CROI), International Federation of Gynecology and Obstetrics (FIGO) World Conference, and the American Congress of Obstetricians and Gynecologists (ACOG).

The following search terms were entered into all computer databases: (“Abortion, Induced” [Majr] OR “Abortion, Therapeutic” [Majr] OR “termination of pregnancy” OR “menstrual regulation”) AND (HIV OR AIDS).



For more information, please contact:

Department of Reproductive Health and Research

World Health Organization

20 Avenue Appia, 1211 Geneva 27

Switzerland

Fax: +41 22 791 4171

Email: reproductivehealth@who.int

Website: www.who.int/reproductivehealth

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