

# We can prevent mothers from dying and babies from becoming infected with HIV



Joint Action for Results  
UNAIDS Outcome Framework:  
Business Case 2009–2011



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Uniting the world against **AIDS**

# UNAIDS Joint Action for Results

In *The Joint Action for Results: UNAIDS Outcome Framework, 2009–2011*, UNAIDS Executive Director, Michel Sidibé, called for a new and more focused commitment to the HIV response. The Outcome Framework committed the UNAIDS Secretariat and cosponsors to leverage their respective organizational mandates and resources to work collectively with national and global partners to deliver results for people at country level. It outlined 10, interconnected priority areas, each representing a pivotal component of the AIDS response, all of which are reflected in the UNAIDS 2010–2011 Unified Budget and Workplan. It opened each of the ten areas with an affirmative challenge (see inside back cover).

For each priority area, a business case was developed by a global UNAIDS interagency working group, building upon and complementing action on the ground. Each business case is different, due to differences in the scope, knowledge base and stage of development of the policies and programmes involved. However, each business case succinctly explains the rationale for the priority area and outlines why success in this area will dramatically decrease new HIV infections and improve the lives of people living with and affected by HIV. The business cases delineate what is currently working and what needs to change in order to make headway in the 10 areas. They are intended to guide future investment and to hold UNAIDS accountable for its role in achieving tangible results. Each priority area business case presents three results to be achieved globally by 2011, which mark important progress towards our shared 2015 goals. These business cases informed both the UNAIDS 2011–2015 Strategy and the development of the 2012–2015 Unified Budget, Results and Workplan.

In 2009, UNAIDS' Executive Director asked each country Joint United Nations Team on AIDS, in consultation with their national AIDS programme, to identify three to five of the priority areas for intensified, unified United Nations (UN) support in 2009–2011. The global priority area working groups also proposed strategies to maximize UNAIDS' impact – some focusing on countries with the largest disease burden, and others on phasing waves of research or technical support according to learning opportunities and demand from local stakeholders. The work at country, regional and global levels has strengthened the foundations and baselines for action toward the ten goals of UNAIDS' 2011–2015 Strategy, *Getting to Zero*.

Focused, concrete and synergistic actions in the ten areas have the potential to change the trajectory of the epidemic. They will help to achieve universal access to HIV prevention, treatment, care and support, and contribute to achieving the Millennium Development Goals. Optimizing partnerships between national governments, communities, the UN, development partners and other stakeholders, the business cases recommend ways forward that build on decades of research and experience, and focus our work, hearts and minds on a unified and strategic vision.



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# We can prevent mothers from dying and babies from becoming infected with HIV

## 1. WHY IS THIS A PRIORITY AREA?

HIV has a significant impact on maternal, infant and child health and survival. Globally, the proportion of people living with HIV who are women has remained stable at around 50%, but women have a disproportionate share of HIV infection, especially in sub-Saharan Africa, where an estimated 60% of people living with HIV are female. HIV is now the leading cause of mortality among women of reproductive age worldwide (1), with HIV-related maternal mortality rates increasing and surpassing other causes.

Each year, approximately 1.4 million women living with HIV in low- and middle-income countries become pregnant. In sub-Saharan Africa, the proportion of antenatal clients who are living with HIV ranges from below 1% to over 45%. HIV infection in childbearing women is the main cause of HIV infection in children; more than 90% of infections of infants and young children occur through mother-to-child transmission, either during pregnancy, labour and delivery, or through breastfeeding. Without any intervention, about one in three children born to HIV-infected mothers will be infected. In 2009, an estimated 370,000 children were newly infected with HIV, 90% of whom lived in sub-Saharan Africa.

In contrast, mother-to-child transmission of HIV has been largely eliminated in high-income countries through provider-initiated HIV testing and counselling, access to highly-effective antiretroviral prophylaxis and treatment, safer delivery practices, family planning and safe use of replacement feeding.

Although encouraging progress has been made in high-burden and middle- and low-income countries, it is an immense inequity that mother-to-child transmission of HIV has not yet been eliminated globally. Successful implementation of the 2010 World Health Organization (WHO) guidelines (2) on the use of antiretroviral drugs for preventing mother-to-child transmission of HIV (PMTCT), and on HIV and infant feeding, would significantly contribute to the elimination of mother-to-child HIV transmission and would improve the health and survival of mothers and children living with HIV in need of treatment.

The cost of inaction is high—most HIV-infected children die within their first two years of life. In addition, children born to mothers with advanced HIV infection are also more likely to die, even if they are not infected. The combined effects of maternal morbidity and death have a devastating effect on both women and their children—the mother’s death can double the child’s own risk of death (3, 4).

The United Nations has developed a comprehensive approach to PMTCT, which includes HIV prevention measures and a range of care for mothers and their children. The approach has four components or prongs:

- ▶ **primary prevention of HIV among women of childbearing age;**
- ▶ **prevention of unintended pregnancies among women living with HIV;**
- ▶ **prevention of HIV transmission from a woman living with HIV to her infant;**
- ▶ **provision of appropriate treatment, care and support to women living with HIV and their children and families.**

For each component, PMTCT puts into operation the concepts of combination prevention and treatment as prevention for both mothers and children. It also focuses on the health and well-being of families. Further, PMTCT incorporates an integrated approach to reproductive health, including the improvement of antenatal, delivery and postnatal care.

In this regard, PMTCT contributes directly to four of the Millennium Development Goals (MDGs), where HIV is currently holding back progress:

- ▶ **MDG 4: reduce child mortality**—by reducing the number of infants infected with HIV; by providing treatment, care and support for both uninfected and infected children born to mothers living with HIV; and, indirectly, by improving maternal health and ensuring safer feeding practices;
- ▶ **MDG 5: improve maternal health**—through primary prevention of HIV and provision of family planning in women of childbearing age; and by ensuring care, treatment and support for mothers living with HIV;
- ▶ **MDG 6: combat HIV/AIDS, malaria and other diseases**—by preventing the spread of HIV through primary prevention in women of childbearing age; preventing vertical transmission; and treating mothers, children and partners living with HIV;
- ▶ **MDG 3: promote gender equality and empower women**—by offering a channel to address gender equality issues, including ending gender-based violence, supporting women’s reproductive rights, increasing access to information and sexual and reproductive health services, and engaging male partners.

## 2. WHAT NEEDS TO BE DONE?

Mother-to-child transmission is linked to other Outcome Framework priority areas, especially sexual transmission of HIV, HIV treatment, empowering young people and stopping violence against women and girls. It is also integrally linked to the priority areas relating to tuberculosis, injecting drug use, punitive laws and social protection. Because several PMTCT interventions (but not all) are implemented in health facilities, cross-cutting issues—such as health systems development, and the structural, political, capacity and technical barriers that hamper scale-up of PMTCT programmes—play a critical role. Furthermore, providing PMTCT services can be more complex where populations are underserved and excluded from national programmes, such as in remote and rural areas, humanitarian crisis situations, in conflict settings and in fragile states.

This business case is aligned with other global and regional initiatives that aim to reduce vertical transmission, including the new UN Secretary-General's Joint Action Plan for Women's and Children's Health (5), the African Union's commitments towards elimination of mother-to-child transmission of HIV, the South Africa Development Community operational plans for HIV prevention (6) and commitments of Member States in Europe and the Americas to eliminate vertical transmission of HIV and congenital syphilis together (7).

### Goal and bold results

The **goal** of this priority area is to eliminate new HIV infections in children and improve maternal, newborn and child health and survival in the context of HIV. "Elimination of mother-to-child transmission of HIV" is considered achieved when a country meets two requirements: a) 90% reduction of new HIV infections among children, AND b) the rate of HIV transmission from mother to child is less than 5% at a population level. Action on the four components or prongs of PMTCT to achieve these ends contributes to UNAIDS 2011-2015 goal of eliminating vertical transmission and reducing AIDS-related maternal mortality by half, and to the goal of reducing sexual transmission of HIV by half, by 2015.

Three **bold results** are envisaged by 2011 in 10 of the 22 countries with the greatest number of HIV-positive pregnant women:

- ▶ **Achieve at least 80% coverage of effective antiretroviral drugs for PMTCT.**
- ▶ **Provide antiretroviral drug coverage to at least 50% of HIV-positive pregnant women who are eligible under the 2010 WHO guidelines, for treatment for their own health.**
- ▶ **Reduce by 50% the current unmet need for family planning among all women.**

Financial and technical support needs to focus international and national commitment on the elimination of mother-to-child transmission. In addition to establishing clear targets and committing to current international guidelines, support is needed to achieve:

- ▶ decentralization of service delivery;
- ▶ integration of PMTCT into routine antenatal, delivery and postnatal care settings and other sexual and reproductive health services (e.g. family planning, management of sexually transmitted disease);
- ▶ integration of paediatric HIV care, particularly for HIV-exposed infants and children, into routine child health service delivery;
- ▶ integration of paediatric HIV treatment into existing treatment programmes.

Family-based care across the range of services will be paramount, especially providing support for women and children through their families, and strengthening families through both health and community systems.

During the past 10 years of global efforts to scale up delivery of increasingly more effective PMTCT interventions, experience from countries has highlighted six key gaps:

- ▶ insufficient global commitment and funding;
- ▶ insufficient advocacy and political commitment at the country level;
- ▶ programme fragmentation and parallel funding at the country level, with a concentration of services in urban settings;
- ▶ insufficient integration and linkages within maternal, newborn and child health services and other sexual and reproductive health services, including family planning;
- ▶ insufficient evidence base and monitoring and evaluation capabilities;
- ▶ weak national health systems and programmes.

These gaps can be addressed in the following ways.

**Improved global commitment and funding.** Despite recent momentum, PMTCT has so far received an inadequate level of HIV funding, typically as a small part of donor-funded programmes. The foremost requirement for the elimination of mother-to-child transmission is a renewed commitment from all players to place this area high on the agenda (especially in countries with a high HIV burden) and to keep it there. The funding required for PMTCT will increase as countries implement the 2010 WHO guidelines for earlier initiation of more efficacious PMTCT antiretroviral drug regimens, increased eligibility for lifelong treatment, and improved mother and child follow up, monitoring and treatment (2). UNAIDS is using its convening power to unite key partners, including maternal health partners, to mobilize and reallocate resources in a comprehensive and sustainable response.





**Improved high-level advocacy at the country level.** Significant political will and commitment are essential for successful programmes; however, country-level programmes in many countries are often led by technical experts who lack the power to generate sufficient political commitment from governments, civil society and nongovernmental organizations. More sustained and evidence-informed high-level advocacy and leadership from the UN and its partners will help generate leadership within countries and political commitment to scale up PMTCT services. UNAIDS is bringing together global partners—including global maternal health and congenital syphilis elimination initiatives, and networks of people living with HIV—to promote inclusive action, policy direction and global guidance and to ensure coordinated advocacy messages and programming.

**Improved coordination at the country level.** In countries with no significant progress, there is often weak coordination among national HIV and health programmes, UN agencies, key donors and implementers, and nongovernmental organizations. Programme planning and implementation are frequently donor driven, with key players working in isolation from the government through myriad small-scale initiatives and projects with different channels for procurement and supply management, data and reporting. Donor-driven financing, which often has an urban and central focus, may also be unsustainable.

Renewed commitment from global players must support a harmonized approach at the country level. Partners' efforts should be coordinated with national government policies, strategic workplans and priorities, and should support unified national PMTCT programmes in the context of overall HIV national strategic plans. Closer links between programmes and partners must also include joint advanced planning and consensus on priorities, through the development and implementation of a single national PMTCT scale-up plan with time-bound population-based targets.



### **Better integration and linkages within maternal, newborn and child health services and other sexual and reproductive health and treatment services.**

Currently, HIV services, maternal, newborn and child health services and other sexual and reproductive health services are often provided through parallel structures. PMTCT efforts cannot be effective or sustainable if they continue to be managed as vertical, individually funded programmes. Instead, they should be closely linked to HIV care and treatment services and integrated into maternal, newborn and child health and other sexual and reproductive health services. HIV testing and counselling should also be integrated into family planning clinics. Integration is required at every level, including programme management and planning, funding and resources, service delivery, and monitoring and evaluation.

### **Strengthening the evidence base and national monitoring and evaluation systems.**

Consensus on evidence and strong monitoring and evaluation systems are vital to the establishment of appropriate and effective population-based targets, programmes, implementation strategies and resource allocation. Global, national and facility-based monitoring must be improved by building sustainable information systems, developing local ownership around consensus baselines and projections, and strengthening the evidence base. Evidence-based operational research needs to be supported to identify barriers to access and to improve programme efficiency, effectiveness and estimates of programme costs.

### **Strengthening national health systems and improving programme implementation.**

Key issues at the programme level include weak health systems; limited coverage of comprehensive PMTCT services; insufficient integration with reproductive–maternal–newborn–child health (RMNCH) services; poor quality of programmes; lack of follow-up to provide continuing care to women, their children and families; insufficient family and community involvement; and gender imbalances. These areas are addressed below.

- ▶ **Addressing health systems.** Scaling up PMTCT programmes provides an opportunity to address wider structural health system issues, particularly in relation to RMNCH services. This can be achieved through support to human resource innovations such as task shifting and sharing; development and implementation of simplified, locally adapted, field-level versions of programme tools; laboratory capacity building; and improving procurement and supply management systems.
- ▶ **Scale-up of coverage.** PMTCT coverage remains low for key activities, including HIV testing and counselling, antiretroviral drugs for HIV-positive pregnant women, and family planning for women living with HIV. In 2009, an estimated 53% of all pregnant women living with HIV in low- and middle-income countries were provided with antiretroviral drugs for PMTCT—far short of the target of 80% coverage for 2010, set by the UN General Assembly Special Session on HIV/AIDS in 2001(8). In addition, high unmet needs for family planning have resulted in a global unintended pregnancy rate of 38%, with estimated unintended pregnancy rates of 51–90% among women living with HIV according to some studies (8). The only way to meet these gaps is to focus on national scale-up, decentralization and devolution to the subnational level, and to assure adequate financial investment, infrastructure and human resources.

- ▶ **Quality, efficiency and efficacy.** A number of key quality issues relate to antiretroviral regimens for PMTCT, HIV testing for infants, and counselling and support for infant feeding:
  - Several sub-Saharan countries, for example, still use single-dose nevirapine rather than combination regimens, despite nevirapine's lower efficacy. Critically, the next year will see a transition to new guidelines recommending more effective regimens.
  - Early diagnosis of HIV in infants is often difficult, due to lack of a simple HIV test that can be used for children, underdeveloped laboratory capacity and difficulties in transporting blood specimens and delivering test results.
  - Current feeding practices for HIV-exposed infants generally do not optimize their chances of healthy HIV-free survival, and services to support HIV-positive mothers in making safer decisions about feeding their infants remain inadequate in many countries.
  - Counselling on both HIV prevention and infant feeding during antenatal care may be insufficient or infrequent. Greater support should be provided to national programmes for the implementation of the 2010 WHO guidelines, essential primary HIV prevention services, family planning and support for safer infant feeding.
- ▶ **Quality continuum of care, support and treatment services to pregnant women living with HIV, mothers and their children.** Across the RMNCH continuum, receipt of essential interventions and services declines significantly between each service point—from the first antenatal care visit through delivery and postnatal visits. Beyond HIV-specific interventions, pregnant women, mothers and their children are missing out on other essential interventions, including those against malaria, tuberculosis, sexually transmitted infections, respiratory infections and diarrhoea. The broad commitment to elimination of vertical transmission offers an opportunity to provide a continuum of high-quality care, support and treatment services to pregnant women living with HIV, mothers and their children, with full support of their families. This will optimize maternal and child health and survival.
- ▶ **Improving family and community involvement and addressing gender imbalance.** Individuals, families and communities, particularly men, need to be engaged in PMTCT programme scale-up. Such an approach will require technical and financial support for community-based organizations that deliver PMTCT and HIV care. It also requires district-wide systems for linking health facilities to communities in order to increase community awareness, create demand, ensure community engagement in service provision where appropriate and increase uptake of available services. Globally, male involvement and partner counselling and testing, especially among couples, have been recognized to strengthen adherence, alleviate stigma and discrimination, prevent HIV-related violence and improve uptake of related services such as family planning, including condom use. In this regard, consideration must be given to socioeconomic and cultural factors, including gender inequalities. Those structural factors often go to the root causes of poor access and inequality, going beyond service availability.

### 3. MOVING FORWARD

The burden of the HIV epidemic is highly uneven, with 22 countries in sub-Saharan Africa and Asia accounting for about 90% of the pregnant women needing antiretroviral drugs for PMTCT. Those countries are also home to more than 80% of the children under 15 needing antiretroviral therapy. A major change in global scale-up strategies and a clear focus on context-specific responses will be necessary to achieve the elimination of mother-to-child HIV transmission by 2015.



With support from implementing partners, UNAIDS global support will focus primarily on the 22 countries with the highest burden (see box). UNAIDS will consider different actions both for improving programme coverage and access and for ensuring that services are comprehensive and of good quality.

Specific programming areas to be addressed include the following:

- ▶ Intensified support will be provided for PMTCT services in all 22 high-burden countries (see box), with a focus on the 13 countries where approximately 80% of HIV-positive pregnant women in need of PMTCT in 2009 live (Cameroon, Democratic Republic of the Congo, Ethiopia, India, Kenya, Malawi, Mozambique, Nigeria, South Africa, Tanzania, Uganda, Zambia and Zimbabwe). This will include mobilizing political commitment and supporting countries to strengthen programme coordination and management.

## The role of UNAIDS

The mandate of UNAIDS cosponsors and Secretariat, the Joint Programme's leadership and political voice, and its reach and presence at the global, regional and national levels, enable UNAIDS to make a distinctive contribution towards the goals and bold results in this priority area. To aid countries to improve their PMTCT services and to strengthen integration with maternal, newborn and child health while addressing barriers beyond the traditional purview of the health sector, each cosponsor leverages its comparative advantage as part of a comprehensive, multi-sectoral approach. Working together, the UNAIDS cosponsors and Secretariat help countries to develop their action frameworks and plans to streamline the delivery of coordinated PMTCT activities and to achieve synergies with work in other priority areas.

UNAIDS provides PMTCT normative guidance, programme leadership, and high level advocacy, to broker value-added partnerships and to catalyze results-driven action at country level towards the elimination of vertical transmission. In the UNAIDS Division of Labour, WHO and UNICEF are the co-conveners of this priority area. Together with agency partners -- the UN Population Fund (UNFPA), the World Food Programme (WFP) -- and other stakeholders, they translate global normative guidance into operational plans and other tools that countries can use to scale up PMTCT. At country and regional level, the UN partners work with governments, regional bodies, NGOs, civil society, people living with HIV and other key stakeholders to access these tools and to promote the rapid and coordinated flow of financial resources and technical assistance.

WHO and UNICEF lead the UNAIDS Inter-agency Task Team (IATT) on Prevention of HIV Infection in Pregnant Women, Mothers and their Children. With its broad membership, this IATT has been a key vehicle for driving change and focusing support for PMTCT. The IATT will continue to provide leadership and policy coordination for this priority area under the leadership of WHO and UNICEF and with UNFPA and other cosponsors.

The role of the Joint United Nations Programme on HIV/AIDS must be considered in the context of ongoing global initiatives. The Global Fund to Fight AIDS, Tuberculosis and Malaria has declared PMTCT a priority and is actively reviewing and reprogramming existing grants with an emphasis on quality services that provide optimal antiretroviral therapy regimens. The Global Fund is also emphasizing PMTCT in new funding rounds.

Additionally, the US President's Emergency Plan for AIDS Relief (PEPFAR) supports the national scale-up of PMTCT programmes in 15 focus countries as part of comprehensive support for HIV prevention, care and treatment. PEPFAR is broadening its support to other countries and is now prioritizing PMTCT as part of a focused initiative of enhanced support. UNITAID is providing support to improve antiretroviral drug access for PMTCT. The Clinton Health Access Initiative (CHAI) and UNITAID apply a business-oriented approach to changing the market for medicines and diagnostics and support PMTCT scale-up efforts in resource-limited countries. The major maternal health initiatives—such as Partnership for Maternal, Newborn, and Child Health; the International Health Partnership; and the H4+1—will also be essential partners. And new partnerships are being forged—for example, the Millennium Villages Project is seeking to curtail vertical HIV transmission as part of its effort to demonstrate that the MDGs can be achieved with an affordable, integrated package of health and development services.

- ▶ In all 22 countries, UNAIDS will promote the following:
  - updating national policies and guidelines to support scaling up of more efficacious regimens and effective programmes;
  - establishing national action plans for the elimination of vertical transmission, including annual targets and a plan for monitoring and accountability
  - strengthening maternal and child health systems, including antenatal care and deliveries by skilled attendants, and integrating PMTCT services with sexual and reproductive health services;
  - improving implementation approaches in marginalized populations in all countries, including urban and rural areas, areas of low HIV prevalence and concentrated epidemic settings;
  - instituting reliable information management and monitoring systems;
  - mobilizing external donor support and technical assistance;
  - giving increased attention to primary prevention and the prevention of unintended pregnancies among women living with HIV



- ▶ Continued support will be provided to countries with low HIV prevalence and concentrated epidemics in addressing their specific policy and programmatic needs in reaching the goal of the elimination of mother-to-child transmission of HIV, and incorporating ongoing strategies on congenital syphilis eradication as appropriate.

UNAIDS will work closely with key donors, implementers and other external partners to ensure a harmonized approach and the most effective allocation of resources. The global response to PMTCT will not happen in isolation, but will be complementary to efforts in other priority areas and to ongoing and new global initiatives towards zero new infections, zero discrimination and zero HIV-related deaths.



**22 highest burden countries:** Angola, Botswana, Burundi, Cameroon, Chad, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Ghana, India, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, South Africa, Swaziland, United Republic of Tanzania, Uganda, Zambia and Zimbabwe.

### Ensuring accountability and measuring progress

The United Nations Special Session on AIDS (UNGASS) in 2001 defined key targets for 2010 as reducing the proportion of infants infected with HIV by 50% by the year 2010, by means of:

- ▶ Ensuring that 80% of pregnant women accessing antenatal care receive information, counseling and other HIV-prevention services; and
- ▶ Increasing the availability of and providing access for HIV-infected women and babies to effective treatment to reduce MTCT, as well as to voluntary and confidential counseling and testing, breast milk substitutes and the provision of a continuum of care.

In this context, UN agencies have provided and updated normative guidance and standardized indicators for monitoring the progress of national PMTCT programs and the global effort. To ensure accountability and measure progress towards elimination of vertical transmission of HIV, the UN will revise its monitoring and evaluation guidelines to reflect the more ambitious goal and targets of this priority area for 2015. It will also strengthen the PMTCT IATT Scale-Up and MTCT Elimination Working Group to enable the UN and the IATT to better support, coordinate and monitor progress.

Although data collected from PMTCT programmes are generally of acceptable quality to monitor trends, most health information systems remain weak and antenatal and PMTCT data collection registers need to be improved. The needs are especially acute in monitoring services for hard-to-reach populations and in rural health facilities. UNAIDS partners will collaborate with national stakeholders to strengthen the quality of PMTCT data.

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## Joint Action for Results UNAIDS Outcome Framework:



We can reduce sexual transmission of HIV.



We can prevent mothers from dying and babies from becoming infected with HIV.



We can ensure that people living with HIV receive treatment.



We can prevent people living with HIV from dying of tuberculosis.



We can protect drug users from becoming infected with HIV.



We can meet the HIV needs of women and girls and can stop sexual and gender-based violence.



We can remove punitive laws, policies, practices, stigma and discrimination that block effective responses to AIDS.



We can support the ability of men who have sex with men, sex workers and transgender people to protect themselves from HIV infection, achieve full health, and realise their human rights.



We can empower young people to protect themselves from HIV.



We can enhance social protection for people affected by HIV.

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