



LETTER TO PARTNERS | 2010

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Dear Friends

This letter comes to you from Swaziland, where I just visited a Family Life Association clinic. This integrated clinic brings together family planning, antenatal care, maternal and child health services, prevention of mother-to-child transmission of HIV services and HIV counselling and testing, along with access to antiretroviral therapy. In the near future, I hope to see many more examples of integrated approaches to HIV.

Swaziland has the highest HIV prevalence in the world, with 26% of the reproductive population aged 15 to 49 living with HIV. It has mounted a concerted effort to achieve its universal access goals. By February 2010, Swaziland reached more than 75% coverage with its programmes to prevent mother-to-child transmission.

Visiting a male circumcision clinic with Health Minister Dr. Benedict Xaba, and Dr. Ladisious Chonzi and a maternal and child health clinic at an integrated health facility run by Family Life Association of Swaziland.



My first year as Executive Director was inspired by boldness. I have been energized by the collaboration with our Cosponsors and the support we have received for the vision and new direction of UNAIDS. However, the best part of my job has to be meeting incredible people whose values are driving them to achieve the impossible.

One of the most memorable meetings I had was with Mahehloa Pitso in Lesotho. We sat in her kitchen, talking about life. She told me she was six months pregnant with her second child when she learned that she was HIV-positive. “At first it was difficult, instead of saying ‘Thank God I’m alive’, I was saying ‘Oh, I am HIV-positive!’”, she said. However, after asking many questions and getting the answers, she told me that she had decided that enough was enough—“I want to live life and live positive”.

A major part of this commitment was making sure that her baby was born without HIV. She was supported by the organization mothers2mothers, which provides education and support for pregnant women and new mothers living with HIV. We talked about her experience at the Mabote clinic where her child was born. Emlyn is two years old and HIV-negative. And now Mahehloa is helping other HIV-positive mothers to live healthy lives and to deliver healthy, HIV-free babies.

Mahebloa with her children. She is now helping other mothers to protect their babies from HIV.



It's for families like Mahebloa's that at the Global Fund to Fight AIDS, Tuberculosis and Malaria Board meeting in May 2009 I called for the virtual elimination of mother-to-child transmission by 2015. I am heartened by the support we have received from advocates such as the First Lady of France, Carla Bruni-Sarkozy, who has said that "it is crucial that we strengthen our efforts and continue to educate women about their health. If we do this, we can eliminate the transmission of HIV from mother to child." UNAIDS will redouble its efforts to make this dream a reality, working with partners such as the United States Global AIDS Coordinator, Eric Goosby, Professor Jeffrey Sachs, Director, Earth Institute at Columbia University, Stephen Lewis, Co-director of AIDS Free World, UNAIDS Cosponsors UNICEF and WHO, as well as the Global Fund.

An exciting example is the partnership UNAIDS launched with the Millennium Villages Project (MVP) last year. The MVP—brainchild of Professor Sachs, Special Adviser to United Nations Secretary-General Ban Ki-moon—demonstrates proof of concept of the feasibility of achieving the Millennium Development Goals. It aims to do this in Africa's most resource-constrained settings by empowering communities and investing in an integrated set of interventions simultaneously.

Together with the MVP, UNAIDS is strengthening prevention of mother-to-child HIV transmission services in the villages to create 'MTCT-free zones'. As a result, communities will innovate with different models for the prevention of mother-to-child HIV transmission, demonstrate what success looks like and provide valuable lessons for scaling up across Africa. We will share new data at the United Nations General Assembly High-level meeting on the Millennium Development Goals, and show concrete progress on ambitious targets—including our progress towards 100% PMTCT coverage of HIV-positive pregnant women—across the villages in 10 countries. I hope that this will stimulate others to get behind our campaign to ensure an HIV-free generation.

It has been a difficult year for many communities. One marked by a slow recovery from the economic crisis, shifts in global threats and complex consensus-building on key issues such as climate change.

Already in 2010 we have seen the devastation in Haiti, the country with the most severe HIV epidemic in the Caribbean. Before the earthquake, there were an estimated 120 000 people living with HIV in the country.

Let me give thanks that our staff in Haiti are safe and pledge my solidarity with UN Secretary-General Ban Ki-moon in supporting the people of Haiti to rebuild their lives and strengthen the national AIDS response. As the UN Special Envoy for Haiti, former US President Bill Clinton, reiterated “relief efforts in Haiti have been increasing to meet staggering needs, but the long road to recovery has just begun.”

Continuing antiretroviral therapy in times of crisis. UNAIDS is working with partners to rebuild Haiti's AIDS response.



AIDS has had its share of triumphs and setbacks in the past year. On the positive side, antiretroviral treatment now reaches more than four million people. For the first time we have trend data showing that the number of new HIV infections has dropped—by 17% worldwide in the past eight years. The most progress has been seen in sub-Saharan Africa, where there were 400 000 fewer new infections in 2008 than in 2001.

We have seen bold leadership on AIDS from governments such as South Africa's, and the lifting of travel restrictions in countries such as the United States. We have renewed hope for vaccine research through a new commitment from the Bill & Melinda Gates Foundation, which pledged US\$ 10 billion for vaccines over the next 10 years. We have seen the Delhi High Court read down a law in India that targeted men who have sex with men.

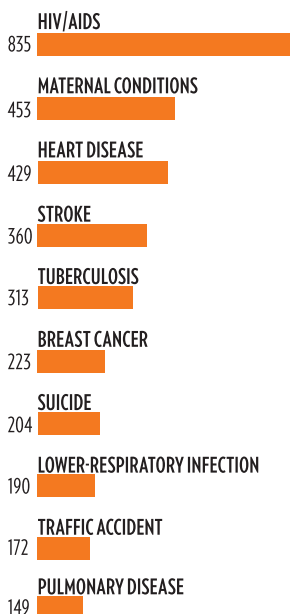
However, we have also seen several countries introduce legislation that restricts human rights. These laws often focus on criminalizing behaviour and can put people at a higher risk of contracting HIV or hinder their access to life-saving services for HIV prevention, treatment, care and support.

The HIV epidemic is in transition. In many countries and regions, HIV transmission patterns are very different from what they were 10 years ago. In Asia, HIV is increasingly affecting heterosexual couples, in addition to sex workers and injecting drug users. In Eastern Europe, HIV transmission is mainly through injecting drug use, but now more and more we are seeing the sexual partners of injecting drug users becoming infected. The AIDS response has to stay ahead of these changes or the virus will get the better of us.

It is with this in mind that my second Letter to Partners focuses on a core set of values that can change the course of the epidemic.

GETTING EQUITY

Top 10 causes of death for women aged 20 to 59 worldwide (in thousands)



Source: WHO.

AIDS is an epidemic of inequities. Last year an overwhelming 97% of all new HIV infections—and 98% of all AIDS-related deaths—occurred in developing countries. Sub-Saharan Africa remains the region most affected and is home to about two thirds of all people living with HIV worldwide. Women in sub-Saharan Africa are disproportionately affected, and HIV responses must urgently revisit the frameworks by which they approach issues of gender. A broader approach is needed that includes issues such as maternal health, property rights and violence. We have seen the powerful outcomes when the AIDS and women’s movements unite.

UNAIDS will continue to accelerate country action for women, girls and gender equality in the AIDS response. We will put into operation a plan—the Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV—developed to address the persistent gender inequalities and human rights violations that still put women and girls at a greater risk of HIV. UNAIDS and its partners will promote 26 specific action points that will be rolled out in countries, starting with Liberia, India and China. Efforts include integrating interventions to address and respond to violence against women within HIV prevention, treatment, care and support programmes, as well as developing the capacity of national AIDS authorities to incorporate gender equality into HIV prevention policies and programmes.

Equity starts with the idea that all people should have equal access to HIV prevention, treatment, care and support. Our challenge now is to take the progress that countries have made towards universal access and use it to achieve the Millennium Development Goals.

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The universal access movement started as a call for countries to be accountable. It was started to make sure that people everywhere have access to HIV prevention, treatment, care and support by 2010. This movement brought voices from all walks of life in each country together to set targets and milestones. As Semereka, a representative of a civil society network in Malawi, said of his country’s universal access movement in 2006, “We finally felt that our voices were being heard and taken into account.”

Many countries have since achieved some of their targets, but collectively we have not met them and are unlikely to by the end of 2010. With five years to go to meet the Millennium Development Goals, we have to review and renew.

The universal access movement in 2006 created space for dialogue and buy in—it's time to bring everyone back under the tent. Country by country, let's take stock of what has worked and of what bottlenecks are keeping us from reaching our targets.

This year UNAIDS will coordinate a series of consultations that bring stakeholders together in every region to review progress made towards universal access. We will strive for accountability and acknowledge achievements. We will also renew our commitment to address remaining obstacles.

BANKING ON EVIDENCE FOR BETTER RETURNS

The HIV epidemic is in transition—increasingly we are seeing shifts in modes of transmission within regions and countries. Today the response must be based on evidence, not sentiment. Using science and data does not mean we cannot respect cultures and tradition.

Recently I was in Nyanza, in south-western Kenya, where HIV prevalence is considerably higher than in other parts of the country. I took part in a Luo council of elders meeting. This group of venerable men and women recounted how they looked at all the evidence to see what they could do to lower the risk of HIV in their community.

One option they explored was male circumcision, even though Luo males do not traditionally practise circumcision. The data showed that HIV prevalence among men who are circumcised in Nyanza was 5.5%, whereas among uncircumcised men it was 17.3%. After learning everything they could about the topic and after much dialogue, they told me they came to the decision to promote male circumcision. As difficult as this surely was, what really amazed me was that their decision immediately mobilized the community. Within six weeks 32 000 men and boys over the age of 12 had voluntarily been circumcised.

Communities around the world need to have these difficult dialogues based on data and evidence around HIV prevention, treatment, care and support. We need to align our politics to the evidence. UNAIDS will highlight how more communities can learn from each other and mobilize more quickly to save lives.

Similar pragmatism has to be used to address issues such as injecting drug use and sex work. We know that after a decade of needle and syringe programmes, Australia is estimated to have saved one and a half billion US dollars. Sentiment will not bring down the number of new HIV infections. Smart investments will.

As the world emerges from the economic crisis, many countries are making difficult choices about the investments they are making in health and development. We need to reinforce the case that the AIDS response is an investment that delivers returns for HIV, as well as larger goals of health, development and human rights.

As was reported in the *Where does the money for AIDS go?* article published in the UNAIDS *Outlook* report, resources too often go to the favoured issues of donors and not necessarily where a country needs it most. According to the Commission on AIDS in Asia, about 95% of HIV infections among young people in the region are among adolescents at higher risk. However, more than 90% of resources for young people are spent on low-risk youth, who account for less than 5% of infections.

In countries where the epidemic is mainly spreading among populations at higher risk, such as sex workers, injecting drug users and men who have sex with men, HIV prevention investments directed at them are a mere 5–7% of the total spending on HIV prevention. For example, in Eastern Europe, a region where some 57% of all new infections occur among injecting drug users, only one US cent per day per person is available for prevention programmes among this group—this is not adequate if we are to provide the clean injecting equipment and substitution therapy essential to reduce the number of new infections.

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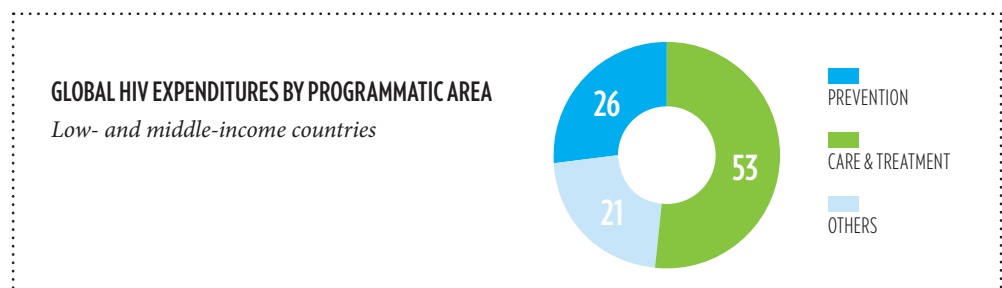
Even though HIV prevalence among prisoners is higher than among the general population in most countries, they are often an overlooked segment of the population. I am pleased that in Africa we, in collaboration with our Cosponsors UNODC, WHO and the World Bank, were able to launch the African HIV in Prisons Partnership Network to help prisoners access quality health services, including for HIV, tuberculosis, mental health and drug use, and to tackle prison overcrowding. Similar initiatives are urgently required in other parts of the world.

We also need to be clear that new treatment guidelines mean more people will be in need of treatment sooner. As new evidence comes available, treatment strategies for first- and second-line regimens will need to be adjusted.

In 50 reporting countries, treatment accounted for 55% of the AIDS investments. However, achieving universal access under the new treatment guidelines will require substantially more resources than the US\$ 15.6 billion that was available for HIV programmes in low- and middle-income countries in 2008.

Last year I wrote that the investments needed for 2010 would be about US\$ 25.1 billion. Now with the updated guidelines, in 2010, for example, we would need an additional US\$ 1.7 billion to achieve country-set universal access targets using the new antiretroviral treatment criteria.

In each country, it will be necessary to make the right investments for the most strategic programme mix in order to do more with less. We must make evidence-



informed choices but still retain our value systems—some things are, of course, non-negotiable, like the need for education for children or ensuring equality for women. But there is an entire realm of cost-effective investments that can still prioritize the vulnerable and those at higher risk first and deliver quality services without cutting corners.

Many countries still fail to undertake full risk assessments and put into place proven interventions. In sub-Saharan Africa few programmes reach men and women in long-term relationships, since they are perceived to be at low risk, even though a majority of infections in many African countries occur among this group.

In our leadership role UNAIDS will work this year to provide clear guidance on making investments while encouraging countries to invest wisely both domestically and internationally. We need a fully funded Global Fund and we need countries to fulfil their commitments.

We have had a full year to develop the initial thoughts in my first letter about UNAIDS' priority areas. Following my first meeting of the UNAIDS Programme Coordinating Board, together with the Cosponsors we have launched a new UNAIDS Outcome Framework. It is supported by a budget, based on evidence, grounded in human rights, holds us accountable for results and is now fully operational in 2010.

Outcome Framework: **nine priority areas**

The UNAIDS Outcome Framework is driven by passion and resolve—'WE CAN'. It shows how our work is focused on results and it holds us accountable. This framework was endorsed by the heads of UNAIDS' Cosponsors in April last year. The nine priority areas were chosen because they directly help to achieve the country-set universal access targets and contribute to the Millennium Development Goals. In the coming months UNAIDS will publish business plans for each of these priorities that outline the actions to be undertaken in the coming year. These actions are bold and long overdue.

1

We can reduce sexual transmission of HIV.

2

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

3

We can ensure that people living with HIV receive treatment.

4

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

5

We can protect drug users from becoming infected with HIV.

6

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

7

We can stop violence against women and girls.

8

We can empower young people to protect themselves from HIV.

9

We can enhance social protection for people affected by HIV.

10

At our most recent Board meeting, UNAIDS was asked to include among its priorities the expansion of comprehensive programmes aimed at reducing HIV transmission among men who have sex with men and transgender people. The UNAIDS PCB recognized that in many countries there is a substantial and increasing number of HIV infections among men who have sex with men and transgender people, and that their human rights need to be respected. UNAIDS will work closely with its partners, including donors, governments, civil society organizations and community members, to take forward these efforts and we will report back to the Board later this year.

ENSURING RIGHTS AND DIGNITY ALWAYS

The AIDS response has been underpinned by a vibrant civil society movement that has relentlessly advocated for human rights.

Dogged civil society pressure, combined with an independent judiciary and a forward-looking government, has led to the decriminalization of consensual adult sexual behaviour in India and to restoring the dignity of men who have sex with men. In Latin America, there is growing public sentiment against homophobia. But many other countries still criminalize same-sex relationships.

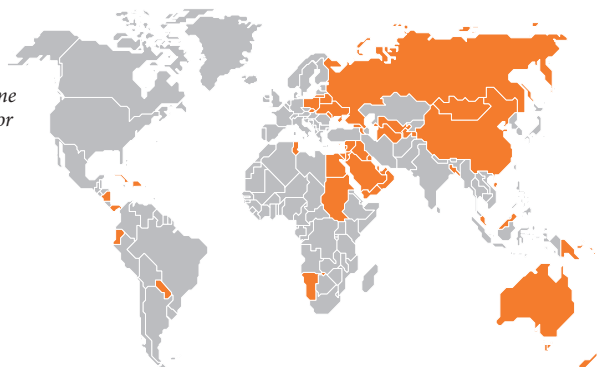
Starting in 2010, people living with HIV are not barred from entering the USA on the basis of their HIV status. Removing the restriction, President Barack Obama said “We talk about reducing the stigma of this disease, yet we’ve treated a visitor living with HIV as a threat. If we want to be the global leader in combating AIDS, we need to act like it.”

Today, there are 57 countries that still impose some form of restriction on entry, stay and residence based on HIV status. UNAIDS will advocate that all people living with HIV must have equal freedom of movement globally.

Travel restrictions

Mapping progress towards universal access. These countries, territories and areas have some form of HIV-related restriction on entry, stay or residence.

YES NO



I have called on all UNAIDS staff to raise the issue of HIV travel restrictions, where they still exist, with key officials, parliamentarians, civil society, the private sector and UN system counterparts. We will stand by people affected by the indignity and injustice of restrictions when they or their family members have tried to go abroad or have been deported because of their HIV status.

UNAIDS will intensify support to governments to review and eliminate laws, policies and practices that restrict entry, stay and residence on the basis of HIV status. We will bring together parliamentarians, government officials, civil society organizations and people living with HIV to chart out a road map for change. This work is one step towards the elimination of all laws, policies, practices, stigma and discrimination that stand in the way of effective HIV responses.

Drug dependence is another area that can benefit from public health approaches—the Supreme Court of Indonesia has ruled that drug users need treatment, not criminalization. The Government of Ukraine has made harm reduction including substitution therapy a part of its official policy. Punitive laws make it difficult to provide HIV prevention and treatment options and they make it difficult for people to access social services. Most importantly, punitive laws rob people—whether sex workers, people in same-sex relationships or drug users—of their dignity as human beings. Striking down such laws will restore faith in universal human rights.

In November 2009 I was in China, where we launched the first stigma index with the Chinese Government. The report showed that 42% of people living with HIV in China who took part in the study have experienced discrimination because of their status. In the United Kingdom some 21% of study participants living with HIV had been verbally assaulted or harassed in the past year.

In 2010 we will continue to work with our partners to gather strategic information to help to reduce stigma and will advocate for rights-based approaches to programmes.

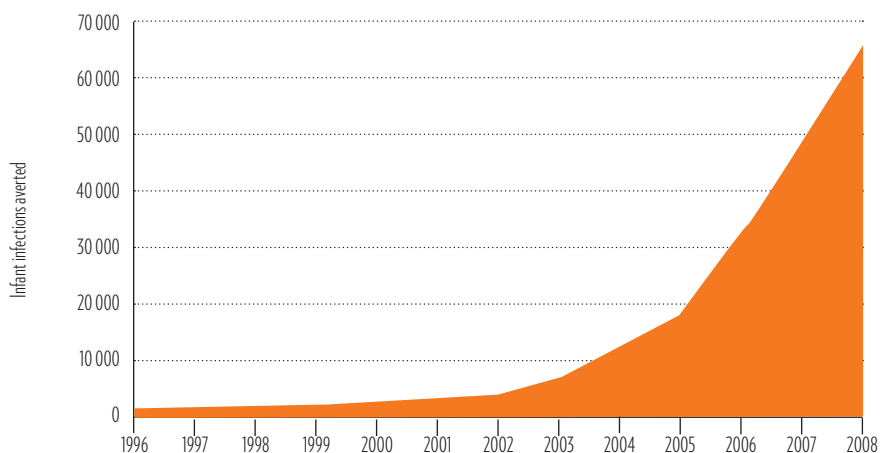
ZERO NEW INFECTIONS—TREATMENT FOR EVERYONE WHO NEEDS IT

As we begin a new decade I have been thinking a lot about the number 0. Specifically zero new HIV infections and how we get there. Getting to 0 will take nothing short of a prevention revolution. At the same time we must continue to ensure treatment for everyone in need—this is especially important with the changes in the new antiretroviral treatment guidelines. We need to know where and why HIV transmission is occurring and we need to find ways to more quickly measure the number of new infections. Each day 7400 more people become infected with HIV—and five people become newly infected for every two people starting treatment.

We must leverage the words of President Jacob Zuma when he told the National Council of Provinces that “if we are to stop the progress of this disease through our society, we will need to pursue extraordinary measures. We will need to mobilize all South Africans to take responsibility for their health and well-being and that of their partners, their families and their communities.”

In December 2009 I called for the formation of a high-level commission on HIV prevention, which will be developed in partnership with Laurie Garrett at the Council on Foreign Relations. My hope is to breathe new life into the prevention movement. One way of doing this is to give countries the best information and to build the best possible scientific and political consensus on the most cost-effective prevention programmes.

GLOBAL ESTIMATE OF THE ANNUAL NUMBER OF INFANT INFECTIONS AVERTED THROUGH PROVISION OF ANTIRETROVIRAL PROPHYLAXIS TO HIV-POSITIVE PREGNANT WOMEN.



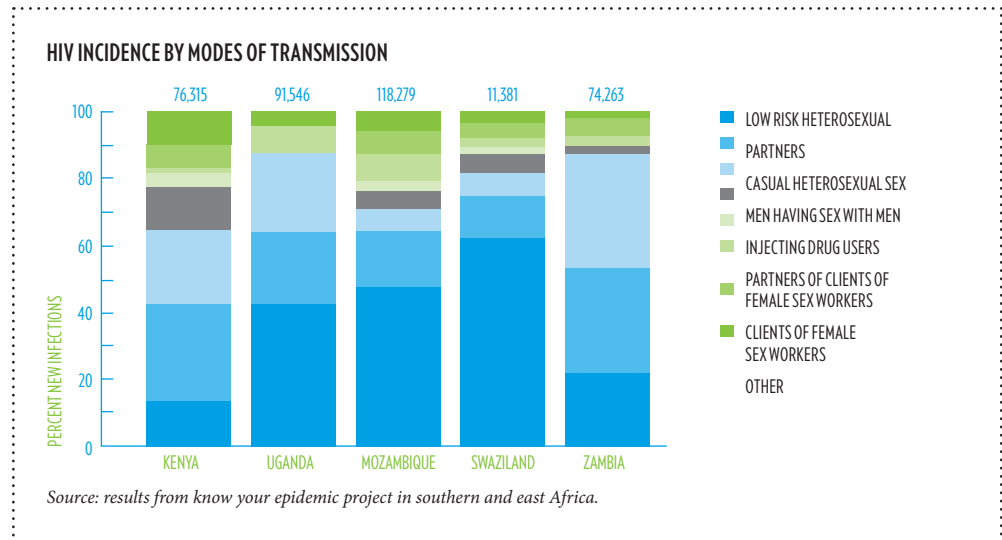
Source: UNAIDS 2009 Epidemic Update.

Successful prevention means scaling up demand for and access to male and female condoms. One of the starting points for prevention has to be a concerted effort to increase condom use. The global condom initiative being led by UNFPA is working in 72 countries to extend nationally owned condom strategies that deal not only with the supply side of the condom equation, but also with demand—so that the motivation for condom use is increased at the same time as availability. Female condoms need to be part of the equation: it has been gratifying to see that over the past year the price of female condoms has reduced by 25%; and an unprecedented 50 million female condoms were distributed in 2009 (36.2 million in Sub-Saharan Africa), compared with 21.1 million in 2008.

Supply of both male and female condoms is less than a quarter of the need.



However, the supply of both male and female condoms is less than a quarter of the need. In sub-Saharan Africa, only four condoms were available each year for every adult male of reproductive age. We have not done enough in promoting this relatively inexpensive and highly effective tool for HIV prevention. And in some places, there are shocking gaps in knowledge about condoms as protection against HIV: in Somalia, for instance, only 4% of young women report accurate knowledge of HIV, and only 11% of adult females are aware that condoms can prevent HIV transmission.



We will also have to scale up safe male circumcision services for heterosexual men in hyperendemic settings. There is a need to continue investment in prevention research and development—particularly for microbicides, vaccines and pre-exposure prophylaxis—as we continue to work towards a cure. The role of

antiretroviral treatment in stopping new infections and how it can be effectively used as part of combination HIV prevention approaches must be further explored, as shown by Dr Julio Montaner, President of the International AIDS Society.

Botswana's former President Festus Mogae is convening African elders as champions for an AIDS-free generation.



Let me congratulate the leadership of Botswana's former President Festus Mogae in convening African elders as champions for an AIDS-free generation. African elders as champions have a responsibility to see that as small gains become visible complacency does not set in. We need champions like him who can boldly take on issues of human sexuality, including transactional and intergenerational sex, sex work, homophobia, gender inequality, gender-based violence and drug use, among their peers and communities to find local and sustainable solutions.

We will also explore ways to magnify the movement launched by GNP+ on 'positive health, dignity and prevention.' With more than four million people on treatment this is a powerful movement for uniting treatment and prevention.

We are seeing that increasingly action starts online rather than on the ground. AIDSspace.org, a social networking site for the global AIDS community, has started sharing information and debating issues such as best prevention practices—I hope that this will accelerate into a greater solidarity among people working on AIDS and development.

We cannot talk about increasing access to prevention without ensuring access to treatment. With more than four million people on treatment today and more than 33.4 million people living with HIV, business as usual won't suffice.

This year I will convene a forum to focus on what UNAIDS is calling Treatment 2.0—a new generation of treatment options. We have seen guidelines change, access increase but fundamentally little discussion has focused on what treatment should look like in the coming years. How will we address issues such as resource gaps and rationing? Should the world only rely on costly second-line treatment? Can we improve the effectiveness of regimens? And, most importantly, how will countries show greater ownership to manage the increasing needs for treatment? I believe that together we can think outside our traditional viewpoints and come up with a comprehensive and sustainable approach to treatment.

LEVERAGING OUR INTERCONNECTEDNESS

We will see in 2010 how interconnected AIDS is to other major issues in the world. From global health and development to rights and economics, being able to leverage the results of the AIDS response means we can increase the number of people receiving its benefits.

Even as we widen access to antiretroviral therapy, we cannot ignore other health and welfare needs. Antiretroviral prophylaxis for an HIV-positive pregnant woman is of little use if there are no safe delivery kits or trained health workers to deliver a baby safely.

Addressing social welfare issues often has a direct impact on HIV prevention, treatment, care and support. Take cash transfers—I was pleased to learn how cash transfer programmes are making a difference in the lives of young girls in Malawi. If a small cash transfer of one US dollar can reduce the number of school drop-outs by 40% we can and should find this money to keep children in school and protect them from HIV.

Across sub-Saharan Africa, the World Food Programme and its partners provide food support not just to people on HIV treatment, but for their entire family. When programmes such as for HIV and tuberculosis are integrated within the health system, both the patient and the clinic benefit.

It is important to provide food and nutritional support to people on antiretroviral treatment.



We are getting better at approaching issues holistically rather than vertically. For example, as Haiti begins its rebuilding process, the focus should be on how we put in place systems that will deliver on all the Millennium Development Goals. And we should do the same elsewhere in the world.

The climate change debate has exposed the continuing vulnerabilities of humankind and the need for collective action. Cabinet meetings of the Government of Nepal at the Everest base camp and the Maldives' underwater meeting highlight how actions far away can influence the situation on the ground at home. Just as the climate change issue can only be tackled with global solidarity, universal access can only be achieved when our vision looks beyond the narrow confines of national boundaries.

This is why UNAIDS is working with the African Union to create a drug agency for Africa. Collective action on this front will bring benefits not just for AIDS but across the health sector.

It is also why I have high hopes for the partnership agreement I signed with the Secrétaire général de la Francophonie, Abdou Diouf. We believe that together we can leverage the AIDS response to mobilize political support across French-speaking countries in Africa and around the world.

In a similar vein, UNAIDS will facilitate South–South cooperation in exchanging expertise and lessons learned from the AIDS response on all fronts—HIV prevention, treatment, care and support.

On the resource front, we know that funding for treatment that supports the majority of the more than four million people on treatment today comes from either the US Government or the Global Fund. Any cuts in funding from these two sources will jeopardize national programmes and put lives at risk. We have to find new ways to spread the investment sources and ensure greater national ownership.

For a start, all G20 countries must fully finance their national AIDS programmes from domestic sources, just as Brazil has been doing for many years. Other countries must increase their share of domestic funding, keeping the Abuja promise and look at innovative health insurance options to broaden health-care coverage. This will help to increase ownership of the national responses to AIDS and will ensure their long-term sustainability.

The younger generation has to embrace the rights-based AIDS response and take it to new heights with fresh perspectives and energy.



Last year I was struck by the words of several leaders at a strategy session convened for frank discussions on the future direction of the response. There was recognition that too many of us around the table had seen the beginning of AIDS up close and personal. As one of the group said, “the consciousness about this pandemic is already shifting under our feet as a younger generation comes into power, comes into influence, and has no institutional or personal memory of the devastation of this pandemic and you now have to go to remoter and remoter places to see the face of the pandemic that those of us that are old bore witness to.” These simple words by Laurie Garrett underscore the need for us to bring new leaders to the table and ensure all world leaders understand what devastation the AIDS epidemic has wrought in its short 29 years.

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LOOKING AHEAD

UNAIDS has a tremendous opportunity to reap what we sowed in 2009. We are finding ways to keep our flexibility and have systems in place that allow us to focus our time and energy on efforts where UNAIDS can make the biggest difference in the AIDS response.

The recommendations of the Second Independent Evaluation of UNAIDS present major opportunities that we won't fail to take advantage of. Assessments focused on

both our Headquarters and the field have given us insights into how we can better organize UNAIDS for maximum returns.

UNAIDS will also be working towards successful outcomes at several major events this year—the International AIDS Conference in Vienna, the United Nations High-level Meeting on the Millennium Development Goals and the important milestone of the Global Fund Replenishment Conference, as well as the 2010 football World Cup in South Africa.

My first year has opened my eyes to the true meaning of the triumph of the human spirit and I promise you that my energy has been reawakened.

Let me re-emphasize three things for this upcoming year:

- 1 The countdown to ending mother-to-child transmission has begun and every step we make should take us closer to virtual elimination.
- 2 Zero new infections and Treatment 2.0. I am calling for accelerated actions and new thinking for better results.
- 3 Focus on tomorrow's leaders. Let us identify, mentor and learn from a new group of long-distance runners that tomorrow will carry the baton across the finish line.

Finally, let me say that I am privileged to work with a team that inspires me daily. And I thank all UNAIDS' partners for their trust. I look forward to getting your feedback on how we can work together to move hope forward.



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