

Speech

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**Speech by
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As everybody knows this is my last PCB meeting. It's therefore with mixed feelings that I am addressing you. Rather than give you my usual report on the work of UNAIDS since the last since the last PCB meeting, I'd like to share some reflections on the past and future of UNAIDS and the aids response. I'm afraid I will be a bit longer than usual.

A fairly detailed honest account of the foundation of UNAIDS and its first ten years can be found in the book UNAIDS: The first 10 years. It gives more of the details of how we struggled to establish ourselves as an organization and how the aids movement has evolved over the last fifteen years.

UNAIDS was created by a resolution of the economic and social council of the United Nations. The resolution gave us a double mission: 1) to defeat aids and 2) to coordinate the UN system around aids.

And when I took the job as Executive Director, I set myself three goals:

1. To put aids on the global agenda—in all countries and major global fora.
2. To build a broad alliance beyond the small circle of aids doctors and aids activists working on the issue for a long time but not going anywhere.
3. To mobilize money: not just for UNAIDS, but for communities and countries to deal with this epidemic.

I also thought that within five years of establishing UNAIDS, we could close down the organization because the work would be done and whole agenda would be taken over by the main institutions in the UN system. I was definitely quite wrong in assuming that.

What I also had not anticipated was that in January 1996—six months after UNAIDS was launched, highly active antiretroviral therapy would become available. This not only revolutionized the way we looked at the epidemic but also revolutionized the lives of those living with hiv. In psycho-political terms it offered a “solution” to aids therefore it became easier to put aids on global agendas. And, as Michel Kazatchkine mentioned yesterday, we have come a very long way since then.

Let me remind you of where we were in June 1995 when the first Programme Coordinating Board meeting was held. UNAIDS did not officially yet exist. There were fifteen employees, ten seconded from different organizations. Some of them were seconded to undermine UNAIDS—so that the programme would never see the light of day. And others were there to make sure that it would happen.

And when I look back—not just from an aids perspective—on how the world was in 1996, and how it is now, it was indeed then a very different time. Official

Development Assistance (ODA) was declining even as the UN General Assembly declared 1996 the international year for eradication of poverty. Barings Bank in the UK had collapsed. Yahoo was founded and Motorola launched the StarTAC cell phone, heralding a major revolution in communication and means of connecting people. In terms of public health there was a major scare with the appearance of mad cow disease (or bovine spongiform encephalitis) which can be transmitted from cattle to human beings.

There were 250 million US\$ spent on aids in low and middle income countries. In 1997 and 1998 hardly anybody living with hiv in these countries was benefiting from antiretroviral therapy. This contrasts with most high income countries where within one year most people in need for antiretroviral treatment were benefiting from it—particularly in countries with social security and health insurance coverage.

There were only two countries where hiv had started decreasing incidence—Uganda and Thailand. Groups of people living with hiv extremely rarely were invited to join the discussion table. Where such groups existed, they demonstrated outside buildings. There was only a handful of countries in Western Europe and Australia that were providing harm reduction programmes to reduce hiv infection among injecting drug users. The UN was at its worst in terms of its response to aids. It was dispersed, running in all kinds of directions. Today it is a very different picture.

In 1996 20 million people were living with hiv, today there are about 33 million. In 1996, 900 000 people had died from aids and last year about 2 million, although there has been a decrease over the last 2 years. Today there are fewer new HIV infections than in 1996 – 2.7 million compared to 3 million.

But there also have been many successes that we never dreamed possible. On the financing front, 10 billion US\$ was spent on aids last year. Between 3 to 4 million people in developing countries on antiretroviral therapy—thanks to efforts of many in this room. In many countries the number of new hiv infections are going down. Civil society organizations are a major force and are members of the Country Coordinating Mechanisms in many countries. Yesterday we heard of the many problems with civil society participation, but at least we can discuss them. In the past, they were not an issue and not present at the table.

We now have a dedicated multilateral fund to deal with aids and with collateral benefits for TB and Malaria. There is the US President's Emergency Plan for AIDS Relief (PEPFAR), which should continue with the new administration. Harm reduction strategies are now practiced in many countries although there are some big countries which have not yet adopted them. The multilateral system is also more united around aids than around any other issue. We can therefore say that there is progress, but we must remember that there is also still a long way to go.

The global environment has changed significantly. In these last 14 years the world population has grown by nearly a billion people. Our planet now has to sustain about one billion people more, feed them, and help find a job and so on. On the geopolitical, economic, and international development fronts too, there have been some very significant changes. In general, I would say that the economic and financial centre of the world is moving towards Asia. But the thought leadership is still largely Western and that also includes the way the UN system thinks and functions. This is where we need far more diversity over the next few years.

Years of unprecedented economic growth have led to serious reduction in poverty in some countries, particularly in China and other parts of South East Asia—unprecedented in the world's history. Also thanks to a major increase in life expectancy in several countries over the last 30 years, a couple of decades have been added to life expectancy. However, across the world inequality between people and within societies has also increased over this timeframe. The Gini coefficient has indicated there is increasing unequal distribution of wealth in almost every country, with very few exceptions. It has been an era of uneven development. And now, the financial soufflé in the West has imploded, generating the worst financial, economic, and possibly the worst social crisis since World War II.

Juan Somavia from ILO recently said, "Let's not forget that for billions of people, there was a crisis even before the current financial crisis because they have been trying to survive on less than one and two dollars a day."

The "knock-on" effects of these massive failures of risk management and risk assessment, and uncontrolled greed, will be enormous, including for the aids response and the spread of hiv, although it will be hard to predict exactly how it will affect the global aids response. For example, we know that economic growth can promote the spread of hiv by generating more disposable income for men, which can be used to buy sex and drugs. On the other hand, increased poverty can mean both more spread of hiv or less spread of hiv.

What is clear is that there is less income for states, for households, for foundations, for private entities. This will increase vulnerability, particularly for those who are already in vulnerable situations or who are living with hiv.

The impact on ODA itself is still unclear. If we look at history and learn from it, countries such as Japan in 1990 in the Nordic Countries in 1991 reduced their ODA. Japan and Finland have still not reached pre-1990 level of ODA. It took over five years for Norway and Sweden to increase ODA. This should be a reminder to us that we cannot behave, or plan, as if the global financial crisis is not happening.

This may be the end of an era and our old ways of doing international development, how it's organized, and maybe, hopefully, the way the UN system works and functions. As WFP's Josette Sheeran said at the World Economic Forum meeting in

November, “This crisis imposes us to reboot the systems which must become better to aid decision making”.

The financial crisis reveals a new era with three major trends.

The first of these, as Bob Zoelich has emphasized, is multilateralism. He said we must change from the current top-down to a multi-lateral assistance system. What we need are far more flexible entities that can adapt to changing requirements and have a different set of responses for a different set of problems. The problems of today are global in nature. For example the sub prime mortgage crisis in the USA is affecting the whole world.

The second is the need to work across sectors with interdisciplinary approaches. This should become the norm for tackling the problems of our time. The current issues are too complex to be addressed by a single discipline.

The third trend is that partnership and methods of engaging with one another are no longer linear. This is an age of networks- for example people are using Facebook to link up with each other.

This means that we have to move our business from “planning for” to “planning with”. Partnerships are becoming far more essential. It is imperative to respond to the complexity of our times. Information technology and connectivity is a major instrument for doing a lot of things but we have not used it for responding to the aids crisis.

So why am spending so much time on all of this?

Because it has become highly relevant for the aids response, for UNAIDS as an organization, and for our future. Handling and accepting complexity, and planning for the long term must all go hand in hand. The response will require a multilateral approach, working across different sectors, and engaging in networks instead of linear approaches.

In that sense, UNAIDS has been a modest pioneer in all of these areas, but we have not been really pushing that agenda widely and fast enough. Being part of the UN system, which in places is still anchored in the twentieth century, has constrained us in several ways. Because we haven’t moved with the times, we will have to work harder in this unstable environment to maintain our momentum.

So the world has changed drastically over the past 13 years and it is in this changed context that we need to look at the aids response now and in the coming years.

Before looking at what lies ahead, let’s first go back and see how we looked at the future. I went back to some of my earlier speeches and to some of the HIV estimates that we made—not only as UNAIDS but collectively with other organizations.

We underestimated many things. I am going to focus on three.

Firstly, we collectively underestimated the extent to which the epidemic would expand all over the world, particularly in areas such as Eastern Europe. Who would have thought in 1996 that there would be a million people living with HIV in the Russian Federation. The hyper epidemic in Southern Africa was also underestimated. A model developed for the Global AIDS Programme by Jim Chin claimed that there was a cap and that no country could go beyond 10% prevalence. The reality today, is unfortunately very different.

Secondly, we also underestimated the extent to which stigma, discrimination, human rights violations, and gender inequality would remain formidable obstacles to tackling the epidemic—even after the increased availability of antiretroviral therapy. And this is still underestimated. I still hear people saying: “We don’t have to worry about gender. “We don’t have to worry about human rights.”

Thirdly, after years of inadequate action, we underestimated the sense of urgency and solidarity that would eventually develop in the global AIDS movement – leading to a rare convergence of political will, money and science. And it’s thanks to that rare convergence that we have been able to overcome some seemingly insurmountable barriers.

Let me name three – The first obstacle was shifting from millions to billions. Today, when we talk about resource needs we talk about billions. Ten years ago we were happy when suddenly there was a \$100 million funding increase over the year. I remember when I launched my call for billions that I received a letter, on behalf of all the donors except France – all the donors present in this room – saying that I should not make that kind of statement. They said that the money was not there, and funding for AIDS would go down. So we weren’t the only ones who were wrong.

The second formidable obstacle was access to treatment. The PCB was actually very pioneering in its session in Nairobi in 1997, when it allowed UNAIDS to start pilot programmes in Africa – in Abidjan, Côte d’Ivoire and in Kampala, Uganda, to find out whether providing antiretroviral treatment is possible in a resource-poor environment.

Everyone was against it but the NGO delegation pushed for it and the PCB agreed and gave me the green light. Even in 2000 and 2001, donor governments as well as African and Asian governments were blocking any reference to antiretroviral therapy as a goal in the Declaration of Commitment from the UN General Assembly Special Session on HIV/AIDS.

This was for a number of valid reasons: health systems were not functioning in many countries, the price of antiretrovirals was still too high, there was no money, etc. However, UNAIDS was able to reduce the price of antiretrovirals by 90%. The first pilot projects for antiretroviral therapy in Africa were not run by NGOs but by

UNAIDS. And this is where I really have to thank you, as a board, for the support you gave us – often against your own governments, against conventional wisdom, and against all odds.

The third tough barrier we overcame was harm reduction. We know that there are very solid scientific grounds showing that harm reduction is highly effective in reducing, if not eliminating hiv among injecting drug users. Who would have thought that today a country like China would have hundreds of methadone centres? Again it was an historic decision of the PCB several years ago, in which every member cooperated to find a solution that would benefit the people.

So together we overcame many barriers. We also overestimated some things.

The first was the pace at which hiv would spread in heterosexual populations outside Africa – outside groups such as men who have sex with men, sex workers and injecting drug users outside Africa. Fortunately this has not happened – except in Papua New Guinea. Nevertheless, in Thailand and Vietnam one third of new infections are occurring among housewives.

And it is definitely not true, as some have claimed that we should not worry about HIV infections among women or heterosexual transmission outside Africa. That is simply not true! The facts are there. Ukraine for example, has a significant proportion of new infections through heterosexual transmission.

But let us not forget that in the short history of aids, we've had so many surprises. Some were predictable – some were not. We are seeing major outbreaks of hiv among men who have sex with men all over Asia, reminding me of what was happening in the 1980s in the West. So we constantly have to remain vigilant and ensure we take a long-term view before we make absolute statements that something is or isn't happening.

We haven't got to a static phase in the aids epidemic. At the same time, however, our capacity to estimate how many people are living with hiv has become increasingly sophisticated. Indeed, it's probably true that there are few issues in development or public health for which we have better estimates than we have for aids. We have also been quite open in saying when we have had new facts and making them public.

Two, we overestimated our capacity to devise technological solutions. In 1984, the Secretary of Health and Human services in the United States while announcing the discovery of the cause of aids said that in a few years time the world would have a vaccine. And for many years we've heard the same song: in five years we'll have a vaccine, or in ten years. Now 24 years later and we still do not have a vaccine, and we have had to go back to the drawing board.

I'm still a strong believer that we need to invest heavily in vaccine development and in microbicide development. We also need some new approaches, both in terms of

the science but also in terms of a much better coordination of the vaccine development efforts. We will try to do this through the Global HIV Vaccine Enterprise, whose board I will chair next year.

We have had two technological breakthroughs: the first was treatment. When I was a medical student and later as an infectious disease specialist, there was no treatment for viral infections. It was very difficult to conceptualize how to kill the virus without killing the host cell. Herpes simplex was the first viral infection for which we had some treatment available. With aids the whole field of antiretroviral therapy has advanced. It is one of the triumphs of pharmacological and antimicrobial research for the past 50 years.

The second is the demonstration that male circumcision is an effective way of reducing the risk for men to acquire hiv infection.

I'm proud that UNAIDS as a programme has always provided the most accurate information on the epidemic and the response. It has refined methods when needed, and stuck to scientific evidence and human rights as the main policy advice. Again, I would like to thank the board for supporting this approach throughout, even if sometimes it was not so easy for everybody to go along with what we as the Secretariat were proposing.

While we are struggling with expanding the response, reducing deaths and new infections, we also had to deal with some recurring myths. We have to understand them, as they will be important for how we shape the future response.

The first myth that I hear often is that aids is only an African problem, and we should not worry about the rest of the world. And that there's no heterosexual transmission outside of Africa and that heterosexual transmission is what matters.

The truth of course is different. Let's us not forget that countries with slower spread but with huge population denominators such as in Asia may at the end of the day have millions of people living with HIV. And if we don't take a long term look we might miss the boat.

In Southern African region, hiv is hyper endemic requires very specific approaches. This is different from the rest of the world, including from other parts of Africa. Recently several of us were in Dakar for the International Conference on AIDS and STIs in Africa (ICASA). The hiv prevalence rates in Senegal, Mali and other neighboring countries is lower than in the Canton de Genève, Washington DC or Harlem in New York. So Africa is also not one monolithic type of continent when it comes to aids.

But the fact remains that aids is universal – with multiple epidemics, diversity and an epidemic that is still evolving. Therefore, we absolutely need to keep the global coalition on AIDS going. We need global action. Anything that is reduced to a problem for just one continent is doomed to become marginalized, with many consequences. In addition you have to “Know your epidemic”. It is not just a slogan, but essential for effective action.

The second myth is that “prevention does not work”. Often the same people who claim this also say “if only you would do this, we could stop this epidemic”. And we have variations on the “if only” theme—if you *only* target sex workers and you don’t worry about anything else. If you *only* deal with concurrent partnerships than you will stop this epidemic. If you *only* circumcise men and nothing else, then we’ll stop the epidemic. Ignoring the fact that in major parts of the world, where few men are circumcised, and there have been are no major epidemics. The list goes on—if *only* you can test everybody or if *only* you treat everybody.

Each of these interventions has their own right role in the prevention strategy. But on their own they are not sufficient. Anything that has the word “*only*” in it doesn’t work for aids.

We had a period of abstinence only and it never worked. But it reflects I think, on the one hand, some true desperation with the lack of serious progress, or medical hubris which is always very prevalent in our business. It could also be the urge to sell a book. Donors also find it simpler to evaluate one specific thing. And it takes away from focusing on difficult issues such as gender, capacity building and ideological problems with social vulnerability.

The truth is that we need an optimal combination of activities to meet local needs and the local epidemics. So please, let us come to terms with complexity and accept it, just as it is for life. And let’s not complicate what’s simple and let’s not simplify what’s complicated.

The third myth is that promoting human rights, gender equality and tackling gender based violence is a waste of time and deterring us from what we really have to do—which is focus on medical interventions. The reality is that if we don’t deal with these issues our programmes will be sub-optimal and will not be effective.

We also have a broader agenda. That is why I do not want to talk about evidence-based approaches but about evidence-informed approaches. If we only go for evidence-based, it means we take a purely technocratic approach that does not include human values.

There is no evidence base to suggest that men and women are equal or that all human beings are equal, but we accept it. We don’t ask for control clinical trials to accept that. We need to act on the main drivers of this epidemic while at the same time do everything to reduce the immediate risk.

The fourth myth is that the aids response undermines health systems—a very popular debate in public health circles. First of all, there is no evidence for it.

The evidence shows that the impact of AIDS is neutral or in many cases strengthened health systems. I would say that because of the aids epidemic and the global response, the need to invest more in the health work force, in health systems has been highlighted. There are been other collateral benefits of the aids response.

The creation of the Global Fund is a good example. Tuberculosis and Malaria would never have had at the funding that they have today without the aids investments. So also let me remind people who think that reduced funding for aids will benefit their area of work that it is an illusion. What will happen is that there will be a decrease in funding for almost everything else.

PEPFAR and the Global Fund have played a major role in strengthening of health information systems, laboratories. This type of approach that focuses on results around a specific theme, and at the same time strengthening systems is fundamentally good development and good business practice. So we need to continue doing both.

The fifth myth—and we've gone through that yesterday a bit with Michel Kazatchkine—is that too much money is going into aids. My main response to this is that there is not enough money for aids and there is not enough money for other health and development issues too. However there is also unprecedented return on the investment when it comes to aids. Therefore, we need to join forces with all those who want to increase the pie for international development.

It is also important to recognize that both aids and the aids response have in many ways been transformational. As a disease, aids doesn't follow the patterns of other diseases in terms of poverty. For example maternal mortality, malaria, and mortality of children under-5 are all closely linked with poverty. That is not the case for aids. Aids is a disease of inequality but also of economic growth. It does not follow these patterns because it's about sex.

Margaret Chan, Director-General of WHO speaking at the 30th anniversary celebration of the Alma Alta "Health For All" movement said that the single most important change we've seen since the signing of the declaration is the onset of the aids epidemic and the global aids response.

Let me give you five examples of how aids and the response to it has been, transformational for public health, development, and the multilateral system.

First, we have taken resolutely a rights-based approach. One example is access to treatment. When the whole world was saying "this is too expensive", "the systems are not working", "there's no funding"—we said we will reduce the cost of drugs. We will make sure there is funding." So instead of the classic approach in public health and in development, which is cost containment and focusing on managing a certain amount of money, we approached it as a right and therefore set about finding the money. We made sure that the systems were being put in place and the resources available.

A rights-based approach also means community participation—"nothing for the people, without the people concerned." We can apply this principle to almost all development issues.

Now is also the time also for true efficiency gains. It's not enough to always call for more money, more money, certainly not in this kind of environment. We need to make sure that there is good value for money.

A second transformational nature in development as a result of the AIDS response has been to focus on results for people. Both are important. Results—as it makes programmes very target-oriented. People—so that the results are real. This is in contrast to decades of development and public health practice where the focus was on systems and processes. Of course they are also important but we forgot about what it's for. Why strengthen a system? It's for people. When you read a document from OECD it is all about the systems and the processes. We need results for people while simultaneously working on systems. This has been a major driver of the aids efforts and has also become an important tool for accountability. If you provide clarity about results and for whom, then there is accountability from all sides including from civil society.

Thirdly, as I mentioned before it has been a multi disciplinary, multi-sectoral and horizontal, networking type of movement. Last week when I was in Bamako, I saw a billboard outside the Ministry of Finance titled – Centre for Coordination of AIDS of the Ministry of Finance. When every ministry of finance has such a signpost, it means that we have penetrated the heart of the system.

The fourth transformational aspect of aids is that the global aids response has been inclusive. It has given voice to those without a voice. Civil society activism, including from most-marginalized populations such as migrants, the poor, sex workers, injecting drug users, and men who have sex with men, now find themselves in the UN General Assembly sharing a podium with a Prime Minister or President.

Finally the aids response is a truly global response with a unique connection between local and global. Aids has triggered one of the great international movements of our time, breaking down old barriers between “donor/recipients”. An event in any place in the world is immediately picked up by activists across the world and in turn creating a global movement.

At the same time aids has been a powerful agent for change—from exposing to overcoming injustices. Thanks to aids, issues around the health workforce crisis and the health systems crisis have been on the agenda. Many human rights issues including gay rights issues, women's rights, and gender-based violence are on the global agenda. Such principles can and should be used for other development issues.

We have tried to transform the way the UN system works—one of our two missions ECOSOC gave us. This proved to be an enormous challenge. How has the United Nations system or being part of the UN impacted UNAIDS? In some ways it gave us access, convening power and universality. In other ways it constrained us tremendously.

On the positive side – I believe that the UN was at its best as a convener. The UN General Assembly Special Session on HIV/AIDS in 2001 was a real tipping point. UNAIDS has been a real pioneer for delivering as one in the UN system. In many countries, the only real joint UN programme is the aids programme. We have brought civil society and business into the UN in genuine ways. And with the Three Ones we have resolutely pushed the UN towards greater harmonization and alignment.

This coordination often works best when it is informal, for example the work of the H8 (Health 8), which brings together the executives of seven multi-lateral health-related agencies and the Gates Foundation. We do business in a very fast way when it's informal.

On the difficult side a few points. One is that some of the UN country teams and theme groups are really disconnected from the country realities and strategies. They are perhaps delivering as one but becoming totally irrelevant inside the country in the process. You can be so well coordinated among yourselves but then for what?

Secondly, we have now joint planning and joint programming, but it has not always resulted in stopping individual planning in each agency. So in other words, just a layer has been added. When you go into a joint effort you need to let go of certain processes and that has not happened. It has become a major cause of frustration for staff as it increases their workload.

Thirdly, many organizations are still running projects and are more concerned about their logos, fundraising, and printing t-shirts rather than focusing on actual capacity building and doing up-stream work which is the main strength of the UN system.

And finally my biggest frustration has been our business practices in the UN system. I have hope that with the leadership of Thoraya Obaid in the High Level Committee on Management, some far-reaching reforms can be achieved.

Let me give three examples of how the current business practices have affected us. I do not mean to single out any agency. However WHO provides administrative support for UNAIDS. The Contract Review Committee in WHO is totally paranoid about any work with the private sector. This committee has consistently undermined us in forging partnerships with private companies. They have missed the fact that we are in the twenty-first century.

Another area is in human resource management. The Board of Appeal and the Administrative Tribunal in the UN system makes performance-based management close to impossible. We need to find ways of improving the business practices in human resource management and make drastic changes. Otherwise it will be like giving an aspirin to somebody who has pneumonia. The lack of incentives and rewards for those who are working hard are equally a problem.

Let me end now and look at the future challenges for UNAIDS. There are many, I will just give a few.

The first one is sustaining leadership and funding for AIDS. In these days of financial crisis, it is going to be extremely important and will probably require us to forge new alliances. And in crisis time we need to make sure that the investments in the aids response are not being lost. It is not just a matter about saving the lives today but also of maintaining the systems that have been developed and set up. These investments are going to be paying off far more now than they have been paying off in the last couple of years.

Secondly, we need to expand and do more of the same. That's particularly true for combination prevention. Mark Dybul said the way we are approaching treatment has evolved, we are becoming more and more efficient in delivery but that has not been the case in hiv prevention. It is time we bring in the professionals of behaviour change from the world of marketing and branding. They can provide us real time marketing research instead of demographic health surveys that are conducted every five years and are giving some very rough indicators. I think this is the future for hiv prevention.

Thirdly, we finally need to implement some science-informed policies. Here I would appeal to the Commission on Narcotics and Drugs to face reality and to fully embrace harm reduction and substitution therapy. Their concern should be saving lives and not engaging in legalistic arguments. The same thing is true about facing the reality of homosexuality in countries. As long as we have countries where sex between same sexes is illegal, it will be impossible to contain the spread of hiv in that population.

Fourth, another challenge, we cannot compromise is fulfilling human rights. The temptation to move away from a rights based approach always seems to be lurking, often coming from the medical side. We have to resist that, because its not only bad human rights but also bad public health.

Lastly a big challenge we are facing is capacity building. We must shift some of our funding from short term results to capacity building—be it monitoring and evaluation, civil society groups, or governments. In some countries civil societies have more capacity than governments, so we really need to invest there. Institutionally this will mean that the Global Fund and UNAIDS will have to come as close together as possible under the current institutional arrangements because that is going to make the money work, that is going to provide some efficiency gains.

So my main lesson of the last fourteen years is that we can move mountains if we have targets, a clear strategy build our work on science and we forge an effective alliance with multiple partners.

I was in Beijing during the Paralympics and there was this big slogan (the Legal Counsel of WHO will be upset as I am going to quote Adidas, a commercial company). That slogan was “Impossible is nothing” and that is actually what I think we have proved with the aids movement: Impossible is nothing.

We should continue on this road. Never wait until systems are fixed. Fight bad politics because they kill people. And support good politics because they save lives.

So this was my swan song. I’m sorry it was so long. It has been a privilege to serve as Executive Director of UNAIDS. It was completely different from what I expected as there were no role models to follow. I made many mistakes but I always tried to learn from them. And I am very grateful to the support in the first place from all the people I work with and from all of you – the PCB members and your predecessors. Without an active board we could not have moved. Every time we got stuck in the UN system, the PCB was there to push us and to say “Yes, you have to go in this direction.”

When I got into this job I fought for two things before I accepted it. The first was “Who’s my boss?” and the second was “Who has the right to hire and fire?”

The original plan was for my boss to be the collective UN system. And my position was that you cannot be judge and jury. Only the stakeholders – member states and NGOs can be my boss, because that’s where the accountability lies. It required an ECOSOC resolution for that to be clarified.

And the right to hire and fire was about being responsible for the management of the organization. And not having every single small decision go through endless committees in the UN system.

So thank you for all your support. I am asking you to support Michel Sidibé to the same extent that you have supported me. Also because I think that there will be difficult times ahead—there have always been difficult times with aids anyway but they will be different and hard.

I’m leaving UNAIDS, but I am not leaving the aids cause – that’s impossible. I was there before UNAIDS existed and I’ll continue. I am going back to where I came from, civil society, so watch out, may be one day I’ll be sitting on these banks.

And I will miss you all.

Thank you very much.